

Ministerial Advisory Panel on Voluntary Assisted Dying

Final Report



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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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ISBN 978-0-7311-7281-8 (Print)

ISBN 978-0-7311-7282-5 (pdf/online)

Available at <https://www2.health.vic.gov.au/about/health-strategies/voluntary-assisted-dying-bill>

Printed by Kosdown Printing, 10 Rocklea Dr, Port Melbourne VIC 3207
(1707022)

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Letter from the Chair

21 July 2017

The Hon. Jill Hennessy MP
Minister for Health
50 Lonsdale Street
Melbourne VIC 3000

Dear Minister Hennessy

On behalf of the Panel, I am pleased to provide you with our final report detailing a safe and compassionate framework for voluntary assisted dying in Victoria.

This report is the result of an extensive consultation process and considered deliberation. The Panel received a broad range of written submissions and contributions from forums the Panel held around Victoria. These contributions have informed our thinking and been crucial in determining our recommendations. We are grateful to the many stakeholders who participated in the consultation process; their participation was constructive and respectful.

The Panel is conscious of the sensitive nature of this topic and the diversity of opinions regarding whether voluntary assisted dying should be established in Victoria. We also appreciate how important and significant this legislation is for many Victorians.

Our work builds on the recommendations of the Victorian Parliament's Legal and Social Issues Committee in their *Inquiry into End of Life Choices: final report*. We have also reviewed a broad range of relevant local and international research and considered similar frameworks in international jurisdictions. While we have benefited from this knowledge, we have focussed on developing a framework that is most appropriate for the Victorian context.

The framework proposed by the Panel will provide access to voluntary assisted dying for those people, and only those people, who are at the end of their lives and suffering, to choose the timing and manner of their death. The request and assessment process the Panel has set out ensures that only those people who satisfy all of the eligibility criteria will be able to access voluntary assisted dying.

The framework focuses on the eligible person who expresses their enduring wish to end their own suffering through access to voluntary assisted dying. It respects their personal autonomy and choice. That autonomy must of course be balanced against the safety of the community. We seek to provide a compassionate outcome for those people who are at the end of their life, while also addressing the concerns of the community.

Providing a safe framework for Victorians has been our paramount consideration. While the Panel has sought to not place undue burden on a person who is suffering at the end of their life, the framework includes a prescriptive multi-stage assessment process with numerous safeguards and comprehensive oversight.

We have also aimed to provide a framework that will function appropriately for eligible people with a range of non-cancer and cancer-related conditions, regardless of their geographical location in Victoria or their clinical setting. This framework also supports existing therapeutic relationships between the person and their health practitioner.

The Panel is also cognisant that voluntary assisted dying will impact on others; in particular, families and health practitioners. We have recommended a framework in which medical practitioners play a key role in supporting the person and undertaking the assessment process. The framework is based primarily on self-administration of a lethal dose of medication, however in very limited cases, where a person is unable to self-administer, a medical practitioner may administer the medication at the request of the person.

It has been important for the Panel to provide clarity about the obligations of, and protections for, health practitioners, including the ability to conscientiously object.

The Panel is aware of the significance of this issue for all Victorians. We understand that parliamentarians will be asked to debate a voluntary assisted dying bill later this year and will vote on their conscience. I hope that this report provides confidence to Victoria's parliamentarians that a thorough process has been undertaken to understand, consider and address all of the relevant issues to ensure a safe and compassionate framework.

The Panel has had the benefit of a skilled and dedicated staff who have worked extremely hard throughout the consultation process and in writing this report. On behalf of the Panel I sincerely thank each of them for their work and support.

I would like to thank the members of the Panel for their contributions and application to the task that we were given. Their diverse professional backgrounds and expertise have been a strength of this process and are reflected in the recommendations.

Sincerely



Professor Brian Owler

Chair

Ministerial Advisory Panel

The Ministerial Advisory Panel



Professor
Brian Owler
Chair

Clinical Professor Brian Owler is an adult and paediatric neurosurgeon based in Sydney. He is a Fellow of the Royal Australasian College of Surgeons and was Federal President of the Australian Medical Association from 2014 to 2016. He has a broad knowledge of Australia's healthcare system through his AMA experience and roles with other healthcare organisations and committees.



Professor
Margaret O'Connor
AM
Deputy Chair

Professor Margaret O'Connor AM is Emeritus Professor of Nursing at Monash University. She has worked in numerous roles in palliative care, encompassing clinical care, management of services, education and research. Professor O'Connor served as President of Palliative Care Australia from 2006 to 2010 and was an Inaugural Trustee of the World Palliative Care Alliance. She has also served as a Member of the Australian Health Ethics Committee of the National Health and Medical Research Council.

In 2005 Professor O'Connor was awarded a Member of the Order of Australia and in 2012 was awarded life membership of Palliative Care Victoria.



Ms Mary Draper
Member

Ms Mary Draper is a Board Director at Austin Health and immediate past CEO of the Health Issues Centre. She has expertise in academic and practical health administration in quality and safety, providing experience in analysing quality and safety of healthcare from a consumer's point of view. Ms Draper served as the Chair of the Health Issues Centre prior to serving as CEO until November 2014.

Ms Draper has experience representing consumer perspectives on a range of quality-related national and state-level committees and for seven years was the Director of Clinical Governance at the Royal Women's Hospital.



Mr Julian Gardner
AM
Member

Mr Julian Gardner AM is a lawyer and immediate past Victorian Public Advocate, providing experience in advocating for vulnerable people. Mr Gardner has previously served as President of the Mental Health Review Board, been the National Convenor of the Social Security Appeals Tribunal, Chair of the WorkCare Appeals Board and a Director of the Victorian Legal Aid Commission.

Mr Gardner is currently the Chair of Mind Australia Ltd, a non-government organisation providing community mental health services and the Deputy Chair of Alfred Health.



Dr
Roger Hunt
Member

Dr Roger Hunt is a palliative medicine consultant who has been a pioneer of palliative care in South Australia. Dr Hunt is a Founding Member of Daw House Hospice and Founding Fellow of the Chapter of Palliative Medicine, and was awarded a doctorate in medicine for published research: '*Epidemiology of terminal care in SA.*' Dr Hunt is also a Senior Lecturer at the University of Adelaide and has developed postgraduate courses at Flinders University.

Dr Hunt has been the Director of a major metropolitan palliative care service for 10 years and is the former Chair and Honourary Life Member of the Palliative Care Council for services to palliative care.



Emeritus Professor
Ian Maddocks AM
Member

Emeritus Professor Ian Maddocks AM was appointed to the first Chair of Palliative Care established at Flinders University. He was the first President of the Australian Association for Hospice and Palliative Care and the first President of the Australian and New Zealand Society for Palliative Medicine. He was a specialist physician in the Australian Administration of Papua New Guinea for 14 years.

Emeritus Professor Maddocks led concern for the prevention of war as President of Australia's Medical Association for Prevention of War and Vice President of International Physicians for Prevention of Nuclear War in 1985, when it received the Nobel Prize for Peace.

Emeritus Professor Maddocks chaired the National Consultative Committee for Peace and Disarmament from 1990 to 2002 and in 2013 he was the National Recipient of the Senior Australian of the Year Award for his lifetime of achievements.



Ms Tricia Malowney
OAM
Member

Ms Tricia Malowney OAM is a health advocate for women with disabilities and was the Inaugural President of the Victorian Disability Services Board. She was also the Deputy Chair of the Victorian Disability Advisory Council.

Ms Malowney is currently the Board Chair of Independent Disability Services and a Board Director for Scope Disability Services and the Australian Orthotics and Prosthetics Association. She is a member of Women with Disabilities Victoria and the Disability Leadership Institute.

In 2008 Ms Malowney was awarded Rotary Australia's Shine On Award for services to Victorians with disabilities and in 2013 was inducted into the Victorian Honour Roll of Women for services to women with disabilities. In 2015 Ms Malowney travelled to Ireland on an Ethel Temby grant to research access to mainstream services for people with disabilities. Ms Malowney was awarded an OAM in 2017 in recognition of her service to people with a disability through advocacy roles.

Terms of reference

Taking the assisted dying framework as outlined by the Legal and Social Issues Committee (the Parliamentary Committee) as the starting point, the Panel's task is to provide advice to government about how a compassionate and safe legislative framework for voluntary assisted dying could be implemented. This will include how it could be implemented in Victoria to provide access to eligible people while minimising risks to potentially vulnerable people.

The Panel will provide an interim report at three months and a final report at six months.

The Panel is asked to consider relevant policy and legal issues including:

- a) The terms used in the final report and the necessary definitions required for the drafting of appropriately clear legislation such as:
 - 'irreparable decline'
 - 'a serious and incurable condition'
 - when a person may be 'physically unable to administer medication'
 - any other key terms or concepts the Panel considers relevant.
- b) The eligibility criteria and how this can be clearly defined in a legislative framework.
- c) The risks to individuals and the community associated with voluntary assisted dying, and how these can be managed.
- d) Safeguards to address risks and procedures for assessing requests for voluntary assisted dying.
- e) The protection of medical practitioners' freedom of conscience.
- f) The appropriate oversight mechanisms.
- g) Integration with existing laws and agencies.
- h) Interaction with the existing healthcare system, including consideration of the necessary clinical and consumer tools and resources and appropriate community information and support.

While the Parliamentary Committee sets out a broad overview of an assisted dying framework in its final report, there is little practical detail about a number of important issues that need to be resolved in developing compassionate and safe voluntary assisted dying legislation. For example, further consideration needs to be given to:

- defining the phrases that would define the scope of voluntary assisted dying
- existing clinical and consumer tools or approaches that have been shown to support medical practitioners and consumers to engage in purposeful conversations for assessment proposes when someone requests voluntary assisted dying

- how the lethal medication would be monitored and prescribed, including the impact Commonwealth regulations may have on accessing and authorising whichever medication is chosen
- how qualification requirements for medical practitioners practising voluntary assisted dying in Victoria would be assessed or registered
- how the public safety challenges of prescribing lethal medication to be taken at a later date and in a non-regulated location (for example, in someone's home) would be managed
- how the administration of the lethal medication to a person physically unable to administer it themselves should be regulated
- how the process for consent and how the interaction with other health services would be managed, including protocols for information sharing to ensure a coordinated system response to an individual who takes the lethal medication
- how deaths as a result of voluntary assisted dying would be monitored or notified
- what type of regulations and powers would be required for a voluntary assisted dying review board to undertake its functions as outlined in the framework
- other terms and issues as identified.

Importantly, the Voluntary Assisted Dying Bill is being developed within the government's broader reform in end-of-life care, which is designed to improve access to end-of-life and palliative care services and give statutory recognition to advance care directives that provide genuine choice and treatment options for people approaching the end of their lives.

A note on language

Voluntary assisted dying is a contentious issue that demonstrates the diversity of views and values held by people in Victoria. The Panel recognises the broad spectrum of views expressed during the Panel's consultation process and is grateful for the constructive conversations that occurred. These diverse views are often reflected in the way people describe voluntary assisted dying. The Panel recognises that language is used to imply judgements about something through its description. As voluntary assisted dying has been discussed in communities throughout history, a range of terms have been developed to describe the process. Each of these suggests some form of value judgement about the process, but also frames who is perceived to be in control of the process and what is perceived to be occurring. The Panel is of the view that it is important to appropriately describe voluntary assisted dying to avoid unnecessary stigmatisation and to ensure the emphasis is on the person.

Euthanasia

Euthanasia refers to the situation when death is induced to relieve suffering. The term derives from the Greek for 'good death'. The term, however, can carry connotations of something good as well as something bad, because of its historic abuse in involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. Many people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. This is usually a comfort to family members who are relieved to see their family pet not suffer further, but it is not something where the family pet has a say. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient.

Dying with dignity

Often advocacy groups use the term 'dying with dignity' to describe voluntary assisted dying. The Panel reject this label for voluntary assisted dying. The Panel is of the view that using the term 'dignity' is problematic because it implies that people in similar circumstances who do not choose voluntary assisted dying are living, and will die, in an 'undignified' manner. Many people, and their families, who are being supported by palliative care would say this support enables them to have a 'dignified' death.

Dignity is a personal characteristic. It cannot be conferred on someone because they have made a particular choice about how they want to die. Many people would prefer to live as long as possible, even with a painful disease or disability; this is not 'undignified'. Voluntary assisted dying allows individuals to make choices about the end of their life. The focus is on individual choice because there is no right or wrong answer, and an individual is best placed to decide what is most appropriate for them. Suggesting there is dignity in choosing voluntary assisted dying, but not in other choices people make about how they want to live or die, suggests there is a 'right' and 'wrong' approach. Dying with dignity is not simply a quality of a particular choice about how a person dies; human dignity is inherent.

Assisted suicide

Some jurisdictions use the term 'assisted suicide'. This places the emphasis back on the person and recognises their active decision making and involvement. There is, however, significant social stigma attached to the term 'suicide'. In Victoria there is a range of critical work being undertaken to prevent suicide and to support those who may be considering suicide. Deaths as a result of suicide are avoidable, and every effort should be made to prevent these deaths. By contrast, the cohort of people who are the focus of this report will face an inevitable, imminent death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe their decision to hasten their impending death. For this reason, the Panel is of the view that the term 'assisted suicide' is not an appropriate term.

Assisted dying

Assisted dying is the term adopted by the Parliamentary Committee. Some US jurisdictions use the term 'physician assisted dying', which emphasises the role of the medical practitioner, rather than the decision and actions of the person. In a small number of circumstances, where a person has decision-making capacity in relation to voluntary assisted dying but cannot self-administer the lethal dose of medication, the Parliamentary Committee recommended there is provision for a medical practitioner to administer the medication. From a medical practitioner's perspective, this may be described as euthanasia. From the person's perspective, this is also assisted dying. The person has made a decision about the timing and manner of their death; however, they are physically unable to self-administer the medication. Labelling this euthanasia disempowers the person and suggests that because they are physically unable to administer the medication, they require the merciful action of a medical practitioner. The Panel is of the view that it is important to emphasise that even if a person is not physically able to self-administer the medication, they are in control of the decision and the process.

Voluntary assisted dying

The Panel uses the words 'voluntary assisted dying'. This puts the focus on the term 'voluntary' as an emphatic statement that this is a decision initiated by a person who is suffering and who takes responsibility for the decision. The Panel is of the view that voluntary assisted dying appropriately reflects a person-centred approach and also reflects the reality of the situation of those who will be eligible to access voluntary assisted dying.

Person-centred

Like the Parliamentary Committee, the Panel recognises that end-of-life care needs to be person-centred. Person-centred care is a philosophical approach to service development and delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for them.¹ The Panel has used the word 'person' throughout the report as this implies a degree of agency and autonomy that the words 'patient' or 'client' do not. The term 'patient' is used to signify the importance of the health practitioner-patient therapeutic relationship.

People also make decisions and choices about the end of their life based on what a good death looks like for them. How a person defines 'a good death' will depend on their preferences, needs and values. Reports highlight that people define a good death in a way that includes more than just being free of pain, and three themes consistently emerge – control, autonomy and independence.² These themes form part of a report by Age Concern England that describe what a good death may look like and include: knowing and understanding what to expect; dignity and privacy; symptom and pain relief; access to information; emotional support and palliative care; having your wishes respected; having control of who is present and having time to say goodbye; to be able to leave when it is time to go; and not to have life prolonged pointlessly.³

The Panel is of the view that these principles should be incorporated into the provision of all person-centred end-of-life care, regardless of the choices people may make about the timing and manner of their death.

1 Valuing People, What is person-centred care?, Alzheimer's Australia, <<http://valuingpeople.org.au/the-resource/what-is-person-centred-care>>.

2 Smith, R (2000), 'A good death', *British Medical Journal*, vol. 320, no. 7228, pp. 129–130; Health Care Group, Debate of the Age (1999), *The future of health and care of older people: the best is yet to come*, Age Concern England, London, <<http://www.remedypartners.com/wp-content/uploads/2016/09/TheFutureofHealthandCareofOlderPeople.pdf>>.

3 Health Care Group, Debate of the Age (1999), *The future of health and care of older people: the best is yet to come*, Age Concern England, London, <<http://www.remedypartners.com/wp-content/uploads/2016/09/TheFutureofHealthandCareofOlderPeople.pdf>>.

Executive summary

Context

The Voluntary Assisted Dying Ministerial Advisory Panel (the Panel) was given the responsibility of developing a safe and compassionate voluntary assisted dying framework for Victoria. An outline was proposed by the Legislative Council's Legal and Social Issues Committee (the Parliamentary Committee) *Inquiry into End of Life Choices*.⁴ The Parliamentary Committee provided a broad policy direction for voluntary assisted dying that focused on allowing a person to self-administer a lethal dose of medication. The role of the Panel was to consider how this could work in practice and to ensure only those making voluntary and informed decisions and at the end of their life could access voluntary assisted dying.

Following its extensive *Inquiry into end of life choices*, the Parliamentary Committee made 49 recommendations, 48 of which related to palliative care and advance care planning. The 49th recommendation outlined their proposal for legalising voluntary assisted dying in Victoria.

The Panel supports the recommended improvements for palliative care and advance care planning, noting that the reforms will ensure people have genuine choice at the end of their life. While the Panel is of the view that voluntary assisted dying implementation should be considered in the context of existing care options available to people at the end of life, detailed consideration of the other 48 recommendations made by the Parliamentary Committee is beyond the Panel's terms of reference.

Consultation

The Panel's recommendations are informed by an extensive consultation process. In January 2017 the Panel released the *Voluntary Assisted Dying Bill Discussion Paper*,⁵ which received 176 submissions. The Panel also conducted 14 forums and a series of roundtables with more than 300 stakeholders across Victoria. This process enabled constructive, open and informative discussions with people who held a broad spectrum of views about voluntary assisted dying.

The forums allowed participants to voice their concerns, ideas and diverse experiences, and to hear responses directly from members of the Panel. The Panel respects the way participants in the forums and roundtable discussions engaged with the process to offer their considered input, reflecting their particular expertise and experience.

Feedback from the consultation process is summarised in the Panel's Interim Report, which was provided to the Minister for Health in April 2017 and publicly released on 17 May 2017.⁶

4 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

5 Voluntary Assisted Dying Ministerial Advisory Panel (2017), *Voluntary Assisted Dying Bill: discussion paper*, Department of Health and Human Services, State of Victoria, Melbourne, viewed 13 February 2017, <<https://www2.health.vic.gov.au/about/publications/researchandreports/voluntary-assisted-dying-bill-discussion-paper>>.

6 Voluntary Assisted Dying Ministerial Advisory Panel (2017), *Interim report of the Ministerial Advisory Panel: consultation overview: Voluntary Assisted Dying Bill*, Department of Health and Human Services, State of Victoria, Melbourne, viewed 20 May 2017, <<https://www2.health.vic.gov.au/about/health-strategies/voluntary-assisted-dying-bill>>.

The Panel did not repeat the consultations conducted by the Parliamentary Committee, who received over 1,000 submissions and conducted numerous hearings. The Parliamentary Committee recommended that Victoria introduce voluntary assisted dying; the role of the Panel was to consider how this could work in practice. This is why the Panel did not consider opinions for or against voluntary assisted dying – this question was beyond the scope of the Panel’s terms of reference, which are about developing a safe and compassionate framework.

Guiding principles

In formulating its recommendations, the Panel relied on a number of guiding principles. These principles are that:

- Every human life has equal value.
- A person’s autonomy should be respected.
- A person has the right to be supported in making informed decisions about their medical treatment and should be given, in a manner that they understand, information about medical treatment options, including comfort and palliative care.
- Every person approaching the end of life should have access to quality care to minimise their suffering and maximise their quality of life.
- The therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.
- Open discussions about death and dying and peoples’ preferences and values should be encouraged and promoted.
- Conversations about treatment and care preferences between the health practitioner, a person and their family, carers and community should be supported.
- Providing people with genuine choice must be balanced with the need to safeguard people who might be subject to abuse.
- All people, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

The Panel recognises the need to balance respect for autonomy with safeguarding individuals and communities in relation to voluntary assisted dying. The Panel is of the view that the eligibility criteria, the process to access voluntary assisted dying, and the oversight measures recommended appropriately balance these aims.

Report structure

The report explains the detailed considerations of the Panel. The voluntary assisted dying recommendation set out by the Parliamentary Committee is the starting point for each of the discussions. The Panel considers the consultation feedback, and reviews the research, the evidence and the experience of other jurisdictions where this is relevant.

The Panel provides recommendations for the development of safe and compassionate voluntary assisted dying legislation that can be applied and understood by people and health practitioners in a range of clinical settings.

Part A provides details on the Panel's recommendations in relation to the eligibility criteria, focusing on the person, the disease, and the circumstances in which a person may be eligible for voluntary assisted dying.

Part B sets out the request and assessment process from the perspective of the person making a request, as well as a medical practitioner's perspective, and describes the requirements and steps the person must go through to access voluntary assisted dying.

Part C sets out the oversight and governance arrangements that provide protections to keep the community safe, including the establishment of a Voluntary Assisted Dying Review Board, reporting requirements, and new offences related to voluntary assisted dying.

This part also sets out the reporting obligations of health practitioners to the Voluntary Assisted Dying Review Board, and the Board's obligations for public reporting.

Part D considers the implementation of voluntary assisted dying within the context of existing care options and sets out recommendations to ensure the implementation of voluntary assisted dying is resourced appropriately, including the development of workforce support, information and guidance materials.

The final report also includes case studies to illustrate how the recommended framework will work in practice. The central case studies focus on people suffering from cancer and motor neurone disease because the experience in international jurisdictions suggests that it will predominantly be people with these conditions requesting voluntary assisted dying.

A summary of the framework is presented in Appendix 1. Appendix 2 describes how Victoria's *Charter of Human Rights and Responsibilities* informed the Panel's deliberations. Appendix 3 compares the 68 safeguards embedded in the proposed voluntary assisted dying framework with other international voluntary assisted dying legislation.

The Panel presents its final report confident that the recommendations it has made will inform safe and compassionate voluntary assisted dying legislation that embeds safeguards, checks and balances at every point of the voluntary assisted dying process.

Part A: Eligibility criteria

Part A sets out the Panel's recommendations on the eligibility criteria for voluntary assisted dying.

The eligibility criteria recommended by the Panel follows the eligibility criteria proposed by the Parliamentary Committee. The Panel has refined the criteria and language to ensure it provides certainty and clarity to the community and health practitioners in Victoria about the circumstances in which a person can request voluntary assisted dying. The eligibility criteria limit voluntary assisted dying to adults who are suffering at the end of their life.

The Panel recommends that to access voluntary assisted dying a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The recommended eligibility criteria ensure voluntary assisted dying will allow a small number of people, at the end of their lives, to choose the timing and manner of their death. There is no intention to give people who are not dying access, and the legislation will not give these people an option to choose between living and dying. The eligibility criteria ensure the voluntary assisted dying framework provides a compassionate response to people who are close to death and choose to request voluntary assisted dying to give them greater control over the timing and manner of their death.

The Panel recommends that a person must have decision-making capacity throughout the voluntary assisted dying process. This requirement is fundamental to ensuring a person's decision to access voluntary assisted dying is their own, is voluntary, and is not the product of undue influence or coercion. The Panel recognises that this will mean some people who may want to request voluntary assisted dying will be excluded. People with dementia who do not have decision-making capacity, for example, will not be able to access voluntary assisted dying. People will also not be able to request voluntary assisted dying in an advance care directive. This may disappoint many people in the community, but the Panel is of the view that having decision-making capacity throughout the voluntary assisted dying process is a fundamental safeguard.



The Parliamentary Committee recommended that only those at the end of life, in the final weeks or months, be eligible to access voluntary assisted dying. The Panel supports this restriction, and recommends a more defined limit. During consultations it was clear that the period of time included in 'final weeks or months' could be interpreted very differently. The Panel recommends that only those whose disease, illness or condition is expected to cause death within no longer than 12 months be eligible for voluntary assisted dying. This will ensure clarity and is consistent with Victorian practice in defining the end of life.

Consistent with the Parliamentary Committee recommendation, the Panel also recommends that mental illness alone should not satisfy the eligibility criteria. The Panel makes an additional recommendation that disability alone should not satisfy the eligibility criteria. This is because the voluntary assisted dying framework is for people who are suffering at the end of their life. The Panel does, however, recognise that if a person fulfils all the eligibility criteria, the fact that they have a mental illness or a disability should not exclude them from accessing voluntary assisted dying.

The refined eligibility criteria remain consistent with those proposed by the Parliamentary Committee. Access is limited to people with an incurable disease, illness or medical condition who are in their final weeks or months of life. The objective clinical assessment of the diagnosis and prognosis has been retained.

Like the Parliamentary Committee, the Panel is of the view that suffering should always be judged by the person themselves. The Panel has taken into account the research that suffering has psychological, social and spiritual aspects as well as physical symptoms such as pain, breathlessness and nausea, and that loss of autonomy or control can also contribute to a person's suffering. The Panel recognises that perceptions and judgements about suffering are inherently individual and subjective.

The Panel is of the view that clear and precise eligibility criteria set out in legislation will prevent any expansion of voluntary assisted dying or any unintended 'scope creep'. The eligibility criteria recommended by the Panel ensure voluntary assisted dying is only available to those who are already at the end of their life and are suffering. With such robust and limited eligibility criteria, the only way to expand the scope of voluntary assisted dying in the future would be to pass new legislation.

The Panel emphasises that *all* of the eligibility criteria must be taken together, and that none of the criteria in isolation is sufficient for a person to be eligible to access voluntary assisted dying.

Part B: Request and assessment process

Part B sets out the request and assessment process from the perspective of the person making a request, as well as a medical practitioner's perspective, and describes the requirements and steps the person must go through to access voluntary assisted dying. Part B describes:

- initiating a request;
- receiving a request;
- making a request; and
- completing the voluntary assisted dying process.

The Panel recommends a prescriptive process that will ensure requests are voluntary, well-considered and enduring, and that only those who meet all of the eligibility criteria will be able to access voluntary assisted dying.

The Panel is also aware that voluntary assisted dying legislation will need to clearly step out the request and assessment process in order to provide health practitioners with clarity about their obligations and ensure it is applicable in a range of clinical settings.

The process recommended by the Panel provides a balance between allowing people to make autonomous decisions and recognising that safeguards are required to ensure these decisions are voluntary and properly informed. The process requires the person to make three separate requests for voluntary assisted dying and undergo two independent medical assessments to ensure the eligibility criteria are met and the person is properly informed about their options. There are a number of steps in the process to identify any coercion or undue influence.

The Panel is of the view that a person should be able to seek information about voluntary assisted dying with a medical practitioner they trust and with whom they feel comfortable before beginning a formal process to access voluntary assisted dying. This will allow a person to consider information without feeling pressured to commence the process. To prevent coercion or inadvertent pressure, a health practitioner will not be able to raise or initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

A person should be able to seek information from, and make a first verbal request to, a medical practitioner with whom they have a therapeutic relationship. If a person requests voluntary assisted dying, a medical practitioner must determine whether they will accept the role of coordinating medical practitioner. This role will require them to coordinate the process and is designed to ensure the person is supported.

The Panel recommends that all health practitioners have the option to conscientiously object to participating in the voluntary assisted dying process. Consistent with existing standards of care, this conscientious objection must not impede a person's access to what would be a legal medical treatment.



The coordinating medical practitioner will be required to conduct the first assessment of the eligibility criteria and to ensure the person is properly informed. If the person meets the eligibility criteria, the coordinating medical practitioner must refer the person to another medical practitioner. The second medical practitioner will become the 'consulting medical practitioner' if they accept the role. They will be required to conduct a second, independent assessment.

The Panel recommends minimum qualifications for medical practitioners involved in voluntary assisted dying. The assessment of the eligibility criteria and conversations about voluntary assisted dying and end of life will require specific experience. The Panel recommends that both assessing medical practitioners must be qualified as Fellows of a College (or vocationally registered) and that at least one of the medical practitioners has at least five years of post-fellowship experience and at least one must have relevant expertise in the person's disease, illness or medical condition.⁷ Prior to conducting an assessment, both medical practitioners will be required to undertake specified training. This will ensure they understand the eligibility criteria and their legal obligations.

If a medical practitioner assesses a person as ineligible, the person may seek a second opinion. The Panel is of the view that this standard medical practice is part of person-centred care and allows people to ensure the issues that concern them are addressed. Given the review of each assessment by the Voluntary Assisted Dying Review Board and potential for professional misconduct or criminal charges, the Panel is confident that medical practitioners will comply with the legislative framework and attempts to 'doctor shop' will be identified.

If both medical practitioners assess a person as eligible for voluntary assisted dying, the person will be required to complete a written declaration to proceed. This will clearly demonstrate the person understands their decision. The declaration will need to be signed by the person and witnessed by two independent witnesses in the presence of the coordinating medical practitioner. The written declaration represents a lasting statement of the person's enduring request.

The person must then make a final verbal request for voluntary assisted dying to their coordinating medical practitioner and appoint a contact person. The final request must be at least 10 days after the first request. The Panel also took into account those exceptional circumstances in which a person's death will occur within 10 days and that it would be unreasonable to preclude them from accessing voluntary assisted dying. In these instances the Panel recommends that the coordinating medical practitioner may waive the 10 day time period if their prognosis is consistent with the prognosis of the consulting medical practitioner. As a clear safeguard, under no circumstances will a person be able to make a final request on the same day as the second independent assessment.

⁷ To obtain Fellowship of a College a medical practitioner must complete additional years of training in a specific field, whilst working as a medical practitioner, and must be accepted into the College after passing additional exams.

As part of the request and assessment process, the person will also be required to appoint a contact person. The contact person will take responsibility for the return of any unused lethal dose of medication after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board. The coordinating medical practitioner must then complete a final check, which will require the practitioner to certify that each step in the process has been completed.

Before writing the prescription, the coordinating medical practitioner will be required to apply for a permit from the Department of Health and Human Services. This process will be similar to the current authorisation process for other restricted drugs and provides an opportunity for an independent check that the process has been complied with before the person accesses the lethal dose of medication.

The lethal dose of medication will be dispensed by a pharmacist, who will be required to appropriately label the medication and inform the person of their obligations to safely store the medication. The pharmacist will only dispense the medication if there is a valid permit issued by the Department of Health and Human Services. This provides another independent check to ensure compliance with the legal requirements. The person will be required to store the medication in a locked box until they decide to self-administer the medication.

The Panel makes a series of recommendations about how the lethal dose of medication is prescribed, dispensed and reported on. These recommendations create a number of protections to ensure safety through constant monitoring of the lethal dose of medication, with a clear line of accountability.

The Panel has recommended protection for health practitioners who may be present when the person self-administers the medication. The Panel understands that for some people this will provide a sense of comfort, while others may want to self-administer the medication without health practitioners present.

The only circumstances in which a medical practitioner will be authorised to administer the lethal dose of medication will be if the person is physically unable to self-administer or digest the medication. In these circumstances, only the coordinating medical practitioner will be authorised to administer the medication. While this option ensures voluntary assisted dying is not discriminatory, the Panel is of the view that it is important to limit the authorisation to administer the medication. The coordinating medical practitioner may only administer the lethal dose of medication at the request of the person and this must occur in the presence of an independent witness. If the coordinating medical practitioner is unwilling or unable to administer the medication, they may transfer the role to the consulting medical practitioner. This can only occur if the consulting medical practitioner accepts the role.

The entire request and assessment process is designed to ensure voluntary and informed decisions, and to identify and prevent potential abuse. The Panel recognises the risk that vulnerable people may be pushed or coerced into requesting voluntary assisted dying but is confident the recommended framework will identify and address instances of abuse.

Part C: Oversight

In addition to providing a clear and compassionate framework for the operation and monitoring of voluntary assisted dying, the Panel recognises that the legislation must also establish protections to keep people who may be vulnerable to abuse safe.

Part C describes:

- protections and offences;
- the establishment of the Voluntary Assisted Dying Review Board;
- medication monitoring;
- monitoring after the person has died;
- monitoring voluntary assisted dying activity; and
- a summary of the legislative safeguards.

The Panel's recommended framework establishes a system of oversight for the entire process and of continuous monitoring of the lethal dose of medication. The process recommended by the Panel includes a series of checks involving a number of health practitioners, the Department of Health and Human Services, and independent witnesses. The system of oversight recommended by the Panel provides an additional level of protection through the review of all voluntary assisted dying activity, not just those cases where voluntary assisted dying is completed.

The Panel recommends the establishment of the Voluntary Assisted Dying Review Board (the Board). The Board will oversee the voluntary assisted dying framework and review every case and every assessment conducted by a medical practitioner to ensure compliance with the statutory requirements. Consistent with the recommendation of the Parliamentary Committee, the Board will not have the power to veto requests or arbitrate appeals.

The Panel considered the options and recommends that the Board is established as a statutory entity to provide strong governance arrangements as part of the legislative framework under which an oversight body operates. The independence of a statutory body will ensure transparency with respect to its operations.

Both the coordinating and consulting medical practitioners will have mandatory requirements to report to the Board. The dispensing pharmacist will also be required to report to the Board, as will the Department of Health and Human Services when a permit is issued. The medical practitioner who certifies the person's death will also be required to report voluntary assisted dying to the Victorian Registrar of Births, Deaths and Marriages, who will report this to the Board. These independent reporting points will ensure the Board is able to accurately review what occurred in each case, and the Board will be able to seek further information if required.

If the Board identifies any improper conduct or potential criminal action, it will be required to refer the matter to Victoria Police, the Australian Health Practitioner Regulation Agency, or the Coroner. The Panel is of the view that these existing bodies should be utilised to investigate wrongdoing, as they already have clearly understood roles and responsibilities. The Board will not only monitor completed cases, but also every assessment for voluntary assisted dying.

The Board will also monitor the lethal dose of medication to make sure it is returned if it is not self-administered. The Panel recommend a requirement to appoint a contact person, who will have clear legal obligations to return any unused medication. The person accessing voluntary assisted dying will be required to appoint a contact person before they are prescribed the lethal dose of medication. The contact person must agree to return any unused medication to the dispensing pharmacist to be destroyed after the person has died.

The Board will receive a report from the pharmacist when the medication is dispensed and when any unused medication is returned. If the medication is not returned, or it is not known whether the person self-administered the medication, the Board will be able to follow up with the contact person. Information from the notification of death will be shared with the Board by the Registrar of Births, Deaths and Marriages. This will enable the Board to follow up a notification that the medication was not self-administered.

Although the Registrar of Births, Deaths and Marriages will obtain information about voluntary assisted dying, the Panel recommends that this not be included on the person's death certificate. Death certificates are used for a range of purposes, and there is no reason to include information about voluntary assisted dying on such a public document. Other information about treatment at the end of a person's life is not included in a person's death certificate. To preserve the privacy of the person, their family, and health practitioners, information about voluntary assisted dying also should not be included. Instead, this information about voluntary assisted dying will be provided to the Board.

The Panel has also recommended a range of new offences that relate specifically to voluntary assisted dying to ensure people are protected. This includes new offences of inducing a person, through dishonesty or undue influence, to request voluntary assisted dying or to self-administer the lethal dose of medication. Other recommended offences include falsifying records related to voluntary assisted dying and failing to report on voluntary assisted dying. These new offences signal the serious nature of any wrongdoing associated with voluntary assisted dying.

Part D: Implementation

Part D sets out the implementation considerations if voluntary assisted dying legislation is passed by the Victorian Parliament. The Part describes:

- voluntary assisted dying in the context of existing care options;
- implementation planning and governance;
- supporting health practitioners;
- supporting patient and health practitioner communication;
- informing the community;
- supporting the safe introduction of voluntary assisted dying;
- research;
- resourcing; and
- commencement.

The Panel supports the view of the Parliamentary Committee that voluntary assisted dying should be incorporated into existing care processes to protect and support patients and to ensure sound medical practice. This will also ensure people get access to the range of treatment and care options based on their clinical needs and care goals.

The Panel notes that some feedback during the consultation process advocated for the establishment of 'independent panels' to undertake voluntary assisted dying assessments and processes. The Panel rejected this approach and concluded that establishing independent panels to provide voluntary assisted dying would create unacceptable risks, including the possibility of fracturing existing therapeutic relationships and concentrating the skill and expertise in the hands of a few medical practitioners. This would negatively impact on the patient's experience and is likely to result in less accurate assessments.

Based on experience overseas, the Panel expects very low rates of utilisation of voluntary assisted dying. The initial uptake of all new medical interventions is low and this will gradually increase over time. The uptake of voluntary assisted dying should be considered in the same way, and an expected gradual increase in use over a number of years reflects the evidence that when new medical interventions are introduced the uptake is gradual. The incremental increase in the use of voluntary assisted dying is demonstrated in the data reported by international jurisdictions and is consistent with the uptake of new medical interventions generally.

The Panel recommends that voluntary assisted dying implementation be considered in the context of existing care options available to people at the end of life. This will support existing therapeutic relationships, and allow review of the practice as part of overall safety and quality monitoring and review processes. To implement this approach Victoria may consider how health services in North American jurisdictions have established programs, and how they have engaged and supported staff.

Accommodating voluntary assisted dying in existing clinical relationships, wherever that is possible, will not only support safe and high-quality practices, but will also provide appropriate professional support for health practitioners. The Panel advocates that support for health practitioners who either choose to participate in voluntary assisted dying, or who conscientiously object, should be developed within existing professional support structures. It will also be important that health service boards and executives play a leadership role in facilitating considerations about service involvement in voluntary assisted dying and how staff are supported if a service decides to offer voluntary assisted dying.

The Panel recognises that the establishment of an Implementation Taskforce is essential to providing the expertise, focus and leadership to develop the necessary resources, processes and systems over the 18 months leading up to the commencement of any voluntary assisted dying legislation.

The Implementation Taskforce will play a pivotal role in focusing and coordinating the work that will need to be completed to prepare for the commencement of the legislation. This should include reviewing the functions proposed in the Parliamentary Committee's report for the new agencies proposed to clarify roles and responsibilities of both the new and existing agencies. The Implementation Taskforce should also provide advice on the development of evidence-based resources, supports and guidelines to build a safe and compassionate voluntary assisted dying service system.

The Panel recommends that the Implementation Taskforce must engage with, and involve, key stakeholders over the 18 month period to develop effective implementation strategies and resources. Consistency in implementation and governance arrangements and staff support may best be facilitated in partnership with professional colleges and bodies such as the Australian Medical Association, Australian Nursing and Midwifery Federation, relevant professional colleges, pharmacy bodies, and consumer, carer and service representatives.

The Panel is of the view that early planning and development of associated resources and training for the implementation of voluntary assisted dying will give health practitioners and services a sufficient period of time in which to build capabilities, models of care and organisational responses.

Ministerial Advisory Panel Recommendations

Guiding Principles

Recommendation 1

That the following principles are included in the legislation to help guide interpretation:

- Every human life has equal value.
- A person's autonomy should be respected.
- A person has the right to be supported in making properly informed decisions about their medical treatment and should be given, in a manner that they understand, information about medical treatment options, including comfort and palliative care.
- Every person approaching the end of life has the right to quality care to minimise their suffering and maximise their quality of life.
- The therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.
- Open discussions about death and dying and peoples' preferences and values should be encouraged and promoted.
- Conversations about treatment and care preferences between the health practitioner, a person and their family, carers and community should be supported.
- Providing people with genuine choices must be balanced with the need to safeguard people who might be subject to abuse.
- All people, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

Part A: Eligibility Criteria

Recommendation 2

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

Recommendation 3

That the capacity test in the Medical Treatment Planning and Decisions Act is used to assess a person's decision-making capacity in relation to voluntary assisted dying.

Recommendation 4

That when an assessing medical practitioner is in doubt about whether a person has decision-making capacity in relation to voluntary assisted dying, a referral must be made to an appropriate specialist for assessment.

Eligibility considerations

Recommendation 5

That mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does mental illness exclude a person from eligibility to access voluntary assisted dying.

Recommendation 6

That disability does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does disability exclude a person from eligibility to access voluntary assisted dying.

Part B: Request and Assessment Process

Initiating a request for voluntary assisted dying

Recommendation 7

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Recommendation 8

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Recommendation 9

That a request for information about voluntary assisted dying does not constitute a first request.

Recommendation 10

That the person may withdraw from the voluntary assisted dying process at any time.

When the person withdraws from the voluntary assisted dying process, they must commence the process from the beginning if they decide to make a subsequent request for voluntary assisted dying.

Recommendation 11

That the legislation support access to voluntary assisted dying for people who are from culturally and linguistically diverse backgrounds and for people who require alternative means of communication, by allowing appropriately accredited, independent interpreters to assist them to make verbal and written requests for voluntary assisted dying.

Receiving a request for voluntary assisted dying

Recommendation 12

That two medical practitioners must undertake independent assessments of a person's eligibility for voluntary assisted dying.

Recommendation 13

That the roles of the two assessing medical practitioners be clearly defined as:

- the coordinating medical practitioner; and
- the consulting medical practitioner.

Recommendation 14

That both the coordinating medical practitioner and the consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered); and

- at least one of the medical practitioners must have at least five years post fellowship experience; and
- at least one of the medical practitioners must have expertise in the person's disease, illness or medical condition.

Recommendation 15

That both the coordinating medical practitioner and the consulting medical practitioner must complete specified training before undertaking an assessment of a person's eligibility for access to voluntary assisted dying.

Recommendation 16

That the specified training comprise of obligations and requirements under the legislation including:

- assessing the eligibility criteria under the legislation;
- assessing decision-making capacity in relation to voluntary assisted dying and identifying when a referral may be required; and
- assessing the voluntariness of a person's decision to request voluntary assisted dying and identifying risk factors for abuse.

Recommendation 17

That the coordinating medical practitioner or the person may request that the role of the coordinating medical practitioner for the voluntary assisted dying process be transferred to the consulting medical practitioner.

Recommendation 18

That a health practitioner may conscientiously object to participating in the provision of information, assessment of a person's eligibility, prescription, supply or administration of the lethal dose of medication for voluntary assisted dying.

Making a request for voluntary assisted dying

Recommendation 19

That the person must make three separate requests to access voluntary assisted dying: a first request, followed by a written declaration of enduring request, and then a final request.

Recommendation 20

That the formal process for requesting voluntary assisted dying proceeds for the person as follows:

- The person makes their first request to a medical practitioner.
- The person undergoes a first assessment by the coordinating medical practitioner.
- The person undergoes a second independent assessment by the consulting medical practitioner.
- The person makes a witnessed written declaration of enduring request to the coordinating medical practitioner.
- The person makes a final request to the coordinating medical practitioner.

Recommendation 21

That the coordinating medical practitioner and the consulting medical practitioner must ensure that the person is properly informed of:

- their diagnosis and prognosis;
- treatment options available to them and the likely outcomes of these treatments;
- palliative care and its likely outcomes;
- the expected outcome of taking the lethal dose of medication (that it will lead to death)
- the possible risks of taking the lethal dose of medication;
- that they are under no obligation to continue with their request for voluntary assisted dying, and that they may withdraw their request at any time; and
- any other information relevant to the person's needs.

Recommendation 22

That the coordinating medical practitioner and the consulting medical practitioner undertake independent assessments to form a view as to whether:

- the person meets the eligibility criteria;
- the person understands the information provided;
- the person is acting voluntarily and without coercion; and
- the person's request is enduring.

Recommendation 23

That the final request may only be made after a period of at least 10 days has passed since the first request.

Recommendation 24

That there is an exception to the 10 day requirement when the coordinating medical practitioner believes that the person's death is likely to occur within 10 days and this is consistent with the prognosis provided by the consulting medical practitioner.

Recommendation 25

That the final request cannot be made on the same day that the second independent assessment is completed.

Recommendation 26

That a person's written declaration of enduring request must be in writing, be signed by the person, and be witnessed by two persons in the presence of the coordinating medical practitioner. The two witnesses must certify that the person appears to be voluntarily signing the declaration, to have decision-making capacity, and to understand the nature and effect of making the declaration.

Recommendation 27

That one of the witnesses to the written declaration of enduring request must not be a family member. The two witnesses must be 18 years and over and cannot be:

- a person who knows or believes that they are a beneficiary under the will of the person making the written declaration of enduring request, or a recipient, in any other way, of a financial or other material benefit resulting from the person's death; or
- an owner or operator of any health care or accommodation facility at which the person making the written declaration of enduring request is being treated or any facility in which the person resides; or
- directly involved in providing health or professional care services to the person making the written declaration of enduring request.

Recommendation 28

That the written declaration of enduring request allows the person to make a personal statement about their decision to access voluntary assisted dying.

Completing the voluntary assisted dying process

Recommendation 29

That the person appoint a contact person who will take responsibility for the return of any unused lethal medication to the dispensing pharmacist within 30 days after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board.

Recommendation 30

That, to conclude the assessment process, the coordinating medical practitioner complete a certification for authorisation to confirm in writing that they are satisfied that all of the procedural requirements have been met.

Recommendation 31

That the prescription of the lethal dose of medication requires an authorisation process.

Recommendation 32

That at the point of dispensing the lethal dose of medication, the dispensing pharmacist must:

- attach labels clearly stating the use, safe handling, storage and return of the medication; and
- provide the person with information about the administration of the medication and the likely outcome.

Recommendation 33

That the person be required to store the lethal dose of medication in a locked box.

Recommendation 34

That the legislation not preclude health practitioners from being present when a person self-administers the lethal dose of medication if this is the preference of the person.

Recommendation 35

That there be protection in the legislation for health practitioners who are present at the time a person self-administers the lethal dose of medication, including that the health practitioner is under no obligation to provide life-sustaining treatment.

Recommendation 36

That not being able to self-administer is defined as being physically unable to self-administer or ingest the lethal dose of medication.

Recommendation 37

That if the person is not able to self-administer, the coordinating medical practitioner may administer the lethal dose of medication.

Recommendation 38

That, in the rare circumstance the person loses the capacity to self-administer the medication after it has been prescribed, they must return to their coordinating medical practitioner if they wish to proceed with voluntary assisted dying. After the previously prescribed medication has been returned to the pharmacist, the coordinating medical practitioner may undertake the process to administer the medication.

Recommendation 39

That, in the rare circumstance where both the coordinating and consulting medical practitioners conscientiously object to administering the lethal dose of medication, the coordinating medical practitioner can refer the person to a new consulting medical practitioner willing to administer the medication. The new consulting medical practitioner must conduct their own independent assessment, after which the coordinating medical practitioner may transfer the role of coordinating medical practitioner to them.

Recommendation 40

That, if the coordinating medical practitioner administers the lethal dose of medication, a witness who is independent of the coordinating medical practitioner must be present. The coordinating medical practitioner and the witness must certify that the person's request appears to be voluntary and enduring.

Part C: Oversight

Monitoring after death

Recommendation 41

That the death certificate of a person who has accessed voluntary assisted dying identifies the underlying disease, illness or medical condition as the cause of death.

Recommendation 42

That accessing voluntary assisted dying should not affect insurance payments or other annuities.

Recommendation 43

That the medical practitioner who certifies death must notify the Registrar of Births, Deaths and Marriages if they are aware that the person has been prescribed a lethal dose of medication or if they are aware that the person self-administered a lethal dose of medication under the voluntary assisted dying legislation.

Recommendation 44

That the Registrar of Births, Deaths and Marriages and the Voluntary Assisted Dying Review Board share information relating to voluntary assisted dying.

Recommendation 45

That a death by means of voluntary assisted dying in accordance with the legislative requirements not be considered a reportable death for the purpose of the Coroners Act.

Voluntary Assisted Dying Review Board

Recommendation 46

That a Voluntary Assisted Dying Review Board be established under statute to review every case of voluntary assisted dying and report on the operation of voluntary assisted dying in Victoria.

Recommendation 47

That the role and functions of the Voluntary Assisted Dying Review Board be:

- reviewing each case of voluntary assisted dying and each assessment for voluntary assisted dying to ensure the statutory requirements have been complied with;
- referring breaches of the statutory requirements to the appropriate authority to investigate the matter such as Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency;
- collecting information and data, setting out additional data to be reported and requesting additional information from medical practitioners or health services, for the purpose of performing its functions;
- monitoring, analysing, considering and reporting on matters relating to voluntary assisted dying,

- supporting improvement by facilitating and conducting research relating to voluntary assisted dying and maintaining and disseminating guidelines to support the operation of the legislation, in collaboration with other agencies and professional bodies and services; and
- any other functions necessary to promote good practice.

Recommendation 48

That the membership of the Voluntary Assisted Dying Review Board be appointed by the Minister for Health, and that the appointments reflect the appropriate knowledge and experience required for the Board to perform its functions.

Monitoring of voluntary assisted dying

Recommendation 49

That there is mandatory reporting by medical practitioners to the Voluntary Assisted Dying Review Board within seven days of:

- completing the first assessment (regardless of the outcome);
- completing the second independent assessment (regardless of the outcome);
- completing the certification for authorisation (which will incorporate the written declaration of enduring request and appointment of contact person forms); and
- when the lethal dose of medication is administered by a medical practitioner.

Recommendation 50

That, in order to monitor the lethal dose of medication, there is mandatory reporting within seven days to the Voluntary Assisted Dying Review Board:

- by the Department of Health and Human Services when the prescription is authorised;
- by the pharmacist when the prescription is dispensed; and
- by the pharmacist when unused lethal medication is returned by the contact person.

Recommendation 51

That reporting forms are set out in the legislation to provide certainty and transparency about the information that is collected. That these forms include a:

- first assessment report (which includes record of first request);
- second assessment report;
- written declaration of enduring request;
- appointment of contact person;
- certification for authorisation;
- dispensing pharmacist report;
- administration by medical practitioner report; and
- return of medication notification.

Recommendation 52

That the Voluntary Assisted Dying Review Board report to Parliament: every six months in the first two years after commencement, and thereafter annually.

Recommendation 53

That the voluntary assisted dying legislation be subject to review five years after commencement.

Protections and offences

Recommendation 54

That the legislation provides clear protection for health practitioners who act in good faith and without negligence to facilitate access to voluntary assisted dying under the legislation.

Recommendation 55

That a health practitioner must notify the Australian Health Practitioner Regulation Agency if they believe that another health practitioner is acting outside the legislative framework.

Recommendation 56

That any other person may notify the Australian Health Practitioner Regulation Agency if they believe that a health practitioner is acting outside the legislative framework.

Recommendation 57

That there be offences for:

- inducing a person, through dishonesty or undue influence, to request voluntary assisted dying;
- inducing a person, through dishonesty or undue influence, to self-administer the lethal dose of medication;
- falsifying records related to voluntary assisted dying; and
- administering a lethal dose of medication to a person who does not have decision-making capacity

Part D: Implementation

Voluntary assisted dying in the context of existing care options

Recommendation 58

That the implementation of voluntary assisted dying should occur within the context of existing care available to people at the end of life, and ensure voluntary assisted dying activity is embedded into existing safety and quality processes.

Implementation planning and governance

Recommendation 59

That work to establish the Voluntary Assisted Dying Review Board begin at least 12 months before the commencement of the legislation and is supported to develop a clear work plan to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engaging and sharing information with other partners (such as the Department of Health and Human Services, Safer Care Victoria, and services and providers) for quality improvement purposes.

Recommendation 60

That the Department of Health and Human Services establish and support an Implementation Taskforce to investigate and advise on the development of voluntary assisted dying. The Implementation Taskforce should have the coordinating role in overseeing and facilitating the work set out in these implementation recommendations.

Recommendation 61

That the functions proposed by the Parliamentary Committee for End of Life Care Victoria be subject to a gap analysis in relation to existing entities and their functions to determine a clear role for the proposed agency.

Implementation support

Recommendation 62

That appropriate workforce support, information, clinical and consumer guidelines, protocols, training, research and service delivery frameworks to support the operation of the legislative framework are developed in a partnership between Safer Care Victoria, the Voluntary Assisted Dying Review Board and the Department of Health and Human Services in consultation with key clinical, consumer and professional bodies and service delivery organisations.

Recommendation 63

That the Implementation Taskforce establishes a collaborative coordination process across responsible agencies to periodically review the resources and frameworks that support the operation of voluntary assisted dying.

Research

Recommendation 64

That the Implementation Taskforce provide advice to the Department of Health and Human Services on engaging with a university to undertake research on the best practice identification and development of medications for use in voluntary assisted dying.

Recommendation 65

That a collaborative research program is developed with existing research entities to identify key clinical, policy and practice issues and align research with these priorities.

Commencement

Recommendation 66

That, in order to prepare for implementation, there is an 18-month period between the passage and commencement of the voluntary assisted dying legislation.

Introduction

Purpose of the final report

This final report presents the recommendations of the Voluntary Assisted Dying Ministerial Advisory Panel (the Panel) for compassionate and safe voluntary assisted dying legislation in Victoria. The Panel's recommendations have built on the foundation provided by the Legal and Social Issues Committee's *Inquiry into end of life choices*.⁸ The Panel's recommendations are informed by an extensive consultation process with a range of stakeholders, relevant end-of-life care research, research on voluntary assisted dying in other jurisdictions, and the Panel's own expertise and experience.

This introduction sets out the context in which the Panel's work has been undertaken and reflects on the consultation process, which is more fully described in the *Interim report of the Ministerial Advisory Panel: Consultation overview*.⁹ As the Panel has undertaken its deliberations, a selection of key contextual issues have been repeatedly brought to its attention. These are the importance of recognising the Victorian context, the significant role of palliative care, and family support. These issues are discussed in turn in this introduction. In concluding this section, the Panel outlines its observations on the principles that have guided its deliberations. These key principles underpin the recommendations in the remainder of the report and the Panel recommends they be included in the legislation as an aid to its interpretation. This report should be read with these principles in mind.

End-of-life care context

Over recent decades medical treatment has provided many cures for acute illnesses and has saved many people's lives. It has also prolonged people's lives by managing progressive and chronic conditions such as cancer, heart disease and neurological conditions. For many of these conditions there is no cure, and people will need to be supported and cared for along their illness trajectory that will, over time, include the need for end-of-life care. Of the approximately 39,000 people who die in Victoria each year, two-thirds die from a chronic disease, including cancer.¹⁰

We now have more medical interventions than ever before, and with this comes increased choice and more complex decision making about what medical treatment to accept or refuse. Just 'letting nature take its course' is no longer a simple proposition because medical interventions may have already changed the course of a person's illness or delayed what once would have been considered a 'natural death'. As a result, people have an extended period of time to contemplate their own death.

8 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

9 Voluntary Assisted Dying Ministerial Advisory Panel (2017), *Interim report of the Ministerial Advisory Panel: consultation overview: Voluntary Assisted Dying Bill*, Department of Health and Human Services, State of Victoria, Melbourne, viewed 20 May 2017, <<https://www2.health.vic.gov.au/about/health-strategies/voluntary-assisted-dying-bill>>.

10 Australian Bureau of Statistics (28 September 2015), 3302.0 – Deaths, Australia, 2015, viewed 20 April 2017, <<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3302.0Main%20Features32015?opendocument&tabname=Summary&prodno=3302.0&issue=2015&num=&view=>>>.



In Victoria, end-of-life care has recently been the focus of significant attention and reform. Over the past two years, a number of community and sector consultations have asked Victorians to consider the role and extent of end-of-life care and, as part of this, their own end-of-life choices.

Drawing on feedback from these consultations, two important reports, *Victoria's end of life and palliative care framework* and the cross-party Legal and Social Issues Committee's *Inquiry into end of life choices: final report* (Parliamentary Committee Report) have set the foundations for the future of end-of-life care and end-of-life choices in Victoria.

The 2015 Improving End of Life Care consultation informed the development of *Victoria's end of life and palliative care framework*. This consultation included 28 forums across Victoria in which almost 700 people participated. The Parliamentary Committee Report followed an extensive consultation, also in 2015. Across these consultations clear and consistent themes have emerged about what matters to Victorians for their care at the end-of-life. These themes include support for the following:

- **Strengthened palliative care.** Victorians generally receive high-quality end-of-life and palliative care, and Victorians want increased government investment to improve access to these high-quality end-of-life care services. This includes greater integration of services and improved access to home-based palliative care.
- **Supporting conversations.** Many people have expressed that it is difficult to engage in conversations about death and dying, about their personal medical conditions, and about their treatment options. Many want more support to have these conversations with their family.
- **Placing people at the centre of decision making about their own medical treatments.** People want their preferences and values to direct the end-of-life treatment and care they receive. Feedback confirmed that people believe the person receiving treatment must be at the centre of clinical decision making and that the individual's decisions about treatment must be respected.
- **Supporting dying people and their families.** The end of a person's life is likely to be difficult for both the person and their family. It is therefore critical that appropriate support is available to anyone who needs it. This includes having access to treatment and care that relieves suffering, pain and other symptoms associated with end-of-life, as well as psychosocial and bereavement support before and after death.
- **Genuine choice that responds to people's needs.** People want genuine choice about their end-of-life care including access to the range of services needed, the place where care is offered and the place where death occurs. For some people this also includes the timing and manner of their death.

Inquiry into end of life choices

The Parliamentary Committee Report identified the need for community members to start conversations about how they envisage the end of their own life and to communicate their preferences and values to their family, friends, general practitioners and other relevant health practitioners. It noted that people should be able to make decisions about the nature and extent of their treatment.

Consistent with other reports, the Parliamentary Committee found that Victoria has good palliative care services. Based on research and evidence that takes into account international experience, and drawing on feedback from the consultations and hearings, the Parliamentary Committee concluded that despite the best efforts of health practitioners, not all pain and suffering can be alleviated, or alleviated in a way that is satisfactory to the person. The Parliamentary Committee made 49 recommendations, 48 of which relate to palliative care and advance care planning. Recommendation 49 broadly outlines a voluntary assisted dying framework.

Following extensive consultations and an examination of the experience of international jurisdictions that have introduced assisted dying, the Parliamentary Committee set out a framework for introducing voluntary assisted dying in Victoria. The Parliamentary Committee recognised that the framework should be implemented alongside other improvements in palliative care and advance care planning.

The Parliamentary Committee recommended that the Victorian Government introduces legislation to allow adults with decision-making capacity who are suffering from a serious and incurable condition, and who are at the end of their life, to have access to voluntary assisted dying in certain circumstances.

The establishment of the Ministerial Advisory Panel on Voluntary Assisted Dying

As part of its response to the Parliamentary Committee's *Inquiry into end of life choices*, on 8 December 2016 the government announced that it will introduce legislation into Parliament in the second half of 2017 to legalise voluntary assisted dying. The announcement specified that it would be for Victorian adults who are at the end of their lives and have a serious and incurable condition that is causing intolerable suffering.

The Minister for Health established the Ministerial Advisory Panel (the Panel) made up of medical, nursing, legal, consumer and palliative care experts and gave it responsibility for developing a framework for the Voluntary Assisted Dying Bill using the framework proposed by the Parliamentary Committee as the starting point.

While the Panel has been specifically asked to advise on the development and implementation of voluntary assisted dying legislation, the Panel upholds the key principle that voluntary assisted dying not be a substitute for palliative care.

The consultation process

The Panel has consulted widely on the development of a compassionate, safe and practical voluntary assisted dying framework for Victoria. In doing so, the Panel used the framework proposed by the Parliamentary Committee as the basis for the consultation process with stakeholders when exploring how voluntary assisted dying could work in practice in Victoria.

The Panel has not repeated the consultations undertaken by the Parliamentary Committee's *Inquiry into end of life choices*, which received more than 1,000 submissions, held 17 days of public hearings and heard from 154 witnesses. The Panel's responsibilities also did not require it to replicate the work done by the Parliamentary Committee in reviewing opinions on whether or not voluntary assisted dying should be legalised.

In undertaking the consultation process, the Panel has respected the variety of views and expertise of stakeholders and has been guided by the following principles:

- The person, and the needs of the person, is the central consideration in all discussions about voluntary assisted dying.
- Respect is maintained for the range of expertise and judgement of all people – providers, family and carers – who support people approaching the end of their life.
- Differing views among providers about voluntary assisted dying is acknowledged, with recognition that individuals may wish to contribute to developing the legislation but choose not to participate in its implementation.
- To help create compassionate and safe voluntary assisted dying legislation, the focus must be on problem solving and resolving contentious issues.
- Any legislation developed must allow application in a way that respects the diversity of culture and values among Victorians.

Written submissions to the discussion paper

The Panel released a discussion paper on the Voluntary Assisted Dying Bill for public comment on 30 January 2017. A summary of the paper was translated into easy English and 16 community languages.

The discussion paper focused on the detail of voluntary assisted dying legislation and built on the work of the Parliamentary Committee. It sought feedback on the key issues that the legislation will need to address. Written submissions in response to the discussion paper closed on 10 April 2017. A total of 176 written submissions were received. The Panel did not consider written submissions that only expressed a position supporting or opposing voluntary assisted dying and provided no substantive comment. The Parliamentary Committee recommended that Victoria introduce voluntary assisted dying; the role of the Panel was to consider how this could work in practice. This is why the Panel did not consider opinions for or against voluntary assisted dying – this question was beyond the scope of the Panel's terms of reference, which are about developing a safe and compassionate framework.

Forums and roundtable discussions

The Panel also held consultation forums and roundtable discussions to inform its deliberations on the detail of the voluntary assisted dying framework.

The Panel conducted 14 consultation forums, including five in regional Victoria. Approximately 300 people attended the forums. Each forum provided stakeholders with an opportunity to discuss, with members of the Panel, the key areas of the eligibility criteria, the voluntary assisted dying request process, and the oversight and safeguards required to implement a compassionate, safe and practical framework. The forums were constructive and allowed stakeholders to voice their concerns, ideas and diverse experiences as well as to hear responses directly from members of the Panel.

The Panel also held a series of roundtable discussions with key stakeholders including medical bodies, consumer and carer groups, disability advocacy groups, legal organisations, mental health providers, commissioners, health administrators and a diverse range of other appropriate experts. The input provided in these roundtable discussions was both considered and practical.

The Panel respects the way stakeholders in the forums and roundtable discussions engaged with the process to offer their considered input, reflecting their particular expertise and experience. Consulting with individuals and receiving feedback was very valuable and strengthened the Panel's understanding and honed its thinking.

The findings of the consultation process are described in detail in the *Interim report of the Ministerial Advisory Panel: Consultation overview*.¹¹

A framework for Victoria

The Panel has carefully considered voluntary assisted dying frameworks from other jurisdictions and used these to inform its recommendations. However, each of these models operates in a different context from Victoria. Victoria needs a voluntary assisted dying framework that is appropriate for the Victorian health-care system, and the Panel has been mindful of not transplanting a model that was developed for a different context.

Five jurisdictions in the US have passed legislation to legalise voluntary assisted dying in limited circumstances. Following a Supreme Court decision, Canada also introduced voluntary assisted dying legislation. The Netherlands, Belgium, Luxembourg, Colombia and Switzerland also allow voluntary assisted dying. Voluntary assisted dying was also briefly legalised in the Northern Territory, but the legislation was overridden by Commonwealth legislation. The legislation in these jurisdictions has built on existing laws in those jurisdictions and is adapted to the context and culture of those jurisdictions. Unsurprisingly, the greatest similarities are between the US jurisdictions. While the Canadian legislation is similar to the US model, there are a number of critical departures. The European jurisdictions have more in common with each other than the North American jurisdictions.

¹¹ Voluntary Assisted Dying Ministerial Advisory Panel (2017), *Interim report of the Ministerial Advisory Panel: consultation overview: Voluntary Assisted Dying Bill*, Department of Health and Human Services, State of Victoria, viewed 20 May 2017, <<https://www2.health.vic.gov.au/about/health-strategies/voluntary-assisted-dying-bill>>.

The Parliamentary Committee recommendation appears largely to be based on legislation in North American jurisdictions, but also borrows from European jurisdictions. The Panel recognises the relevance of legislation in other countries and the evidence of how this legislation has operated, but the Panel also acknowledges that the legislation must be applicable and accessible to Victorians. This includes using terminology that is used and understood in the Victorian healthcare system and utilising existing organisations and safeguards in Victoria.

A critical distinction between Victoria and the US is universal access to medical treatment in Victoria. This ensures, for example, that Victorians have access to high-quality medical care based on clinical need, not on the ability to pay. The Panel is of the view that this important distinction will help to ensure Victorians have genuine choice at the end of their lives and that voluntary assisted dying will never be an alternative to proper medical treatment.

Voluntary assisted dying legislation must also be relevant and workable across both metropolitan and regional Victoria. Although the majority of the population live in metropolitan areas where access to a range of health practitioners is easier, the Panel recognises that for people living in regional Victoria specialist medical practitioners may not be readily accessible. The Panel recognises the importance of developing legislation that makes it possible for people in regional Victoria to access voluntary assisted dying.

Victoria also has a diverse population and voluntary assisted dying legislation must ensure it does not discriminate against people with diverse backgrounds.

Finally, people with a range of values and beliefs must be able to determine the extent of their participation in the provision of voluntary assisted dying, but this should not impede other people's access to voluntary assisted dying based on their values and beliefs if this is what they choose.

The role of palliative care

The Panel recognises that receiving palliative care will most likely provide relief from aspects of suffering. Palliative care provides expert end-of-life care – physical, emotional, spiritual and social – using medical and non-medical interventions through 'early identification' and 'impeccable assessment', to meet the needs of each individual facing the end of their life. Palliative care intends neither to hasten nor postpone death.¹² The range of treatments and medications available to support an individual's quality of life are world-class. Palliative care in Australia has been assessed as among the world's best over many years, evidenced by *The Economist's* survey of 80 countries (2015), assessing indicators of the environment, human resources, quality, affordability and community engagement.¹³

¹² World Health Organisation (2017), WHO definition of palliative care, World Health Organization, viewed 3 June 2017, <<http://www.who.int/cancer/palliative/definition/en/>>.

¹³ The Economist Intelligence Unit (2015), *The 2015 quality of death index: the state of palliative care across the world*, Lien Foundation, London, viewed 7 June 2016, <<https://www.eiuperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf>>.

Dominant arguments about palliative care and voluntary assisted dying portray them as antithetical and attempts at contemporary connections seem contradictory to the values on which palliative care was founded.¹⁴ Such polarisation causes oppositional arguments. For example, in relation to intention, palliative care predominantly seeks to provide comfort, whereas voluntary assisted dying seeks to assist death. These arguments neglect that the intentions of both actions are to relieve the suffering for someone who is dying.

In Belgium it is argued that while respecting a historical stance of palliative care being separate from voluntary assisted dying, individual autonomy has assumed far more societal importance in recent years, influencing much decision making. There is less tolerance for paternalistic approaches, including to an individual's medical treatment and how the end of their life should be managed.¹⁵

The Panel appreciates the objections many palliative care services have about voluntary assisted dying. A particular concern is that voluntary assisted dying will be conflated with palliative care, or be seen as the inevitable extension of palliative care. It will be important in any implementation of voluntary assisted dying that palliative care services are engaged to ensure people have access to high-quality palliative care, regardless of a person's decision to access voluntary assisted dying, and that the purpose of palliative care is made clear.

The European Association for Palliative Care makes a strong argument that in countries where voluntary assisted dying is legalised, there should be no devaluation of palliative care practice.¹⁶ This recognises the importance of the role of experienced health practitioners to comprehensively ascertain a person's care needs and understand their wishes and plans through ongoing clinical partnering with each person. In Belgium and the Netherlands, research suggests the introduction of voluntary assisted dying has not stunted the development of palliative care, and that government funding grew at a consistent rate with countries such as the UK, that have not legalised voluntary assisted dying.¹⁷

The Panel is of the view that the delivery of person-centred care must recognise a person's decisions about their end-of-life care. For some people this may include voluntary assisted dying. Person-centred care will rely on palliative care services continuing to provide palliative care to people based on clinical need, not on what they believe or a choice they may make about the timing and manner of their death.

14 Saunders, C (1976), 'Care of the dying 1: the problem of euthanasia', *Nursing Times*, vol. 72, no. 26, pp. 1003-1005.

15 Bernheim J & Raus K (2017), 'Euthanasia embedded in palliative care: responses to essentialistic criticisms of the Belgium model of integrated end of life care', *Journal of Medical Ethics*, doi:10.1136/medethics-2016-103511.

16 Radbruch, L et al (2016), 'Euthanasia and physician-assisted suicide: a white paper from the European Association for Palliative Care', *Palliative Medicine*, vol. 30, no. 2, pp. 104-116.

17 Bernheim, J et al (2014), 'State of palliative care development in European countries with and without legally regulated physician-assisted dying', *Health Care*, vol. 2, no. 1, pp. 10-14.



In a practical sense, it is not uncommon for palliative care practitioners to be caring for someone with the intention to end their life at a time of their choosing. People's wishes about all aspects of their care, including the timing and manner of their death, are often a starting point for conversations about care; they require sensitive acknowledgement and interpretation. Such conversations are a central skill of those whose expertise is in end-of-life care and there should be no shying away from these responsibilities.

Palliative care practitioners need to remain engaged, even when a person chooses to request voluntary assisted dying. Palliative care offers an 'umbrella' of skills required at the end-of-life; voluntary assisted dying is under the umbrella, not offered, but accepted as some people's means of death. Voluntary assisted death, no less than other paths to death, imposes a duty of care on health practitioners, to those who suffer as they approach their death. Guidelines and clinical scenarios will need to be developed to assist clinicians as they discern their own response to legislation.

Even if an individual health practitioner holds a conscientious objection to assisting a person to die, this should not negate the provision of holistic care, with expert symptom control to relieve suffering, holistic psychosocial and spiritual care and intense communication to better understand the person's underlying values and motivations. Health care and aged care systems also need to be prepared to respond to such expressed needs, with guidance and support for staff at all levels of the organisation.

It is possible for a health practitioner to hold a pluralistic stance in first and foremost caring for the person and their range of end-of-life needs. It is also possible for a health practitioner to be a conscientious objector to participating in voluntary assisted dying and still support a person up until the time they choose to self-administer a lethal dose of medication.

There is room for a more nuanced conversation that brings together the commonalities of a range of actions for people at the end of their life, and a position of 'studied neutrality' may assist individuals and organisations to navigate the contentious issues and ensure intellectual honesty in respective positions.¹⁸

The Panel's focus is on voluntary assisted dying, but it recognises that for the vast majority of people palliative care will minimise their suffering and maximise their quality of life. The high standards of end-of-life care already enjoyed by Victorians also present a unique context for the proposed legislation. Voluntary assisted dying cannot become an alternative to high-quality palliative care. The Panel recognises the exceptional standard of palliative care provided in Victoria and supports the ongoing measures to improve services across the State.

¹⁸ Johnstone, M (2012), 'Organization position statements and the stance of "studied neutrality" on euthanasia in palliative care', *Journal of Pain and Symptom Management*, vol. 44, no. 6, pp. 896–907.

Family support

Most people who are at the end of their life are being cared for by loving family and friends, in all settings. Having a family member or carer who is able to care for a person who wishes to die at home is key in supporting this to happen. Caring for someone who is dying is often described by carers as a privilege, providing opportunities to spend quality time with their loved one and say their goodbyes. However, it can be a very stressful and painful time, and carer exhaustion is often identified as a significant problem by family members. Carers require both emotional and practical support in caring for someone who is dying, and this will also be the case when someone has requested voluntary assisted dying.¹⁹

Emotional and practical support for family members and carers is a central part of end of life and palliative care, including bereavement support. During the consultation process, the Panel heard from stakeholders that family support is a key part of end-of-life care and will need to be offered to those who may choose voluntary assisted dying. It was identified that both emotional as well as practical supports were needed in order to assist family and friends during a person's illness and after a person had died. The Panel notes that there is no requirement that family be involved in access to voluntary assisted dying, and whether or not family members should be involved, and the what extent, should always be the decision of the person.

Grief and bereavement

Grief is a normal reaction to the death of a loved one, and most people will adjust and recover from grief over time supported by family and friends. Research suggests that between 10 and 20 per cent of people will experience complicated or traumatic grief. Complicated grief is associated with a range of risk factors, including the death of a child or partner, sudden loss or an unnatural death such as a murder or suicide.²⁰

The Panel considered the impact a decision to choose voluntary assisted dying may have on a person's family and friends. As it has been suggested that because voluntary assisted dying is not a 'natural' death, this may impact on how they recover from their grief.²¹

It is anticipated that the majority of families will play an important caring role in supporting someone who has requested voluntary assisted dying. This will mean that for the majority of people the death of a person will not be a surprise and the family will have been engaged in the decision making process.

19 Morris, S et al (2015), 'Family carers providing support to a person dying in the home setting: a narrative literature review', *Palliative Medicine*, vol. 29, no. 6, pp. 487–495.

20 Hall, C, Hudson, P, Boughey, A (2012), *Bereavement support standards for specialist palliative care services*, Department of Health, State Government of Victoria, Melbourne, viewed 30 May 2017, <http://www.grief.org.au/ACGB/Publications/Resources_Professionals/Bereavement_Support_Standards/ACGB/ACGB_Publications/Resources_for_Professionals_1/Bereavement_Standards_in_Palliative_Care.aspx?hkey=e2f63a43-96c9-44c6-a440-66a368f4d896>.

21 Van der Maas, P et al (1996), 'Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995', *New England Journal of Medicine*, vol. 335, no. 22, pp. 1699–1705.



Research that followed up with bereaved family and friends of cancer patients who chose voluntary assisted dying has found they coped better in respect to grief symptoms and post-traumatic stress reactions than the bereaved of comparable cancer patients who died a natural death.²² The researchers concluded that improved grief and bereavement outcomes may be the result of having the opportunity to say goodbye while a person was still aware; family and friends being more prepared for the person's death; and being able to talk more openly about death.²³ Similar research in Oregon found that family members of people who had requested voluntary assisted dying were more likely to believe the person's choices had been honoured and less likely to have regrets about the way the person died.²⁴ The research highlighted the importance of promoting these elements for all people diagnosed with a life-limiting illness and their families.

The Panel supports the use of existing grief and bereavement resources, such as the provision of grief and bereavement support set out in the *Bereavement support standards for specialist palliative care services* developed in Victoria by the Australian Centre for Grief and Bereavement and the Centre for Palliative Care.²⁵

22 Swarte, N et al (2003), 'Effects of euthanasia on the bereaved family and friends: a cross sectional study', *British Medical Journal*, vol. 327, no. 7408, p. 189.

23 Ibid. See also, Gopal, A (2015), 'Physician-assisted suicide: considering the evidence, existential distress, and an emerging role for psychiatry', *Journal of the American Academy of Psychiatry and the Law*, vol. 43, no. 2, pp. 183–190, p. 185–186.

24 Ganzini, L et al (2009), 'Mental health outcomes of family members of Oregonians who request physician aid in dying', *Journal of Pain and Symptom Management*, vol. 38, no. 6, pp 807–815.

25 Hall, C, Hudson, P, Boughey, A (2012), *Bereavement support standards for specialist palliative care services*, Department of Health, State Government of Victoria, Melbourne, viewed 30 May 2017, <http://www.grief.org.au/ACGB/Publications/Resources_Professionals/Bereavement_Support_Standards/ACGB/ACGB_Publications/Resources_for_Professionals_1/Bereavement_Standards_in_Palliative_Care.aspx?hkey=e2f63a43-96c9-44c6-a440-66a368f4d896>.

Guiding principles

In formulating the recommendations, the Panel has focused on upholding a number of key principles. These principles helped guide the Panel in its deliberations.

Human rights

The Victorian *Charter of Human Rights and Responsibilities Act 2006* provides important guidance for developing legislation for voluntary assisted dying. The human rights in the Charter are designed to protect people and allow them to flourish, and a balance needs to be struck between the aim of promoting autonomy and the need to provide appropriate safeguards. The Panel has taken into account the rights set out in the Charter in relation to voluntary assisted dying and have carefully considered how the relevant human rights identified in the Charter can be promoted.

Seven human rights are particularly relevant to the development of voluntary assisted dying legislation. These are:

- The right to equality
- The right to life
- The right to protection from torture and cruel, inhuman or degrading treatment
- The right to privacy and reputation
- The right to freedom of thought, conscience, religion and belief
- The right to protection of the best interests of the child
- The right to liberty and security of person

A commentary on the application of human rights to the proposed framework is provided at Appendix 2.

Every human life has equal value

Every human life has equal value and each person must be respected as such. Voluntary assisted dying is not about questioning the value of a life, but about recognising an inevitable death and giving people genuine choice about the timing and manner of their death. The Panel recognises it is critically important to ensure discussions about voluntary assisted dying do not include discussions that make value judgements about lives that are not worth living. Voluntary assisted dying must only be an option for people at the end of their lives and not a means to pressure or impose discriminatory views onto others. Respect for individuals was central to the Panel's considerations and the Panel's recommendations ensure voluntary assisted dying will not allow people to make judgements about the value of another person's life.

Respecting autonomy

In respecting individuals, the Panel has focused on respecting autonomy. This does not mean allowing people to do whatever they want. It is the Panel's view that voluntary assisted dying should be limited to those who are dying and should provide these people with the opportunity to have a degree of control over the timing and manner of their death. This recognises people should be able to determine that, in light of their impending death and their suffering, they would rather die.

In the framework recommended by the Parliamentary Committee, voluntary assisted dying would not give people the option to choose to live or die, as they must already be at the end of their life. While the Panel has been guided by the principle of respect for autonomy, the Panel is of the view that this is an appropriate limit and people should not be given the option to access voluntary assisted dying unless they are already at the end of their lives. Experience in other jurisdictions suggests that even with more liberal eligibility criteria, people will only request access to voluntary assisted dying when they are seriously ill and approaching the end of their lives.²⁶ The Panel has been guided by the principle of respecting autonomy in recognising that people with an incurable disease, illness or medical condition that is advanced and progressive and will cause death should have some control over the timing and manner of their death.

Informed decision making

Recognising that people should be given genuine choice at the end of their lives also means that people must be supported to make properly informed decisions. People must be provided with information about all the options that are available to them and they must be provided with information in a manner they can understand. If a person is not properly informed, their decision will not necessarily reflect their will.

An individual's decision to request voluntary assisted dying is complex, involving not only the person themselves but those who support them, family members or others. Reasons for requesting voluntary assisted dying vary, from seeking relief of suffering and an aversion to loss of independence, to honouring a long-held belief in autonomous control over one's life. It is critical that a person has all the necessary information available to them to identify the option that is the most consistent with their preferences and values. In many cases this will involve identifying other palliative care or treatment options.

Genuine choice

Access to voluntary assisted dying should never be viewed as an alternative to end-of-life care that will maximise a person's quality of life. The Panel is of the view that voluntary assisted dying should only ever be an option for people who are already at the end of their life and who have a range of treatment options available to them. Voluntary assisted dying cannot be an alternative to palliative care or being offered the best available treatment.

²⁶ Meier, D et al (2003), 'Characteristics of patients requesting and receiving physician-assisted death', *Archives of Internal Medicine*, vol. 163, no. 13, pp. 1537–1542.

The Panel recognises that many people may seek access to voluntary assisted dying because of a fear of what lies ahead. The Panel also recognises the critical role played by palliative care to ensure that people's fears of dying an agonising death are not realised. It is important that when people seek access to voluntary assisted dying their treatment options are explained to them and that they understand the effectiveness of the care and treatment options available to them. Having genuine choice requires that people have access to a full range of treatment options.

Supporting therapeutic relationships

In recognising the ongoing importance of high-quality end-of-life care, the Panel also recognises the critical role of health practitioners. People build important relationships with their health practitioners and have trust and confidence in their judgements. The Panel is of the view that wherever possible, these therapeutic relationships should be maintained when a person requests voluntary assisted dying to ensure continuity of care. This will help promote open discussions about death and dying and how best to promote a person's preferences and values at the end of their life.

Supporting existing therapeutic relationships will also help to ensure appropriate and responsive treatment is provided. Health practitioners who have been treating a person over a period of time will have a better understanding of the person's disease, illness or medical condition and their needs. Maintaining this relationship will not only provide continuity of care, it will also allow more accurate diagnosis and prognosis by medical practitioners who are familiar with the history of the person's disease, illness or medical condition.

Open discussions

The Panel recognises that discussions about death and dying are difficult, but is also of the view that it is extremely important to have open and honest discussions with health practitioners, family and friends. These discussions will enable a person to explain their preferences and values and will help them and their health practitioners plan for the future.

Conversations with family, carers and others will also help to ensure a person's preferences and values are understood. This may help the bereavement process, as family and friends can be confident the person died in a manner consistent with their preferences and values, and will ensure everyone is working towards common goals.

Appropriate safeguards

Providing people with genuine choice at the end of their life is important; however, this must also be weighed against the need to ensure there are appropriate safeguards in place to protect individuals and the community. This means there must be strong checks to ensure people are acting voluntarily as well as constant monitoring of the lethal dose of medication to prevent improper use.

The desire for strong oversight must, however, be balanced by the recognition that invasive requirements may have unintended consequences. For example, constantly checking up on the lethal dose of medication may inadvertently pressure people to self-administer the medication earlier than they had intended.

Respecting diversity

The voluntary assisted dying framework must also recognise the diversity of cultures and beliefs in Victoria. People's beliefs should be respected and they should be given the opportunity to live in accordance with those beliefs. Health practitioners and their patients must respect each other's beliefs and should not impose their personal beliefs onto each other.

Showing respect for people's beliefs also requires people to recognise that even though someone's life is different from their own, it has value and the person is entitled to live in accordance with their beliefs. The Panel recognises the importance of each person's beliefs and has focused on building a framework that will ensure respect for diversity.

The Panel proposes that these fundamental principles should underpin the consideration of the recommendations in the remainder of the report as well as the interpretation of the proposed voluntary assisted dying legislation.

Ministerial Advisory Panel Recommendation 1

That the following principles are included in the legislation to help guide interpretation:

- **Every human life has equal value.**
- **A person's autonomy should be respected.**
- **A person has the right to be supported in making properly informed decisions about their medical treatment and should be given, in a manner that they understand, information about medical treatment options, including comfort and palliative care.**
- **Every person approaching the end of life has the right to quality care to minimise their suffering and maximise their quality of life.**
- **The therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.**
- **Open discussions about death and dying and peoples' preferences and values should be encouraged and promoted.**
- **Conversations about treatment and care preferences between the health practitioner, a person and their family, carers and community should be supported.**
- **Providing people with genuine choices must be balanced with the need to safeguard people who might be subject to abuse.**
- **All people, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.**

Policy intent

The principles reflect the Panel's key considerations in formulating the recommendations and should be used to interpret the recommendations and the legislation.

Report structure

In this introduction, the Panel has set the context in which voluntary assisted dying will be considered, including the important role played by palliative care in supporting people who are dying. With this broader context in mind the Panel also sets out the principles that should guide people in considering the framework.

The remainder of the report explains the detailed considerations of the Panel. The report aims to take the reader through the recommended voluntary assisted dying process step by step, describing and explaining the considerations, conclusions and recommendations made by the Panel at each point in this process.

The voluntary assisted dying recommendation set out by the Parliamentary Committee is the starting point for each of the discussions. The Panel considers the consultation feedback, and reviews the research, the evidence and the experience of other jurisdictions where this is relevant. The Panel provides recommendations for the development of safe and compassionate voluntary assisted dying legislation that can be applied and understood by people and health practitioners in a range of clinical settings.

Part A provides details on the Panel's recommendations in relation to the eligibility criteria, focusing on the person, the disease, and the circumstances in which a person may be eligible for voluntary assisted dying. The eligibility criteria set out by the Parliamentary Committee have been further clarified to ensure both the community and health practitioners are clear about the circumstances under which a request for voluntary assisted dying can be made.

Part B sets out the request and assessment process from the perspective of the person making a request, as well as a medical practitioner's perspective, and describes the requirements and steps the person must go through to access voluntary assisted dying. It also discusses those recommendations that will make the request and assessment process safe and of high-quality. This includes the proposed qualifications and additional training required for assessing medical practitioners, clearly setting out how the person makes a written declaration of their enduring request, and the authorisation and monitoring process for the lethal dose of medication.

Part C sets out the oversight and governance arrangements that provide protections to keep the community safe, including the establishment of a Voluntary Assisted Dying Review Board, reporting requirements, and new offences related to voluntary assisted dying. This part also sets out the reporting obligations of health practitioners to the Voluntary Assisted Dying Review Board, and the Board's obligations for public reporting.

Part D considers the implementation of voluntary assisted dying within the context of existing care options. It sets out recommendations about planning and governance to ensure the implementation of voluntary assisted dying is resourced appropriately if the Bill is passed by the Victorian Parliament, including the development of workforce support, information and guidance materials.



Case studies are also included throughout the report to illustrate how the recommended framework will work in practice. The two central case studies focus on people suffering from cancer and motor neurone disease because the experience in international jurisdictions suggests that it will predominantly be people with these conditions requesting voluntary assisted dying.

A summary of the framework is presented in Appendix 1. Appendix 2 describes how Victoria's *Charter of Human Rights and Responsibilities* informed the Panel's deliberations. Appendix 3 compares the 68 safeguards embedded in the proposed voluntary assisted dying framework with other international voluntary assisted dying legislation.

The Panel presents its final report confident that the recommendations it has made will inform safe and compassionate voluntary assisted dying legislation that embeds safeguards, checks and balances at every point of the voluntary assisted dying process.





Part A: Eligibility criteria

This Part sets out the Panel's recommendations on the eligibility criteria for access to voluntary assisted dying. The eligibility criteria recommended by the Panel follow the eligibility criteria proposed by the Parliamentary Committee. The Panel has refined the criteria and language to ensure it provides certainty and clarity to the community and health practitioners in Victoria about the circumstances in which a person is eligible to access voluntary assisted dying. The eligibility criteria limit voluntary assisted dying to adults who are suffering at the end of their life.

Eligibility overview

The Parliamentary Committee Inquiry

In its *Inquiry into end of life choices: final report* the Parliamentary Committee stated that 'A clear and transparent legislative framework is necessary to ensure access to assisted dying for those, and only those, who meet the eligibility criteria'.²⁷ The Parliamentary Committee noted the eligibility criteria used in other jurisdictions that have voluntary assisted dying frameworks protect vulnerable people by ensuring access is provided only to those who qualify.²⁸

In the Parliamentary Committee's recommended framework the eligibility criteria to access voluntary assisted dying was that a person:

- be an adult, 18 years and over;
- be ordinarily resident in Victoria and an Australian citizen or permanent resident;
- have decision-making capacity about their own medical treatment;
- be suffering from a serious and incurable condition that is causing enduring and unbearable suffering that cannot be relieved in a manner the person deems tolerable; and
- be at the end of life (final weeks or months of life).

The Parliamentary Committee recommended that each assessing medical practitioner must independently judge whether the person's request satisfies all of the eligibility criteria, noting that it is the person themselves who judges whether the suffering they are experiencing cannot be relieved in a manner they deem tolerable.²⁹

Discussion

The Panel, like the Parliamentary Committee, has considered the eligibility criteria from other jurisdictions that have voluntary assisted dying frameworks, as well as the research that has guided these jurisdictions.

The Panel agrees with the Parliamentary Committee that all of the eligibility criteria must be met for a person's request for voluntary assisted dying to proceed. Having strict eligibility criteria that must all be met sets clear parameters around who may access voluntary assisted dying and provides a safeguard that limits access to the people for whom voluntary assisted dying is intended.

²⁷ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 215, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

²⁸ *Ibid*, p. 216.

²⁹ *Ibid*, p. 237.

Overall the Panel supports the eligibility criteria proposed by the Parliamentary Committee, however, has included additional detail to provide further guidance and clarity to the community and health practitioners. The amended eligibility criteria remain consistent with those proposed by the Parliamentary Committee as they:

- continue to limit eligibility for access to voluntary assisted dying to people who are in the final weeks or months of life;
- retain the objective clinical definitions for diagnosis and prognosis; and
- retain the subjective test that allows a person themselves to judge whether they are experiencing suffering that cannot be relieved in a manner they deem tolerable.

The Panel emphasises that all of the eligibility criteria must be taken together, and that none of the criteria in isolation is sufficient for a person to be eligible to access voluntary assisted dying. Each of the eligibility criteria proposed by the Panel, and the rationale for each, is discussed in greater detail in the sections that follow.

Ministerial Advisory Panel Recommendation 2

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- **be an adult, 18 years and over; and**
- **be ordinarily resident in Victoria and an Australian citizen or permanent resident; and**
- **have decision-making capacity in relation to voluntary assisted dying; and**
- **be diagnosed with an incurable disease, illness or medical condition, that:**
 - **is advanced, progressive and will cause death; and**
 - **is expected to cause death within weeks or months, but not longer than 12 months; and**
 - **is causing suffering that cannot be relieved in a manner the person deems tolerable.**

Policy intent

To ensure voluntary assisted dying is limited only to the people for whom it is intended.

To provide clear guidance to the community and health practitioners about who may be eligible to access voluntary assisted dying.

Be an adult, 18 years and over

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- **be an adult, 18 years and over; and**
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that voluntary assisted dying be accessible only to adults, 18 years and over.³⁰ The Parliamentary Committee was firmly of the view that ‘Victorian values do not support allowing assisted dying to be provided to those who are yet to reach adulthood’.³¹

Discussion

Most jurisdictions that have legalised voluntary assisted dying limit access to people aged 18 years and over. The US jurisdictions of California, Colorado, Oregon, Vermont and Washington, as well as Canada and Luxembourg, all require a person to be an adult, 18 years and over. Only the Netherlands and Belgium allow a person under 18 years to access voluntary assisted dying, and the Panel notes that in these jurisdictions such cases are rare and only occur in exceptional circumstances.³²

³⁰ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 221, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

³¹ *Ibid*, p. 217.

³² In the Netherlands, a person aged between 16 and 18 years may request voluntary assisted dying when they are deemed to have a reasonable understanding of their own interests and their parent(s) or guardian(s) are involved in the decision process (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 2.3). A person aged between 12 and 16 years may request voluntary assisted dying when they are deemed to have a reasonable understanding of their own interests and where their parent(s) or guardian(s) agree with the decision (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 2.4). In Belgium, a person under 18 years of age may request voluntary assisted dying provided they ‘be in a hopeless medical situation of constant and unbearable suffering that cannot be eased and which will cause death in the short-term’, are ‘conscious’, have ‘a capacity of discernment’, have been ‘counselled’ by medical practitioners and a psychiatrist or psychologist, and the person’s parent(s) agree(s) with the decision. See White, B & Willmott, L (2014), ‘Belgium’s child euthanasia law: implications for Australia’, *The Conversation* (online), 17 February, <<http://theconversation.com/belgiums-child-euthanasia-law-implications-for-australia-23250>>. The Commission on Assisted Dying (2011), *The current legal status of assisted dying is inadequate and incoherent ...*, Demos, London, p. 194, viewed 9 May 2017, <https://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>; External Panel on Options for Legislative Response to *Carter v. Canada* (2015), *Consultations on physician-assisted dying: summary of results and key findings: final report*, Government of Canada, Ontario, p. 56, viewed 1 May 2017, <<http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html>>.

The majority of feedback the Panel received about age limitations during the consultation process came from the forums. There was strong support for a requirement that a person be 18 years and over to access voluntary assisted dying because it was perceived to signal a level of maturity reflected in other responsibilities taken up by a person at the age of 18 years. Some people noted the ability of people under 18 years to make important medical and health care decisions, and that some young people have a high level of maturity. However, only a small number of people considered that people under 18 years should be able to request voluntary assisted dying.

The Panel has considered the legislated age requirements of other jurisdictions, as well as the feedback from the forums, and has reached the view that a person must be an adult, 18 years and over, to access voluntary assisted dying.

The age at which a person is deemed to have attained full age and full capacity in Victoria is 18 years.³³ This age is used to set appropriate limits for particular kinds of decision making and responsibilities such as making a will, changing a name, voting, driving independently, purchasing and owning a gun, gambling and purchasing or selling alcohol.³⁴ The Panel considers it important that voluntary assisted dying legislation is consistent with other Victorian legislation that recognises adult decision-making capacity from 18 years.

All people aged 18 years and over are presumed to have decision-making capacity to consent to medical treatment in Victoria.³⁵ A person under 18 years may have decision-making capacity to make certain medical treatment decisions where they are able to understand the nature and consequences of the decision that needs to be made.³⁶ Decision-making capacity is also decision-specific; while a person under 18 years may have decision-making capacity to consent to some medical treatment, this does not necessarily mean they have decision-making capacity to make decisions about medical treatment with more severe consequences.

A decision to access voluntary assisted dying is complex, requiring a person to have a well-developed capacity for abstract reasoning – a capacity that young people develop at different ages. The Victorian law uses the age of 18 years to clearly identify the point at which people are generally deemed to have developed the necessary capacity to make important decisions about their life.

The Panel acknowledges that people under 18 years may meet all of the other eligibility criteria for voluntary assisted dying and understands why some people advocate they should also have access. Nevertheless, the Panel considers that requiring a person to be at least 18 years to access voluntary assisted dying represents an appropriate safeguard by striking a balance between providing choice for adults who are at the end of their life and protecting young people who do not have the appropriate level of maturity, capacity for abstract reasoning, or life experience to make the decision to access voluntary assisted dying.

³³ *Age of Majority Act 1977* (Vic), s. 3.

³⁴ Victoria Legal Aid (2016), *Am I old enough: common legal issues for young people*, Melbourne, pp. 17, 20, 31, 34, 51, 59, 65, 67, viewed 6 May 2017, <<https://www.legalaid.vic.gov.au/find-legal-answers/free-publications-and-resources/am-i-old-enough-common-legal-issues-for-young-people>>.

³⁵ *Medical Treatment Planning and Decisions Act 2016* (Vic), s. 4(2).

³⁶ *Secretary, Department of Health and Community Services v. JWB* (1992) 175 CLR 218, 331 ('*Marion's Case*').

Be ordinarily resident in Victoria and an Australian citizen or permanent resident

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- **be ordinarily resident in Victoria and an Australian citizen or permanent resident; and**
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that voluntary assisted dying be accessible only to people who are ordinarily resident in Victoria and an Australian citizen or permanent resident.³⁷ The Parliamentary Committee stated:

This criterion is designed to prevent people coming from outside Victoria to obtain assisted dying. The responsibility for determining whether a patient is a Victorian resident and Australian citizen or permanent resident lies with the primary and secondary doctors.

The primary and secondary doctors may satisfy themselves that a patient is ordinarily resident in Victoria through their established relationship with the patient, and/or if necessary through documentary evidence. This could include:

- a Victorian driver's licence
- enrolment to vote in Victorian elections
- medical records
- evidence that the patient owns or leases property in Victoria.

The Committee believes that doctors are best suited to determine residency on a casebycase basis, as occurs in other jurisdictions. There is precedence for this approach being effective in Oregon.³⁸

³⁷ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 221, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

³⁸ *Ibid*, p. 221.

Discussion

Legislation in all North American jurisdictions contains an express requirement that a person be a resident to access voluntary assisted dying. In contrast, there are no express residency requirements in European jurisdictions, although residency is considered to be enforced through provisions about the length and type of therapeutic relationship that exists between a person requesting voluntary assisted dying and their health practitioners. Switzerland is the only jurisdiction that allows non-residents to access voluntary assisted dying through private organisations such as Dignitas and Exit International.³⁹

The US jurisdictions of California, Colorado, Oregon and Washington all set out factors that demonstrate a person's residency in their legislation. In Oregon, for example, these factors include, but are not limited to:

- possession of an Oregon driver's licence
- registration to vote in Oregon
- evidence that the person owns or leases property in Oregon
- filing of an Oregon tax return for the most recent tax year.⁴⁰

There was strong support for a residency requirement at the forums. The Panel also notes reports of what is sometimes called 'death tourism' (where a person travels to another jurisdiction to access voluntary assisted dying) occurring in Switzerland where there is no residency requirement.⁴¹

The Panel shares the view of the Parliamentary Committee and does not support legislation that will allow people from another country, or Australian state or territory, to travel to Victoria to access voluntary assisted dying. The voluntary assisted dying legislation, if passed, will be Victorian legislation that is intended to apply to Victorian residents. It is therefore appropriate to require a person be resident in Victoria and an Australian citizen or permanent resident to access voluntary assisted dying.

The Panel supports the use of the words 'ordinarily resident' in the eligibility criteria. This is consistent with provisions in other Victorian legislation and support received at the forums.⁴² The Panel agrees with the Parliamentary Committee that assessing medical practitioners must satisfy themselves that a person is ordinarily resident in Victoria and that assessing medical practitioners are best placed to determine a person's residency on a case-by-case basis. It considers that, as in Oregon, a person could demonstrate to their assessing medical practitioner that they are ordinarily resident in Victoria and an Australian citizen or permanent resident by providing documentation such as a Victorian driver's licence and a birth certificate or a Victorian lease agreement and evidence of permanent residency.

39 White, B & Willmott, L (2012), 'How should Australia regulate voluntary euthanasia and assisted suicide?', *Journal of Law & Medicine*, vol. 20, no. 2, pp. 410-438, p. 426.

40 *Death with Dignity Act* (Oregon), s. 127.860.

41 White, B, McDonald, F & Willmott, L (2014), 'Euthanasia and assisted suicide', in Cameron Stewart (ed.), *Health Law in Australia*, Thomson Reuters, Sydney, pp. 505-542, p. 535.

42 See, for example, *Births, Deaths and Marriages Registration Act 1996* (Vic), ss. 25(1)(b)(iii), 26(1)(b)(iii), 34(4); *Firearms Act 1996* (Vic), ss. 17(1)(ab), 20(1)(ab), 23(1)(ab), 27(1)(ab), 29(1)(ab), 32(1A), 42(2)(ba), 46A(4); *Working with Children Act 2005* (Vic), s. 32.

While some stakeholders suggested that the words 'ordinarily resident' be defined according to the length of time a person must live in Victoria before being eligible to access voluntary assisted dying, the Panel notes that no minimum period of residency is incorporated into legislation in other jurisdictions. The Panel considers that prescribing a minimum period of residency will place a further administrative burden on people who are dying and suffering, and that it is unnecessarily onerous to require people who are dying and suffering to collect 12 months of electricity bills, for example, to demonstrate how long they have lived in Victoria.

The Panel acknowledges the potential for cross-border issues to arise where residents in New South Wales or South Australia access Victorian healthcare services. For clarity, the Panel confirms that only people who are ordinarily resident in Victoria and an Australian citizen or permanent resident will be eligible to access voluntary assisted dying.

Have decision-making capacity in relation to voluntary assisted dying

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- **have decision-making capacity in relation to voluntary assisted dying; and**
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that voluntary assisted dying be accessible only to people who have decision-making capacity about their own medical treatment.⁴³ The Parliamentary Committee noted that medical practitioners routinely carry out assessments of decision-making capacity and considered that this same expertise could be applied, with judicious care, to people who decide to request voluntary assisted dying.⁴⁴ The Parliamentary Committee was also of the view that allowing people who do not have decision-making capacity to access voluntary assisted dying was not supported by Victorian values and did not support access to voluntary assisted dying through advance care directives.⁴⁵

Discussion

The Panel supports the Parliamentary Committee's recommendation that a person must have decision-making capacity to access voluntary assisted dying. The Panel agrees that requiring a person to have decision-making capacity throughout the voluntary assisted dying process represents an important safeguard to protect against abuse.⁴⁶ The requirement is fundamental to ensuring a person's decision to access voluntary assisted dying is their own, is voluntary, and is not the product of undue influence or coercion. The strong positive feedback this criterion received during the consultation process supports the Panel's decision.

43 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 221, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

44 *Ibid.*, p. 221.

45 *Ibid.*, p. 217, 221.

46 *Ibid.*, p. 218.

Every other jurisdiction with a voluntary assisted dying framework requires a person to have decision-making capacity *at the time* they request voluntary assisted dying. There is, however, some variation about whether the request may be made in advance or whether a person with decision-making capacity may only request voluntary assisted dying at the time they want to access it. North American jurisdictions require a person to have decision-making capacity as part of their eligibility criteria, whereas some European jurisdictions allow people to make written requests for voluntary assisted dying in advance.⁴⁷ Decision-making capacity is considered to be a key safeguard in North American jurisdictions.

Legislation in Victoria states that a person has decision-making capacity in relation to a decision when they are able to:

- understand the information relevant to the decision and the effect of the decision;
- retain that information to the extent necessary to make the decision;
- use or weigh that information as part of the process of making the decision; and
- communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.⁴⁸

There was strong support for the requirement that a person have decision-making capacity throughout the voluntary assisted dying process in forums and submissions. The requirement was generally supported on the basis that it represented an important safeguard in ensuring a person's decision to access voluntary assisted dying is their own and has been made voluntarily.

The Panel's recommended process ensures there are mandated points at which a person is given the opportunity to review and reflect on their decision to access voluntary assisted dying. It is important that this occurs at points along the voluntary assisted dying process so that medical practitioners can check a person's decision-making capacity and confirm they still want to proceed with voluntary assisted dying.

The Panel has refined the Parliamentary Committee's recommendation by proposing that a person have decision-making capacity in relation to 'voluntary assisted dying' rather than in relation to 'their own medical treatment'. The Panel considers that requiring a person to have decision-making capacity in relation to their own medical treatment is too broad and could be interpreted in a range of different ways. For example, a person may have decision-making capacity in relation to taking an antihistamine but not in relation to major surgery. These are both examples of medical treatment. Requiring a person to have decision-making capacity in relation to voluntary assisted dying makes it clear that a person must specifically understand the nature and consequences of requesting and accessing voluntary assisted dying.

⁴⁷ In the Netherlands a person who is aged 16 years or older can make a written statement containing a request for termination of life (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 2.2). In Belgium a person can make a written request through an advance directive (*Act on Euthanasia of 28 May 2002* (Belgium), s. 4). In Luxembourg a person can make a written request through end-of-life provisions where certain criteria are met (*Law of 16 March 2009 on euthanasia and assisted suicide* (Luxembourg), art 4.1–3).

⁴⁸ *Medical Treatment Planning and Decisions Act 2016* (Vic), s. 4(1); *Mental Health Act 2014* (Vic), s. 68(1); *Powers of Attorney Act 2014* (Vic), s. 4(1).

Assessing decision-making capacity

The Parliamentary Committee did not indicate how a person's decision-making capacity should be assessed in its recommended framework. Legislative tests for capacity currently exist in the *Medical Treatment Planning and Decisions Act 2016*, the *Mental Health Act 2014*, and the *Powers of Attorney Act 2014*.

These Acts state that a person is presumed to have capacity.⁴⁹ These Acts also recognise that a person may have capacity to make some decisions and not others (that is, their capacity may be decision-specific), and that where a person does not have decision-making capacity for a particular decision, it may be temporary and not permanent.⁵⁰ Feedback during the consultation process revealed strong support among stakeholders for the use of a test for decision-making capacity that recognises and applies these principles. The test set out in the *Medical Treatment Planning and Decision Act* received substantial support and was endorsed by medical, nursing, and legal representatives and organisations.

The Panel considers that the four part decision-making capacity test in the *Medical Treatment Planning and Decisions Act* should be used to assess an adult's decision-making capacity in relation to voluntary assisted dying. The Act is contemporary, having been passed in 2016, and is generally regarded as appropriate to test decision-making capacity for a wide range of medical treatment decisions. In addition, use of this test takes into account feedback received during the consultation process that having one test that applies across a range of medical interventions is likely to achieve consistent application by medical practitioners.

Ministerial Advisory Panel Recommendation 3

That the capacity test in the *Medical Treatment Planning and Decisions Act* is used to assess a person's decision-making capacity in relation to voluntary assisted dying.

Policy intent

To ensure medical practitioners use a contemporary and context-relevant capacity test to assess decision-making capacity in relation to voluntary assisted dying.

⁴⁹ The *Medical Treatment Planning and Decisions Act 2016* (Vic) uses the word 'adult'. See *Medical Treatment Planning and Decisions Act 2016* (Vic), s. 4(2); *Mental Health Act 2014* (Vic), s. 70(2); *Powers of Attorney Act 2014* (Vic), s. 4(2).

⁵⁰ *Medical Treatment Planning and Decisions Act 2016* (Vic), s. 4(4); *Mental Health Act 2014* (Vic), s. 68; *Powers of Attorney Act 2014* (Vic), s. 4(4).

Advance care directives

Decision-making capacity and requests for voluntary assisted dying in advance care directives

Feedback to both the Parliamentary Committee and the Panel was that future loss of decision-making capacity is one of people's biggest fears and is something they often want to avoid. People who had witnessed the progression of a loved one's cognitive deterioration considered that people with conditions that cause such deterioration should have the same ability to control the timing and manner of their death as people with decision-making capacity. It was these circumstances that led some stakeholders to support the option for voluntary assisted dying requests to be made in advance care directives.

In overseas jurisdictions where making a request for voluntary assisted dying in an advance care directive is allowed, how it is handled varies. In Belgium voluntary assisted dying may only be provided through an advance care directive if a person is unconscious.⁵¹ In the Netherlands, legislation does not provide any guidance about the time or circumstance in which an advance care directive for voluntary assisted dying comes into effect.

The Panel considers that there is a fundamental difference between refusing life-sustaining medical treatment in an advance care directive and requesting voluntary assisted dying. When refusing medical treatment in an advance care directive, a person identifies medical treatment that would be unacceptable to them, they do not ask to die. By contrast, if a person requested voluntary assisted dying in an advance care directive they would need to identify a point at which they would want to die in advance of reaching this point. The Panel is of the view that while a person may appreciate the nature and effect of different medical treatments in advance, and consent to or refuse these, it is not possible for them to accurately identify in advance a point in time at which they would want to die.

The framework recommended for voluntary assisted dying does not provide for universal access to voluntary assisted dying. The person must complete a request and assessment process to demonstrate eligibility and it is not clear how this process would work in an advance care directive. By contrast, everyone has the right to refuse medical treatment and the obligations of medical practitioners are clear in these circumstances. A person cannot demand treatment in an advance care directive; they may consent to clinically indicated medical treatment or refuse medical treatment. Voluntary assisted dying will not be a clinically indicated treatment that a medical practitioner offers. This means it is not clear who would commence the assessment process, or when they would commence it, if people were allowed to include a request in an advance care directive.

⁵¹ *Act on Euthanasia of 28 May 2002* (Belgium), s. 4(2).



The Panel is of the view that excluding people who do not have decision-making capacity from accessing voluntary assisted dying creates a clear and enforceable line. This means access will only be granted to people making voluntary and properly informed decisions to access voluntary assisted dying at the time they may make a request. This removes any doubt or ambiguity about their intention.

Dementia and requests for voluntary assisted dying in advance care directives

Stakeholders, including people in the early stages of dementia, expressed concern that people with dementia would not be able to make requests for voluntary assisted dying in advance care directives so that a lethal dose of medication could be administered when they no longer had decision-making capacity.⁵² People who had a 'lived experience' of dementia (either a diagnosis of dementia themselves, or as carers), health practitioners who worked in the field, and advocacy groups all commented on the distressing nature of dementia and the impact it can have on the person, their family and friends. These stakeholders also recognised the complexity and challenges that would need to be addressed for legislation to allow people with dementia to request voluntary assisted dying in advance care directives.

The challenge for health and social care delivery is that while dementia is now recognised as a terminal medical condition, people may live for many years with dementia with varying levels of incapacity, and how an individual adjusts to its progression may change over this time. The Panel acknowledges the terminal nature of dementia, that decision-making capacity for someone with dementia may fluctuate, and that cognitive ability will decline over a person's illness trajectory.

The Panel considered the issue of people with dementia requesting voluntary assisted dying in advance care directives at length in light of the literature, international experience, and feedback from the consultation process. After considerable reflection, the Panel continues to hold the view that balancing principles of respecting individual autonomy and the need to ensure effective safeguards for people without decision-making capacity requires that requests for voluntary assisted dying in advance care directives are invalid.

The Panel has made this decision noting that, in other jurisdictions, a significant percentage of people do not take the lethal dose of medication after they have filled the prescription. In Oregon, for example, 30 per cent of people who have the medication prescribed do not take it. The Panel notes that there is no ability to check with a person who does not have decision-making capacity whether they still want to administer the lethal dose of medication and at what point. The timing of this would always be a subjective judgement made by another person. Requiring a person to have decision-making capacity to choose to administer or not administer the lethal dose of medication is a fundamental safeguard.

⁵² Dementia describes the symptoms of a large group of illnesses that cause a progressive decline in a person's functioning through loss of memory, intellect, rationality, social skills and physical functioning. There are many types of dementia including Alzheimer's disease, vascular dementia, frontotemporal dementia and Lewy Body Disease. See Alzheimer's Australia (February 2017), *Key facts and statistics 2017*, viewed 29 May 2017, <<https://www.fightdementia.org.au/media/key-facts-and-statistics>>.

The Panel acknowledges that loss of cognitive capacity may cause distress to people and accepts there may be people who feel the criterion unfairly discriminates against people with dementia. Nevertheless, the existence of decision-making capacity is such a fundamental safeguard to the protection of individual autonomy and the voluntary assisted dying process that it must be included in the eligibility criteria. Voluntary assisted dying must be 'voluntary' – that is, a person must have decision-making capacity to make an autonomous choice – at all stages of the process. Failure to have this safeguard could 'put very vulnerable people at great risk of manipulation and abuse'.⁵³

Referral requirement

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that where a person's decision-making capacity is in question due to mental illness they must be referred to a psychiatrist for assessment.⁵⁴ The Parliamentary Committee indicated that when a medical practitioner refers a person to a psychiatrist, they would determine whether the person is suffering from a mental illness that makes them incapable of making properly informed decisions about medical treatment.⁵⁵ They also noted that not all cases of mental illness impair a person's decision-making capacity.⁵⁶

Discussion

The requirement to refer people with suspected mental illness exists in other jurisdictions. For example, in Oregon and Washington a physician must refer a person for counselling by a psychiatrist or psychologist when, in their opinion, the person may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement.⁵⁷ In California a physician must refer a person for a mental health specialist assessment where there are indications of a mental disorder.⁵⁸

The consultation process revealed widespread support for a requirement that an assessing medical practitioner refer a person to a psychiatrist where mental illness is suspected to be impairing a person's decision-making capacity. However, there were divergent views as to whether all people who request voluntary assisted dying should be referred for psychiatric assessment. Those who supported psychiatric referrals for all requests for voluntary assisted dying generally did so on the basis that not all medical practitioners would be able to accurately identify when a person has a mental illness that may be impairing their decision-making capacity. This applies particularly to those in the early stages of their medical career who may not yet have the appropriate qualifications, training and expertise, and such referral represents a good safeguard.

⁵³ The Commission on Assisted Dying (2011), *The current legal status of assisted dying is inadequate and incoherent ...*, Demos, London, p. 310, viewed 9 May 2017, <https://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>.

⁵⁴ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. xxxvi, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsic/inquiry/402>>.

⁵⁵ *Ibid*, p. 225.

⁵⁶ *Ibid*, p. 226.

⁵⁷ *Death with Dignity Act* (Oregon), s. 127.825; *Death with Dignity Act* (Washington), s. 6.

⁵⁸ *End of Life Option Act* (California), s. 443.5(a)(1)(A)(i)–(iii). A similar provision also exists in the *End-of-life Options Act* (Colorado), ss. 25.48.106(f), 25.48.108(1)–(3).



Those who did not support psychiatric referrals for all requests for voluntary assisted dying expressed confidence in the ability of experienced medical practitioners to identify issues relating to mental illness that would warrant referral to a psychiatrist.

Mental health specialists indicated that they did not want to be seen as 'gatekeepers' to voluntary assisted dying and that referrals in all requests for voluntary assisted dying may compromise the therapeutic role a psychiatrist may play. Further, it could create an access barrier for people living in rural areas or create unnecessary delays.

While there were divergent views about mandating a role for psychiatrists, there was strong support throughout the consultation process for ensuring medical practitioners have appropriate qualifications, training and expertise. The Panel recognises the importance of this in supporting high-quality assessments and referrals, and has made clear recommendations about the expected qualifications, training and expertise of assessing medical practitioners (see Recommendations 14, 15 and 16).

The Panel also received strong feedback during the consultation process that legislation should not limit referral requirements to psychiatrists. It was noted that there are other factors that have the potential to impact on a person's decision-making capacity that are not related to mental illness and, as a result, psychiatrists may not always be the most appropriate medical practitioner to receive referrals.

Geriatricians, psycho-geriatricians, neurologists, neuropsychologists, psycho-oncologists, psychologists and palliative care specialists were all identified as specialists who could potentially make assessments about a person's decision-making capacity depending on the nature of the concern giving rise to the doubt about a person's capacity. For example, when an assessing medical practitioner suspects an elderly person may have a degree of cognitive impairment that may be impacting on their decision-making capacity in relation to voluntary assisted dying the assessing medical practitioner may refer them to a geriatrician for assessment. Where an assessing medical practitioner suspects a person's brain tumour or previous cerebrovascular accident may be impacting on their decision-making capacity they may refer them to a neuropsychologist for assessment.

The Panel agrees with the Parliamentary Committee's recommendation that where an assessing medical practitioner has doubt about a person's decision-making capacity to access voluntary assisted dying due to the presence, or suspected presence, of mental illness, then a referral to a psychiatrist must be made. The Panel considers that in this situation the psychiatrist should assess whether or not the person has decision-making capacity in relation to voluntary assisted dying, but that this does not preclude the psychiatrist from offering clinically indicated treatments. The Panel is also of the view that a person's prior history of mental illness may not always warrant referral to a psychiatrist for assessment in relation to voluntary assisted dying.⁵⁹

⁵⁹ For example, a person with a history of mental illness that occurred 20 years ago may not require referral to a psychiatrist for assessment in relation to voluntary assisted dying, whereas a person with a history of recurring mental illness may require referral to a psychiatrist for assessment in relation to voluntary assisted dying.

The Panel does not consider that psychiatric referrals are required for all people who request voluntary assisted dying. Such a requirement is likely to create an unnecessary access barrier for people, particularly those living in rural areas, and make the voluntary assisted dying process more onerous than it needs to be.⁶⁰

Furthermore, psychiatrists are not the only arbiters of decision-making capacity. While they do have expertise in assessing decision-making capacity in the context of mental illness, they do not necessarily have the expertise in relation to other factors that may be impairing a person's decision-making capacity. This is consistent with the Royal Australian and New Zealand College of Psychiatrists' 2016 position statement on physician assisted dying, which states that 'Psychiatrists may have a role with patients who are considering or wish to discuss [physician-assisted suicide] through the identification and treatment of mental illness and when appropriate, making recommendations for patients' mental health treatment and care'.⁶¹

The Panel considers it important that where referrals are required they are made to appropriate specialists with the necessary qualifications, training and expertise to assess a person's decision-making capacity. Consistent with existing good practice, where an assessing medical practitioner is in doubt about whether a person has decision-making capacity they must refer them to an appropriate specialist for assessment of decision-making capacity in relation to voluntary assisted dying. The purpose of the referral would be to inform the assessment of the assessing medical practitioner in relation to the person's eligibility to access voluntary assisted dying, not to refer responsibility for undertaking the entire assessment to the specialist health practitioner.

Ministerial Advisory Panel Recommendation 4

That when an assessing medical practitioner is in doubt about whether a person has decision-making capacity in relation to voluntary assisted dying, a referral must be made to an appropriate specialist for assessment.

Policy intent

To ensure that when a person's decision-making capacity in relation to voluntary assisted dying is in doubt it is assessed by the most appropriate expert so that assessing medical practitioners can be confident in finding a person has adequate decision-making capacity to access voluntary assisted dying.

60 Gopal, A (2015), 'Physician-assisted suicide: considering the evidence, existential distress, and an emerging role for psychiatry, *Journal of the American Academy of Psychiatry & the Law*, vol. 43, no. 2, pp. 183–190, p. 188.

61 Royal Australian and New Zealand College of Psychiatrists (2016), *Position statement 67: physician assisted suicide*, viewed 19 June 2017, <https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-67-Physician-Assisted-Suicide-Feb-2016.aspx>.

Be diagnosed with an incurable disease, illness or medical condition

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- **be diagnosed with an incurable disease, illness or medical condition, that:**
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that voluntary assisted dying be accessible to people who are suffering from a serious and incurable condition that is causing enduring and unbearable suffering that cannot be relieved in a manner the person deems tolerable, and who are at the end of life (final weeks or months of life).⁶²

Discussion

The Panel has considered the Parliamentary Committee's recommendation and is of the view that further clarification for the community and health practitioners is required. The Panel has therefore made a more detailed recommendation in relation to a person's eligibility in this area.

As a starting point, the Panel recommends that to access voluntary assisted dying a person must be 'diagnosed with an incurable disease, illness or medical condition' that must also satisfy additional criteria discussed in the sections that follow. In reaching this position the Panel has taken into account the considerable variation in views expressed during the consultation process about the meaning and application of the word 'serious', as recommended by the Parliamentary Committee. While this terminology is used in North America, Victorian healthcare providers do not routinely use it to indicate a person is approaching the end of life, and the Panel considers that the terminology used in Victorian voluntary assisted dying legislation should reflect how language is understood in the Victorian context.

⁶² Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 223, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

Serious

The Panel received conflicting feedback during the consultation process about the meaning of the word 'serious' and how it would be assessed. The majority of feedback suggested that because the word 'serious' is subjective in nature it should be defined according to a person's own view, rather than the view of medical practitioners. However, the Panel also received feedback that the word 'serious' would need to be defined in legislation to provide guidance to the community and health practitioners. This would require an objective determination about the word's meaning.

The Panel is of the view that the word 'serious' is too broad and subjective, making it difficult to define in a way that would provide useful and consistent guidance to the community and health practitioners. The Panel recommends a more precise definition of the types of conditions intended to be captured by voluntary assisted dying legislation. These words are discussed in further detail below.

Incurable

Most stakeholders did not consider the word 'incurable' as requiring further definition, but some feedback questioned whether it meant all other treatment options have to be exhausted or proven futile. Feedback generally supported a definition of incurable that took into account the treatments a person deems acceptable.

The Panel recognises that people have the right to refuse life-sustaining medical treatment even when this will result in their death. People with an incurable medical condition may refuse life-sustaining medical treatment for a number of reasons. These reasons may include a reduction in the quality of their life, the experience of unwanted side effects, or their religious beliefs. Sometimes a person may refuse medical treatment because they view the burden of the medical treatment as being greater than the burden of their medical condition. Treatments for medical conditions such as cancer, renal failure, chronic heart failure, chronic obstructive airway diseases and motor neurone disease may all be extremely intrusive and intolerable. The Panel considers that denying a person access to voluntary assisted dying because they have refused medical treatment options that are available but are not acceptable to them would be inconsistent with the right to refuse life-sustaining medical treatment and may infringe other human rights and amount to discrimination.

The Panel has chosen to retain the word 'incurable' in its recommendation because it considers it is well understood by medical practitioners to mean a medical condition that cannot be cured. Medical treatment for a person suffering from an incurable medical condition, such as those identified above, may have the effect of delaying a person's death; however, it will not cure the person's medical condition. Instead, the medical treatment aims to manage the symptoms of the medical condition to promote the person's quality of life and ensure their comfort. The Panel is firmly of the view that a person should not be prevented from accessing voluntary assisted dying when they exercise their right to refuse life-sustaining medical treatment that is managing the symptoms of their incurable medical condition and they meet all of the eligibility criteria for access to voluntary assisted dying.



The Panel notes that a pre-defined list of 'incurable' medical conditions was not supported during the consultation process. It agrees with feedback that a pre-defined list would be too difficult to incorporate into legislation and would become quickly outdated.

Disease, illness or medical condition

The Panel also considers that use of the words 'disease, illness or medical condition' better describes the conditions intended to be captured by voluntary assisted dying legislation. If a person is suffering from an advanced, progressive condition that will cause death and is causing suffering, they should not be precluded from accessing voluntary assisted dying because it is considered a medical condition, rather than a disease or illness. The Panel recommends the use of the words 'medical condition', rather than just 'condition' to clarify that voluntary assisted dying cannot be accessed for suffering associated with decline as a result of ageing or frailty for example. The Panel is of the view that although a disability may be the result, or a symptom, of a disease, illness or medical condition, the disability itself should not be considered a disease, illness, or medical condition for the purposes of the eligibility criteria.

Advanced, progressive and will cause death

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - **is advanced, progressive and will cause death; and**
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

The Parliamentary Committee Inquiry

As noted in the section above, the Parliamentary Committee recommended that to access voluntary assisted dying the nature of a person's condition has to be 'serious' and 'incurable'.

Discussion

There is variability in the way the nature of a person's condition is described in other jurisdictions. For example, Canada requires a person to have a 'grievous and irremediable condition', while the US jurisdictions of California, Oregon and Washington require a person to have a 'terminal disease'.⁶³ Belgium requires a person to have a 'serious and incurable disorder caused by illness or accident'.⁶⁴

Advanced and progressive and will cause death

The Panel received feedback during the consultation process that alternative words better describe the nature of a person's condition for the purposes of eligibility to access voluntary assisted dying. The word 'advanced' was suggested on the basis that it is better understood by practitioners and more specific than the word 'serious'. Furthermore, it relates to a point in the trajectory of a disease, illness or medical condition rather than just describing the disease, illness or medical condition more generally. The word 'progressive' was also suggested on the basis that it indicated an active deterioration in a person's disease, illness or medical condition such that the person is not going to recover and instead will continue to decline. The Panel agrees with this feedback and is of the view that the inclusion of these words will provide the clarity necessary for the community and health practitioners in determining eligibility for access to voluntary assisted dying.

During the consultation process the Panel received considerable feedback that a 'serious and incurable condition' will not always cause death. For example, people with osteoarthritis may describe this medical condition as 'serious and incurable' but it will not cause death. The majority of feedback supported the inclusion of only diseases, illnesses and medical conditions that will cause death.

'Terminal disease' and 'will cause death'

Legislation in California, Oregon and Washington requires that a person have a terminal disease to be able to access voluntary assisted dying. The most common terminal diagnoses for accessing voluntary assisted dying in these jurisdictions are cancer, neurodegenerative diseases, such as motor neurone disease (amyotrophic lateral sclerosis), and heart and respiratory disease.⁶⁵ The European jurisdictions of the Netherlands and Belgium do not require a person to have a terminal disease to access voluntary assisted dying.

63 *Medical Assistance in Dying Act* (Canada), ss. 241.2(1)(c), 241. 2(2); *End of Life Option Act* (California), s. 443.2(1); *Death with Dignity Act* (Oregon), s. 127.805(1); *Death with Dignity Act* (Washington), s. 2(1). Colorado requires a person to have a 'terminal illness' (*End-of-life Options Act* (Colorado), s. 25.48.103(1)(a)) and Vermont requires a person to have a 'terminal condition' (*Patient Choice At End of Life Act* (Vermont), s. 5283(a)(5)(A)).

64 *Act on Euthanasia of 28 May 2002* (Belgium), s. 3.

65 See, for example, Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, p. 9, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>. This is also consistent with data in Government of Canada (31 May 2017), Interim update on medical assistance in dying in Canada June 17 to December 31, 2016, viewed 6 June 2017, <<https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html>> and California Department of Public Health (2017), *California End of Life Option Act 2016 data report*, State of California, viewed 30 June 2017, <<https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act.aspx>>.

The Panel notes that during the consultation process the word 'terminal' was understood to mean different things to people. For example, some considered terminal to describe a person who has a small amount of time left before they die, while others considered terminal to mean that the disease, illness or medical condition is not curable, rather than stipulating closeness to death. Dementia is an example of a disease that unfolds over many years but is still described as terminal. The Panel considers that the words 'will cause death' are more precise and will be better understood by health practitioners in Victoria.

The Panel acknowledges that restricting voluntary assisted dying to people with an incurable disease, illness or medical condition that is advanced, progressive and will cause death will limit the range of people to whom legislation may apply.⁶⁶ However, the Panel agrees with the Parliamentary Committee that 'assisted dying is intended to provide an option that can limit suffering at the end of life, not a way to end life for those who are otherwise not dying'.⁶⁷

The Panel considers that its recommendation that a person be diagnosed with a 'disease, illness or medical condition that is advanced, progressive and will cause death' provides the clarity necessary for the community and health practitioners when it comes to determining eligibility for access to voluntary assisted dying. This terminology reflects contemporary understanding of diseases, illnesses and medical conditions that are clearly 'serious' and will cause death, and is well understood in the Victorian healthcare context.

Expected to cause death within weeks or months, but not longer than 12 months

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - **is expected to cause death within weeks or months, but not longer than 12 months; and**
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

66 Bartels, L & Otlowski, M (2010), 'A right to die? Euthanasia and the law in Australia', *Journal of Law & Medicine*, vol. 17, no. 4, pp. 532–555, p. 537.

67 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 224, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that voluntary assisted dying be available to people who are at the end of life (final weeks or months of life). In making this recommendation the Parliamentary Committee stated:

The Committee's view is that assisted dying in Victoria should be provided only to those who are at the end of life, as determined by a primary doctor and an independent secondary doctor. The Committee does not support an assisted dying framework that extends beyond this. Assisted dying should provide an option that can limit suffering at the very end of life, not a way to end life for those who are otherwise not dying.

The evidence shows that simply knowing there is an option of assisted dying can be immensely beneficial to a person nearing the end of life, whether or not they choose to use it. In Oregon, approximately 30 per cent of people who are prescribed a lethal drug under the assisted dying framework do not take it. For some the feeling of control such an option provides helps to ease suffering and fear of a painful death. This was reflected in evidence the Committee heard from people who are seriously ill and want another option at the end of life.

Doctors are best placed to assess whether a patient is at the end of life. The Committee trusts the judgement of doctors, specialists and health practitioners in determining whether a patient is at the end of life, according to the nature of their condition and its likely trajectory. The Committee believes that empowering doctors to make this assessment is preferable to allocating an arbitrary time limit based on factors that are not applicable to the Victorian context. For example, the six-month requirement specified in the Oregon framework which is based on access to hospice benefits is not applicable to the Australian context which provides universal health care. The Committee believes that this model would in practice apply to those with weeks or months to live, not years, as is the experience in overseas jurisdictions.⁶⁸

Discussion

The Panel agrees with the Parliamentary Committee's recommendation that voluntary assisted dying be available to people who are at the end of life, however, considers that the words 'end of life (final weeks or months of life)' require further clarification. The Panel recommends that a person be diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death, and 'is expected to cause death within weeks or months, but not longer than 12 months'.

In making this recommendation the Panel has taken into account feedback that the criterion of 'final weeks or months of life' as proposed by the Parliamentary Committee is somewhat unclear. During the consultation process it was apparent that people had interpreted the criterion in a range of ways, with some of the view that it meant a person had less than two months to live, while others thought it included those with 24 months to live. The Panel considers that this ambiguity is likely to lead to confusion among the community and medical practitioners who will need guidance as to the parameters

⁶⁸ Ibid, pp. 223–224.

around who may access voluntary assisted dying. For these reasons the Panel has determined that a timeframe should be included in the legislation. The Panel also considers that including a timeframe will prevent expansion of this criterion through practice.

There was no clear consensus during the consultation process as to what an appropriate timeframe would be. The Panel received feedback that supported the use of a range of timeframes including 'foreseeable future', six, 12, 18 and 24 months. The Panel has considered each of these timeframes.

Foreseeable future

The Panel does not support the use of a 'foreseeable future' timeframe. While this timeframe may allow for a variety of clinical circumstances to be taken into account, it remains open to interpretation by individual medical practitioners who are conducting assessments of a person's eligibility to access voluntary assisted dying. As the timeframe does not provide any clear guidance it places the onus on medical practitioners to determine what is foreseeable.

Six months

The Panel notes that a six-month timeframe is used in most US jurisdictions to comply with administrative requirements associated with hospice care. In Victoria there is no such timeframe imposed for access to hospice and palliative care services. The Panel agrees with the Parliamentary Committee that a timeframe should not be incorporated into legislation based on factors that are not relevant to the Victorian healthcare context.

The Panel notes that although a six-month timeframe is more consistent with an end of life clinical trajectory for most advanced cancers, it does not necessarily reflect the clinical trajectories of people who have other non-malignant incurable diseases, illnesses or medical conditions that are advanced, progressive and will cause death, such as motor neurone disease or chronic heart failure. The Panel is of the view that a timeframe should, wherever possible, take into account the clinical trajectories of people with non-cancer illness and so does not support the use of a six-month timeframe.

During the consultation process concern was expressed about people who retain decision-making capacity but have a disease, illness or medical condition that causes them to suffer for a long period prior to their death. Motor neurone disease was often cited when this issue was raised.⁶⁹ The Panel received strong feedback that people with motor neurone disease should not be disadvantaged because of the nature and clinical trajectory of this disease.

⁶⁹ Motor neurone disease describes a group of neurological diseases in which the nerve cells that control the movement of voluntary muscles and assist in movement, speech, swallowing and breathing progressively weaken and die, leading to paralysis. See MND Australia (2013), What is MND?, viewed 14 June 2017, <<https://www.mndaust.asn.au/Get-informed/What-is-MND.aspx>>; MND Victoria (2017), About Motor Neurone Disease (MND), viewed 14 June 2017, <https://www.mnd.asn.au/about_mnd.html>; MND Victoria (2017), What is MND – Introduction, viewed 14 June 2017, <https://www.mnd.asn.au/about_mnd/what-is-mnd/9-what-is-mnd-intro.html>.

12 months

The Panel finds merit in the incorporation of a 12-month timeframe into the legislation. This timeframe is consistent with existing end of life policy documents including the *National Consensus Statement on essential elements for safe and high-quality end-of-life care* and *Victoria's end of life and palliative care framework*.⁷⁰ These documents are familiar to many health practitioners in Victoria, and the *Victorian quality account reporting guidelines for 2016–17*, developed by Safer Care Victoria, will require health services to report on actions taken to incorporate and implement these policy documents in the future.⁷¹

The Panel also agrees with feedback that the use of a 12-month timeframe is more likely to encompass the clinical trajectories of neurodegenerative diseases such as motor neurone disease, where the average life expectancy from disease onset is 2.5 years.⁷² As people with motor neurone disease lose their fine motor skills relatively early in the disease's trajectory they may also lose the physical ability to self-administer the lethal dose of medication. It is important that people with diseases, illnesses and medical conditions that affect fine motor function are given sufficient time to consider all of their options, and a 12-month timeframe will give them this opportunity.

The Panel recognises that considering a 12-month timeframe is also consistent with existing practice. During the consultation process many health practitioners commented that they use the 'surprise question' (Would I be surprised if my patient died in the next 12 months?) when planning and discussing the treatment and care of people who are at the end of life.⁷³ The Panel clarifies that although the surprise question involves consideration of a 12-month timeframe, this question would not be appropriate for assessing the Panel's recommended eligibility criteria.

David is diagnosed with motor neurone disease

David is 57 years old and was diagnosed with motor neurone disease (MND) three years ago. When David was diagnosed with MND his neurologist talked to him about how his symptoms would progress and what this may mean for his care. David understands there is no cure for MND and that he will die.

David's neurologist offers treatments to help manage his symptoms and refers him to MND Victoria where he finds lots of useful information. He joins their peer support group program, Living Well.

David's story continues in Part B.

70 Australian Commission on Safety and Quality in Health Care (2015), *National consensus statement: essential elements for safe and high-quality end-of-life care*, Sydney, pp. 2, 17, 18, viewed 22 March 2017, <<https://www.safetyandquality.gov.au/publications/national-consensus-statement-essential-elements-for-safe-high-quality-end-of-life-care/>>; Department of Health and Human Services (2016), *Victoria's end of life and palliative care framework: a guide for high-quality end of life care for all Victorians*, State of Victoria, Melbourne, pp. 5, 24, viewed 1 May 2017, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/end-of-life-and-palliative-care-framework>>.

71 Safer Care Victoria (2017), *Victorian quality account: reporting guidelines for 2016–17*, State of Victoria, Melbourne, p. 16, viewed 16 June 2017, <<https://www2.health.vic.gov.au/about/participation-and-communication/quality-account>>.

72 MND Australia (2013), Facts and figures, viewed 14 June 2017, <<https://www.mndaust.asn.au/Get-informed/What-is-MND/Facts-and-figures.aspx>>, citing Deloitte Access Economics (2015), *Economic analysis of motor neurone disease in Australia*, Motor Neurone Disease Australia, pp. iii, 19, 74, viewed 15 June 2017, <<https://www2.deloitte.com/au/en/pages/economics/articles/economic-analysis-motor-neurone-disease-australia.html>>.

73 Murray, S & Boyd, K (2011), 'Using the 'surprise question' can identify people with advanced heart failure and COPD who would benefit from a palliative care approach', *Palliative Medicine*, vol. 25, no. 4, p. 382.



The Panel also notes that including a timeframe in the legislation will signal a clear point at which the Voluntary Assisted Dying Review Board (discussed in Part C) can collect and analyse data to assess the operation of the legislation. For example, the collection of data will allow the Board to determine the number of people who have been prescribed a lethal dose of medication and have survived beyond the 12-month timeframe.

The Panel acknowledges that there may be rare instances where a person eligible for voluntary assisted dying does survive beyond the 12-month timeframe. When this occurs the Panel considers that neither the person nor the medical practitioners who assessed the person's eligibility for voluntary assisted dying in good faith and reasonably under the legislation should be penalised.

18–24 months

There is no evidence to support an 18- or 24-month timeframe. The Panel is of the view that this timeframe would include people who had a significant amount of time to live and who are too far away from the final weeks or months of life. Such a timeframe would be inconsistent with the intention of the legislation, which is to apply to people who are at the end of life and close to death.

Is causing suffering that cannot be relieved in a manner the person deems tolerable

That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - **is causing suffering that cannot be relieved in a manner the person deems tolerable.**

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that to be eligible to access voluntary assisted dying a person be experiencing enduring and unbearable suffering that cannot be relieved in a manner the person deems tolerable.⁷⁴ The Parliamentary Committee noted that:

... while a doctor's advice will be invaluable in assisting patients in their decision, in the shift towards patient-centred medicine the Committee believes it is not for others to decide what is and is not tolerable for a patient.⁷⁵

Discussion

The Panel recommends that to be eligible to access voluntary assisted dying a person must be diagnosed with an incurable disease, illness or medical condition that:

- is advanced, progressive and will cause death; and
- is expected to cause death within weeks or months, but not longer than 12 months; and
- is causing suffering that cannot be relieved in a manner the person deems tolerable.

Suffering

Not all pain and suffering can be alleviated. In its *Inquiry into end of life choices: final report* the Parliamentary Committee noted evidence that in a small number of cases, palliative care cannot relieve all pain and suffering.⁷⁶ The Parliamentary Committee identified a core value of end-of-life care as the alleviation of pain and suffering for those who are unwell.⁷⁷ The Panel agrees with this value and that voluntary assisted dying legislation should provide an option for a small number of people whose pain and suffering cannot be relieved in a manner they deem tolerable to control the timing and manner of their death.

The existence of a requirement that a person is suffering in order to access voluntary assisted dying varies among other jurisdictions that have implemented voluntary assisted dying frameworks. The European jurisdictions of the Netherlands, Belgium and Luxembourg all require that a person be experiencing some degree of suffering to be eligible to access voluntary assisted dying.⁷⁸ On the other hand, the US jurisdictions of California, Oregon and Washington only refer to a requirement that a person have a 'terminal disease'.⁷⁹ There is no additional requirement that a person be suffering.

74 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxv, xxxvi, 217, 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

75 *Ibid*, p. 218.

76 *Ibid*, pp. 51, 194.

77 *Ibid*, p. 16.

78 A person's suffering must be 'lasting and unbearable' in the Netherlands (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 2.1.b), 'constant and unbearable' in Belgium (*Act on Euthanasia of 28 May 2002* (Belgium), s. 3.1), 'constant and unbearable' in Luxembourg (*Law of 16 March 2009 on euthanasia and assisted suicide* (Luxembourg), art 2.1.(3)), and 'enduring' in Canada (*Medical Assistance in Dying Act* (Canada), s. 241.2(2)(c)).

79 *End of Life Option Act* (California), s. 443.2(1); *Death with Dignity Act* (Oregon), s. 127.805(1); *Death with Dignity Act* (Washington), s. 2(1).

The Panel agrees with the Parliamentary Committee that the Victorian legislation should require that a person be approaching their death (the North American model) and be suffering (the European model). These dual requirements represent strong safeguards.

Suffering is subjective

Suffering at the end of life may include the physical symptoms of a disease, illness or medical condition such as pain or vomiting, as well as non-physical aspects such as loss of function, control and enjoyment of life, and the nature and prognosis of the disease, illness or medical condition. For some people, unbearable suffering may occur as a result of their experience of one aspect of suffering, while for others, it may be the result of the sum experience of overall suffering.⁸⁰

An incurable disease, illness or medical condition can lead to suffering along a person's clinical trajectory that they may consider unbearable. It is important for health practitioners to discuss and explore any concerns, unmet needs or feelings a person has at the end of their life about the suffering their disease, illness or medical condition is causing. Research shows that a person's experience of the nature and intensity of their suffering is entirely subjective.⁸¹

In their study to develop a patient-oriented measure to assess suffering in end-stage cancer patients in the Netherlands, Ruijs et al (2009) note that:

... years of clinical, and research experience within the research group showed a recurring phenomenon: in patients in whom no difference in quality of life was observed or expressed some would consider their suffering unbearable and ask for euthanasia, and others would not. In other words, the extent to which burdensome signs or symptoms are present does not necessarily parallel the experience of unacceptability.⁸²

80 Ruijs, C et al (2009), 'Unbearability of suffering at the end of life: the development of a new measuring device, the SOS-V', *BMC Palliative Care*, doi:10.1186/1472-684X-8-16; The Task Force to Improve the Care of Terminally-Ill Oregonians Center for Ethics in Health Care, Oregon Health & Science University (2008), *The Oregon Death with Dignity Act: a guidebook for health care professionals*, The Greenwall Foundation, viewed 11 May 2017, <<https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>>.

81 Beijk, M (1998), 'Unbearable suffering. What is it, what is the cause and who determines its presence?', *Med Contact*, vol. 53, pp. 825–827.

82 Ruijs, C et al (2009), 'Unbearability of suffering at the end of life: the development of a new measuring device, the SOS-V', *BMC Palliative Care*, doi:10.1186/1472-684X-8-16.

Suffering in the context of voluntary assisted dying

A person's request for voluntary assisted dying is usually motivated by multiple, interactive factors in relation to progressive, serious illness, including both physical and psychological suffering, a desire to control the circumstances of one's death and to relieve distress over the loss of autonomy.⁸³

International studies and data collected on the reasons why people request voluntary assisted dying have identified the multi-faceted nature of such requests.⁸⁴ Data has been collected in Oregon since 1998 from medical practitioners, family and friends on the reasons why people access voluntary assisted dying. This data has consistently shown that in the majority of cases more than one factor motivates a person's request for voluntary assisted dying. The most commonly cited factors motivating a person's request are:

- loss of autonomy;
- decreased ability to participate in activities that make life enjoyable; and⁸⁵
- loss of dignity.⁸⁶

Consistent with the data collected under Oregon's legislation for the past two decades, the most recent report for 2016 indicates that concerns about loss of autonomy featured in 89.5 per cent of requests, decreased ability to participate in activities that make life enjoyable also in 89.5 per cent of requests, and loss of dignity in 65.4 per cent of requests.⁸⁷

Additional factors cited as motivating a person's request include loss of control of bodily functions; becoming a burden on family, friends and caregivers; having control over their time of death; and physical suffering.⁸⁸

During the consultation process the Panel received considerable feedback that a person's experience of suffering is individual and subjective. It was, however, noted that for a person to become eligible to access voluntary assisted dying, their suffering should be causally linked to their disease, illness or medical condition. People expressed the view that requiring someone to be experiencing 'enduring and unbearable suffering' would be cruel because a person would be required to suffer unnecessarily before being able to access voluntary assisted dying. This was considered to be inconsistent with the compassionate intent of the legislation.

83 Pearlman, R et al (2005), 'Motivations for physician-assisted suicide', *Journal of General Internal Medicine*, vol. 20, no. 3, pp. 234–239, p. 238; Willmott, L et al (2016), '(Failed) voluntary euthanasia law reform in Australia: two decades of trends, models and politics', *University of New South Wales Law Journal*, vol. 39, no. 1, pp. 1–46, pp. 8, 35; Li, M et al (2017), 'Medical assistance in dying: implementing a hospital-based program in Canada', *New England Journal of Medicine*, vol. 376, no. 21, pp. 2082–2088, p. 2088.

84 Richards, N (2017), 'Assisted suicide as a remedy for suffering? The end-of-life preferences of British "suicide tourists"', *Medical Anthropology*, vol. 36, no. 4, pp. 348–362.

85 These first two factors have been consistently identified in all annual data summary reports since 1999.

86 Questions in relation to 'loss of dignity' were first asked in 2003.

87 Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, p. 6, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

88 'Physical suffering' includes pain, dyspnoea (difficult breathing), dysphagia (difficulty swallowing) and the side effects of medication.



Like the Parliamentary Committee, the Panel is of the view that suffering should always be judged by the person themselves. The Panel has taken into account the research that suffering has psychological, social and spiritual aspects as well as physical symptoms like pain, breathlessness and nausea on the one hand and issues of anxiety, lack of dignity and loss of autonomy or control on the other. The Panel also notes that the research shows that perceptions and judgements about suffering are inherently individual and subjective. As a result, the Panel considers it difficult to develop useful objective criteria for assessing a person's overall experience of suffering.

Allowing a person to assess their own suffering avoids the possibility of the criterion being determined by medical practitioners, who may have different understandings about what constitutes suffering.⁸⁹ A Netherland's study found that medical practitioners assess suffering differently depending on the 'cognitive routes' they use when assessing a person's suffering in the context of a request for voluntary assisted dying.⁹⁰ Assessments were influenced by how medical practitioners thought they would experience the situation that the person was in. The study also found that assessments are sometimes influenced by a medical practitioner's private norms, values and emotions around voluntary assisted dying. To eliminate this possibility the Panel considers that only the person themselves should determine their suffering. This is fundamental to autonomy and person-centred care.

Betty is diagnosed with colon cancer

Betty is 67 years old and recently retired as a company manager. She has been diagnosed with colon cancer and undergoes surgery and a subsequent course of chemotherapy, and makes a good recovery. Eight months after the surgery Betty notices persistent abdominal pain and investigations show a recurrence of the cancer. Her oncologist recommends a different chemotherapy, and warns Betty that it will need to be more aggressive. At the same time Betty's general practitioner refers her to palliative care for on-going support. After each weekly infusion of the chemotherapy Betty experiences nausea and extreme tiredness for several days, and she becomes aware of her hair thinning. In the next two months Betty experiences unstable pain and nausea and has two emergency admissions to hospital with fever and increasing abdominal pain. Further tests reveal that the cancer had spread to her liver and right lung. Betty's oncologist explains to her that it is likely she will die within the next few months.

Betty refuses any further chemotherapy because of its negative physical side effects and impact on her quality of life. She completes an advance care directive which is witnessed by her general practitioner and shared with her partner, John, and her oncologist. It states her preference to avoid hospital admission if possible, and for her care to focus on comfort. She states that no attempts at resuscitation be made if her condition suddenly deteriorates.

Betty's story continues in Part B.

89 Willmott, L et al (2016), '(Failed) voluntary euthanasia law reform in Australia: two decades of trends, models and politics', *University of New South Wales Law Journal*, vol. 39, no. 1, pp. 1–46, p. 37.

90 Van Tol, D, Rietjens, J & van der Hilde, A (2012), 'Empathy and the application of the 'unbearable suffering' criterion in Dutch euthanasia practice', *Health Policy*, vol. 105, no. 2-3, pp. 296–302, p. 296.

The Panel has diverged from the Parliamentary Committee by not recommending that a person experience 'enduring and unbearable' suffering. In reaching this position the Panel agrees with the report by the United Kingdom's Commission on Assisted Dying that such words are too subjective, excessive and unreasonable for a medical practitioner to assess.⁹¹

The Panel has considered the research and taken into account the feedback that requiring a person to experience 'enduring and unbearable' suffering would require people to suffer unbearably for too long before they become eligible to access voluntary assisted dying. The Panel has also concluded that requiring suffering to be 'enduring and unbearable' does not provide any meaningful additional safeguard and is not in keeping with its aim of developing compassionate voluntary assisted dying legislation. The word 'suffering', on its own, denotes a sufficiently high threshold for eligibility to access voluntary assisted dying.

Tolerability

The Panel agrees with the Parliamentary Committee that it is not for others to decide what is and is not tolerable for a person. Health practitioners have an important role in providing options that might relieve a person's suffering; but ultimately, whether or not this suffering can be relieved in a manner that is tolerable, is a judgement that has to be made by the person who is experiencing the suffering.

Voluntary assisted dying must be person-centred and the Panel affirms that suffering should be judged by the person. The evidence discussed above suggests that people may judge some suffering more intolerable to them than others. For example, some people may find loss of autonomy more unbearable than pain, while others may find pain the most unbearable element of the disease, illness or medical condition. Adding further description to the suffering such as 'enduring and unbearable' may mean others would apply their own meaning to these words and it would therefore cease to be an assessment made by the person themselves. If a medical practitioner could find that a person's suffering was not sufficient for eligibility to access voluntary assisted dying, this would no longer be a subjective test and would instead become a medical judgement. The Panel has concluded that suffering that is deemed intolerable by the person themselves, and not by others, represents an important safeguard.

⁹¹ The Commission on Assisted Dying (2011), *The current legal status of assisted dying is inadequate and incoherent ...*, Demos, London, pp. 27, 305, viewed 9 May 2017, <https://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>.

Eligibility considerations

During the consultation process there was discussion about the dual concerns of discrimination and potential vulnerability to abuse. In this section, the Panel addresses these considerations in relation to people with mental illness and people with disabilities.

Mental illness

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that suffering as a result of mental illness only does not satisfy the eligibility criteria for voluntary assisted dying. It noted it did not receive evidence during its inquiry that compelled it to consider including mental illness alone as part of the eligibility criteria.⁹²

Discussion

The Panel agrees with the Parliamentary Committee and recommends that having mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying. However, the Panel has also recommended that having mental illness does not exclude a person from accessing voluntary assisted dying if they meet all of the eligibility criteria.

The approach to mental illness differs among other jurisdictions with voluntary assisted dying frameworks. Legislation in the European jurisdictions of the Netherlands, Belgium and Luxembourg is silent about the presence or suspected presence of mental illness. However, in the Netherlands a request must be 'well-considered', and in Belgium and Luxembourg the person making the request is generally required to be either 'competent' or 'capable', subject to some limited exceptions to make a request. The US jurisdictions of Oregon and Washington expressly require that an assessing medical practitioner refer a person for counselling when they are suspected to be suffering from a psychiatric or psychological disorder or depression causing impaired judgement. In Canada, a person with a mental illness may be eligible for medical assistance in dying if they meet all of the eligibility criteria.⁹³

⁹² Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 223, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

⁹³ Government of Canada (24 April 2017), Medical assistance in dying, viewed 8 June 2017, <<https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a2>>.

People with mental illness alone do not satisfy the eligibility criteria for voluntary assisted dying

The Panel acknowledges that allowing a person to access voluntary assisted dying solely on the basis of mental illness is a significant concern for many in the community. During the consultation process there was almost universal agreement that mental illness alone should not be a reason for a person to access voluntary assisted dying, acknowledging that, for some people, suffering from mental illness may be very significant and difficult to bear. The Panel agrees, noting that mental illness alone would not satisfy the eligibility criteria it has proposed because it is not a medical condition that 'will cause death'.

People with mental illness who satisfy the eligibility criteria for voluntary assisted dying

During the consultation process, it was, however, acknowledged that people with mental illness may be diagnosed with an incurable disease, illness or medical condition that is advanced, progressive and will cause death. There was strong feedback from stakeholders that people who have decision-making capacity in relation to voluntary assisted dying and meet all of the other eligibility criteria should not be denied access to voluntary assisted dying just because they also have mental illness. Stakeholders considered that people with mental illness should have the same opportunities and protections as others members of the community, and to not provide these same opportunities and protections would be discriminatory.

Stakeholders also noted during the consultation process that reactive or situational depression and demoralisation may be part of a normal and expected response in people who have been diagnosed with an incurable disease, illness or medical condition that will cause death, and are treatable.⁹⁴

A systematic review of research in the Netherlands and Oregon has concluded that:

Up to half of patients requesting [voluntary assisted dying] may show symptoms of depression but, in the Dutch regulatory system, most patients with depression have their requests refused and the rate of depression in cases is not significantly different from that of the surrounding population.⁹⁵

The Panel acknowledges that many people at the end of their lives may experience psychological or emotional distress because of the disease, illness or medical condition that will cause their death. It is of the view that if a person meets all of the eligibility criteria, they should not be denied access to voluntary assisted dying just because they are experiencing this psychological or emotional distress about their suffering and impending death.

⁹⁴ Gopal, A (2015), 'Physician-assisted suicide: considering the evidence, existential distress, and an emerging role for psychiatry', *Journal of the American Academy of Psychiatry and the Law*, vol. 43, no. 2, pp. 183–190, p. 187.

⁹⁵ Levene, I & Parker, M (2011), 'Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review', *Journal of Medical Ethics*, vol. 37, no. 4, pp. 205–211, p. 210.

The Panel considers that Recommendation 5 (below) strikes an appropriate balance between providing a necessary safeguard to protect people who may be vulnerable without unreasonably restricting the opportunity to access voluntary assisted dying for people with mental illness who meet all of the eligibility criteria. The strict eligibility criteria to access voluntary assisted dying act as a safeguard for people with mental illness because access is not available unless a person has decision-making capacity in relation to voluntary assisted dying and meets all of the other eligibility criteria.

The Panel also reiterates that it recommends that where an assessing medical practitioner is in doubt about whether a person has decision-making capacity in relation to voluntary assisted dying (that would include due to the presence, suspected presence or, in some circumstances, history of mental illness), a referral must be made to an appropriate specialist for assessment. As noted, this means that where an assessing medical practitioner suspects mental illness may be influencing a person's request for voluntary assisted dying they have an obligation to refer the person for a psychiatric assessment.

Ministerial Advisory Panel Recommendation 5

That mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does mental illness exclude a person from eligibility to access voluntary assisted dying.

Policy intent

To ensure people with mental illness are afforded the same rights and protections as other members of the community and that people with mental illness who meet all of the eligibility criteria are not unreasonably denied access to voluntary assisted dying.

Disability

The Parliamentary Committee Inquiry

The Parliamentary Committee did not make any recommendations or observations about people with disabilities and voluntary assisted dying.

Discussion

The Panel recommends that disability does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does disability exclude a person from eligibility to access voluntary assisted dying.

Equality

Victorian law recognises that people with disabilities have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities.⁹⁶ People with disabilities have the same right as other members of the community to:

- respect for their human worth and dignity as individuals;
- live free from abuse, neglect or exploitation;
- realise their individual capacity for physical, social, emotional and intellectual development;
- exercise control over their own lives;
- participate actively in the decision that affect their lives and have information and be supported where necessary, to enable this to occur;
- access information and communicate in a manner appropriate to their communication and cultural needs;
- services which support their quality of life.⁹⁷

During the consultation process people with disabilities expressed the view they should have the same rights and protections as other members of the community in relation to voluntary assisted dying and should not be denied the opportunity to access voluntary assisted dying if they also meet all of the eligibility criteria.

⁹⁶ *Disability Act 2006 (Vic)*, s. 5(1).

⁹⁷ *Ibid*, s. 5 (2).

Scenarios involving people with disabilities

In Victoria, people with disabilities have the same rights and responsibilities as everyone else, and meeting the eligibility criteria and undertaking the request and assessment process for voluntary assisted dying is no different. The Panel is clear that having a disability will not be a reason for accessing voluntary assisted dying. However, having a disability will not stop a person from accessing the process. Three potential scenarios about requesting voluntary assisted dying are briefly set out here to highlight the key issues.

Tom's story

Tom is 27 years old and had a diving accident two years ago, which left him with an incomplete spinal cord injury resulting in quadriplegia. This led to Tom losing much of his independence. Having lost his employment, and believing he has very limited future prospects, Tom moved in with his parents, and is reliant on them to meet his support needs.

Tom's family have supported him with very little formal assistance. Tom has decided that he wants to access voluntary assisted dying and requests this from his medical practitioner.

Tom's medical practitioner advises him that he does not meet all of the eligibility criteria for access to voluntary assisted dying. While he does have a serious and incurable condition, it will not cause death within weeks or months.

Tom's medical practitioner refers him to a disability service provider specialising in spinal cord injury that has counsellors who are skilled in providing support to people who have acquired a disability through injury. A counsellor helps Tom negotiate access to the National Disability Insurance Scheme to improve his access to services and employment through further education.

The Panel agrees that a person who meets all of the eligibility criteria and also has a disability should not be denied access to voluntary assisted dying just because they have a disability. The Panel considers this would be discriminatory.

Concerns about abuse and devaluing people with disabilities

The Panel acknowledges concern among some members of the disability community that people with disabilities may be vulnerable to abuse if voluntary assisted dying legislation is introduced in Victoria. The Panel has considered and recommends a number of additional safeguards as part of the voluntary assisted dying legislation that protect individuals, including people with disabilities. It emphasises that people with disabilities will not be able to access voluntary assisted dying unless they meet all of the eligibility criteria, including having decision-making capacity in relation to voluntary assisted dying and be diagnosed with an incurable disease, illness or medical condition (that is, advanced, progressive and will cause death, and is expected to cause death within weeks or months, but not longer than 12 months, and is causing suffering that cannot be relieved in a manner they deem tolerable).

Like other people, the issue must be raised by the person themselves, and a request cannot be made on behalf of another through an advance care directive or substitute decision-maker. The safeguard of requiring a person to have decision-making capacity to access voluntary assisted dying is designed to ensure the request is the person's own, is voluntary and is not the product of undue influence or coercion. The Panel is also of the view that a person with a disability that affects their ability to communicate should be able to access communication assistance, including qualified interpreters, to request voluntary assisted dying and has made a recommendation in relation to this (see Recommendation 11).

Joe, Cathy and Charlie's story

Joe and Cathy are the parents of Charlie, who is 37 years old. Charlie has an intellectual disability as well as a physical disability and lives in a group home, where he receives 24 hour support.

Charlie has been diagnosed with an incurable medical condition which will cause death within weeks or months.

Charlie's parents have responsibility for all decisions about every aspect of his life, including his health needs. Driven by concern that Charlie is in considerable pain and traumatised by medical treatment, they request that he be able to access voluntary assisted dying. Their request is denied because a request for voluntary assisted dying must always be initiated by the person themselves and the person must have decision-making capacity in relation to voluntary assisted dying. Only Charlie can make a request for voluntary assisted dying and he needs to meet all of the eligibility criteria.

Charlie's general practitioner recommends increased palliative care, and requests that his case worker seek increased support from the National Disability Insurance Scheme so that he can be cared for and, when the time comes, die in the familiar environment of his group home.

Tina's story

Tina is 43 years old and has cerebral palsy. Fully employed as a disability advocate and educator, Tina lives independently and communicates using a communication tool.

Six months ago Tina was diagnosed with an aggressive cancer for which she has now exhausted all treatment options.

Tina has decided that she wants to access voluntary assisted dying. As Tina meets all of the eligibility criteria she has the same rights as other Victorians to access the voluntary assisted dying request and assessment process, which includes assessing that Tina's request is voluntary and enduring.

The process followed is no different than it is for other Victorians. Tina's alternative method of communication will be no barrier to access as the proposed framework requires that communication be in a manner which suits the person.

Ministerial Advisory Panel Recommendation 6

That disability does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does disability exclude a person from eligibility to access voluntary assisted dying.

Policy intent

To ensure people with disabilities are afforded the same rights and protections as other members of the community and that people with disabilities who meet all of the eligibility criteria are not denied access to voluntary assisted dying.



Part B: Request and assessment process

A voluntary assisted dying framework should offer the person genuine choice at the end of their life. Having genuine choice means a full range of options are open to the person and that decisions arise out of considered preferences and not a lack of opportunity to explore other options. The request and assessment process recommended by the Panel will ensure the person's request for voluntary assisted dying is their autonomous choice, and is voluntary, informed and enduring. The Panel's recommended request and assessment process will also ensure a person has the opportunity to explore all of the available treatment options, including palliative care, before proceeding with a request for voluntary assisted dying.

Initiating a request for voluntary assisted dying

The request and assessment process provides an important safeguard to ensure only people who meet all of the eligibility criteria will be able to access voluntary assisted dying. At the same time it recognises a person's autonomy within the parameters of the legislation as well as the existing therapeutic relationships that a person has with the health practitioners who are managing their end-of-life care. The request and assessment process should strike a balance between providing protection from abuse and not being unduly burdensome for a person who is suffering from an incurable disease, illness or medical condition that is advanced, progressive and will cause their death. This section describes the requirements and steps that a person must go through to access voluntary assisted dying and is written from the perspective of the person making a request.

The request must be voluntary

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that a request for voluntary assisted dying must come from the person themselves.⁹⁸ A substitute decision-maker may not request voluntary assisted dying on another person's behalf, despite any power granted to them by virtue of their appointment as substitute decision-maker.⁹⁹ The person must also have decision-making capacity and a request cannot be included as part of an advance care directive.¹⁰⁰

The Parliamentary Committee affirmed that the request must be completely voluntary and properly informed. The voluntariness of the decision, and whether it is free of coercion, is to be judged first by a person's primary medical practitioner, and then by an independent secondary medical practitioner.

Discussion

The person requesting voluntary assisted dying must initiate the request themselves, and must do so voluntarily. Ensuring requests are completely voluntary is fundamental to a voluntary assisted dying framework built on the principle of respect for individual autonomy. No jurisdiction anywhere in the world permits involuntary assisted dying. Other international jurisdictions that have legalised voluntary assisted dying ensure this in a range of ways but generally require multiple requests from the person themselves. Belgium and the Netherlands are the exception to this, as a person may request voluntary assisted dying in an advance care directive.¹⁰¹ Nevertheless, from 2008 to 2011 in the Netherlands between 3.5 per cent and 8.5 per cent of requests were rejected because a lack of voluntariness was identified.¹⁰² In the US jurisdictions a person

98 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 222, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsic/inquiry/402>>.

99 Ibid, p. 222.

100 Ibid, pp. xxxvi.

101 White, B & Willmott, L (2012), 'How should Australia regulate voluntary euthanasia and assisted suicide?', *Journal of Law & Medicine*, vol. 20, no. 2, pp. 410–438, p. 416.

102 Lewis, P & Black, I (2013), 'Adherence to the request criterion in jurisdictions where assisted dying is lawful? A review of the criteria and evidence in the Netherlands, Belgium, Oregon, and Switzerland', *Journal of Law, Medicine & Ethics*, vol. 41, no. 4, pp. 885–898, p. 890.

must make three separate requests.¹⁰³ This demonstrates that the person's request is enduring, and its repetition at different points in time also helps confirm that the request is voluntary. North American jurisdictions also require a person to make their request in writing and that it be witnessed by independent witnesses, who also certify that the request is voluntary.¹⁰⁴

There was universal agreement throughout the consultation process that requests for voluntary assisted dying must be voluntary and should be free of coercion from family members, health practitioners or others. Views differed, however, about the most appropriate way to ensure this. Most stakeholders were of the view that an appropriately rigorous request process would ensure requests were voluntary. The Panel notes the strong stakeholder view that only the person themselves should be able to initiate a request for voluntary assisted dying.

Stakeholders expressed particular concerns about elder abuse. It is therefore important that an independent process for assessing requests for access to voluntary assisted dying confirms that requests are voluntary, enduring and free from coercion. The Panel's recommended request and assessment process is far more rigorous than any existing process in Victoria for medical treatment and provides greater opportunity to identify instances of elder abuse. Medical practitioners are not ordinarily required to specifically consider the risk of elder abuse, but will be asked to do so during their assessment. This will be part of specified training proposed by the Panel (see Recommendation 15). This specified training for voluntary assisted dying assessments will be supported by the broader focus on identifying elder abuse.¹⁰⁵

Ensuring requests for access to voluntary assisted dying are indeed voluntary is a key means of protecting people who may be vulnerable to abuse, and the processes in other jurisdictions also appear to be framed to ensure this. A study of people accessing voluntary assisted dying in Oregon and the Netherlands found there was no disproportionate impact on 10 groups of people potentially vulnerable to abuse. The groups included the elderly, those with low educational status, those with physical disabilities, and those from a lower socio-economic background.¹⁰⁶ This suggests that a rigorous request and assessment process ensures that potentially vulnerable groups of people are not over-represented in those who access voluntary assisted dying, and fears that people from particular groups will be pushed into making such requests are ill-founded. Instead, rigorous request and assessment process provide protection from abuse.

¹⁰³ *End of Life Option Act* (California), s. 443.3(a); *Death with Dignity Act* (Oregon), s. 127.840; *Patient Choice At End of Life Act* (Vermont), s. 5283; *Death with Dignity Act* (Washington), s. 9.

¹⁰⁴ *End of Life Option Act* (California), s. 443.11(a); *Medical Assistance in Dying Act* (Canada), s. 3(b); *Death with Dignity Act* (Oregon), s. 127.897; *Patient Choice At End of Life* (Vermont), s. 5283(4); *Death with Dignity Act* (Washington), s. 22.

¹⁰⁵ Department of Health and Human Services (2017), *Elder abuse prevention*, State Government of Victoria, Melbourne, viewed 27 June 2017, <<https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/preventing-elder-abuse>>.

¹⁰⁶ Battin, M et al (2007), 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups', *Journal of Medical Ethics*, vol. 33, no. 10, pp. 591–597.

During the consultations a range of stakeholders raised concerns that people may seek access to voluntary assisted dying because they feel like a burden. The most common reason for accessing voluntary assisted dying in Oregon is loss of autonomy, with 91.4% of people reporting this as a reason.¹⁰⁷ In Oregon 42.2% of people report feeling like a burden as one of a number of reasons they access voluntary assisted dying.¹⁰⁸ There are a range of reasons people may feel concerned about being a burden, including because of the experience they have had caring for another family member with a similar condition. The Panel notes that during the assessment process medical practitioners will be required to explore alternative treatment options and must explain all the support that is available. This assessment process will provide an opportunity for people to openly discuss their concerns with two medical practitioners and will give these medical practitioners an opportunity to connect people to supportive care arrangements that will alleviate these concerns.

The Panel is of the view that the additional safeguards it has recommended will ensure decisions in relation to voluntary assisted dying are voluntary. These safeguards and the assessment process also provide a further opportunity to identify potential abuse; even if a person does not meet the eligibility criteria for voluntary assisted dying, the assessment process will still provide an opportunity to alert health practitioners and services to the situation so they can address any abuse. The Panel notes that while legitimate concerns about elder abuse and coercion must be taken into account in assessing requests for access to voluntary assisted dying, most people who are dying have loving and supportive families and it is important that these relationships are maintained throughout the request and assessment process.

¹⁰⁷ Ibid.

¹⁰⁸ Oregon Public Health Division, Oregon Health Authority (2016), *Oregon's Death with Dignity Act: 2015 data summary*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

Elder abuse

Recent reports by the Australian Law Reform Commission and a New South Wales Parliamentary Committee have highlighted the issue of elder abuse.¹⁰⁹ The World Health Organization defines elder abuse as ‘a single, or repeated act, or lack of appropriate action, occurring with any relationship where there is an expectation of trust which causes harm or distress to an older person’.¹¹⁰ The Australian Law Reform Commission recognised five forms of elder abuse: physical, psychological, financial and sexual abuse, and neglect.¹¹¹ There is limited evidence on the extent of elder abuse in Australia.¹¹²

Neither the Australian Law Reform Commission nor the New South Wales Parliamentary Committee explored the link between elder abuse and voluntary assisted dying or pressuring people to take their own life. The focus of both reports is on preventing financial abuse and the misuse of legal appointments and other documents.

The Panel recognises the importance of preventing abuse and ensuring people’s requests for voluntary assisted dying are voluntary and properly informed. The process recommended by the Panel will identify potential abuse through the two independent assessments conducted by medical practitioners. The person will also be required to create a written declaration of their enduring request, which will also be witnessed by two independent witnesses. These witnesses will also be required to certify that the request appears to be voluntary.

It is important that elder abuse is addressed, and the Panel is of the view that its recommended framework will identify and manage instances of elder abuse. The Panel notes work being undertaken by the Department of Health and Human Services to address elder abuse, including the project to develop an integrated model of care to strengthen responses to elder abuse. This project includes training clinical staff to respond to suspected elder abuse, funding counselling and mediation services, funding full-time liaison officers, and establishing local networks for preventing elder abuse. The Panel also notes that bodies like Seniors Rights Victoria as well as the Commissioner for Senior Victorians and the Ambassador for the Prevention of Elder Abuse already undertake significant work to address elder abuse, including providing training, advice and resources to health practitioners.

109 Australian Law Reform Commission (2017), *Elder abuse: a national legal response*, viewed 27 June 2017, <<https://www.alrc.gov.au/publications/elder-abuse-report>>; Legislative Council General Purpose Standing Committee No. 2 (2016), *Elder abuse in New South Wales*, Parliament of New south Wales, Sydney, viewed 24 May 2017, <<https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2387>>.

110 World Health Organisation (2002), *Toronto Declaration on the Global Prevention of Elder Abuse*, World Health Organization, viewed 27 June 2017, <http://www.who.int/ageing/publications/toronto_declaration/en/>.

111 Australian Law Reform Commission (2017), *Elder abuse: a national legal response*, [2.26], viewed 27 June 2017, <<https://www.alrc.gov.au/publications/elder-abuse-report>>.

112 Ibid, [2.29].

Abuse of people with a disability

In 2016, a Victorian Parliamentary Committee *Inquiry into abuse in disability services* identified widespread abuse and neglect of people with a disability in disability services in Victoria.¹¹³ Concerns about a lack of respect for people with a disability or different treatment of people with a disability were also raised during consultations. The Panel recognised the importance of addressing these concerns when considering its recommendations.

The Panel supports the Government's 'zero tolerance of abuse of people with a disability' and notes the measures taken by the Government in response to the *Inquiry*, including strengthening oversight of disability services.¹¹⁴ This includes the creation of a new code of conduct for disability workers and greater support and training to identify and respond to abuse of people with a disability. Recent steps to clarify the roles of Victoria Police and the Disability Services Commissioner will also assist in responding to instances of abuse effectively.

The framework recommended by the Panel does not allow people to make judgments about the lives of others. The framework allows people who are already at the end of their life to make a choice about how they will die. This decision must always be made by the person themselves. The Panel is confident that the process recommended will identify any coercion or undue influence, and ensure that this is dealt with appropriately.

Ministerial Advisory Panel Recommendation 7

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Ministerial Advisory Panel Recommendation 8

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Policy intent

To ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person's own voluntary decision.

¹¹³ Family and Community Development Committee (2016), *Inquiry into abuse in disability services: final report*, Parliament of Victoria, Melbourne, viewed 19 June 2017, <<http://www.parliament.vic.gov.au/fcdc/inquiries/article/1851>>.

¹¹⁴ Foley, M (2016), *Zero tolerance of abuse of people with a disability: response to the inquiry into abuse in disability services*, State of Victoria, Melbourne, viewed 19 June 2017, <<http://www.parliament.vic.gov.au/fcdc/inquiries/article/3209>>.

Seeking information about voluntary assisted dying

The Parliamentary Committee Inquiry

The Parliamentary Committee made no specific comments about information seeking.

Discussion

The majority of people are likely to initially seek information about voluntary assisted dying through a medical practitioner with whom they already have a therapeutic relationship. This discussion should be part of the usual therapeutic relationship where the patient and medical practitioner discuss the person's disease, illness or medical condition, their diagnoses and prognosis, and all of the treatment options available. Discussions should include family members and friends when this is what the person wants.

The Panel is of the view that the person who is seeking information about voluntary assisted dying should be provided with the opportunity to have these discussions with a medical practitioner with whom they feel comfortable. Being provided with information from a medical practitioner may provide the person with the opportunity to consider voluntary assisted dying and other care options through a more informal process without feeling pressured to begin the request and assessment process. The person also needs to be confident that seeking information about voluntary assisted dying will not result in discrimination or reduced access to treatment or care.

During the consultation process stakeholders suggested that people seeking information or making general enquiries about voluntary assisted dying need to be able to do this without necessarily triggering the formal request and assessment process. This was considered an important safeguard to address the issue of people requesting voluntary assisted dying when they are not aware of alternative options or do not fully understand the process. Through informal conversations, a medical practitioner may ensure the person understands all of their treatment options.

To make properly informed decisions, people need access to appropriate information. The provision of information about voluntary assisted dying may, however, be taken as a suggestion by a health practitioner that their patient should request and access voluntary assisted dying. During the consultation process, a number of stakeholders expressed concerns about health practitioners suggesting voluntary assisted dying to their patients. Health practitioners have considerable influence over the decisions and treatment options

Betty requests information on voluntary assisted dying

Betty is fearful of pain, nausea and weakness. She appreciates the assistance being provided by palliative care, but explains to her general practitioner that everyday activities are becoming increasingly difficult and moving around is becoming more and more painful. She tells her general practitioner that she has very little appetite, is losing weight and is feeling continuously fatigued. While the morphine syrup her general practitioner has prescribed is providing some relief for her abdominal pain, she is experiencing breakthrough pain at increasing intervals and hates the side effects of increased doses such as drowsiness and confusion.

She tells her general practitioner that she is beginning to think seriously about voluntary assisted dying. He talks with her about the options available for her care. He also provides her with some written material about voluntary assisted dying, and briefly explains the process that would be followed if she made a request. He indicates that if she wants to make a formal request, she should make a further long appointment with him. He also suggests that her partner, John, attend with her if this is what she wants.

Betty's story continues below.

their patients may consider. This is why the Panel is recommending that a health practitioner should not be allowed to initiate a conversation about voluntary assisted dying with their patient. Stakeholders were also concerned that people should not be requesting voluntary assisted dying unless they are properly informed. So although a health practitioner should never initiate a discussion about voluntary assisted dying, when asked for information it is important that they are able to provide it, or at least explain where such information may be found. The location of reliable information about end-of-life care options and voluntary assisted dying for members of the community and health practitioners is an issue that will need to be addressed as part of the implementation of legislation.

In the Netherlands medical practitioners receive two to three requests for voluntary assisted dying per year on average, but there are 10 times more requests for voluntary assisted dying than instances of people dying as a result of voluntary assisted dying.¹¹⁵ People may seek information about voluntary assisted dying for a range of reasons, and do so now in Victoria even though it is illegal. For some people, this is a way of signalling that they are experiencing intolerable suffering and should trigger a conversation about how their suffering may be better managed.

Where social issues, such as a feeling of isolation, are driving a person's request for information about voluntary assisted dying, it may be possible to address the person's isolation. It is important that medical practitioners and their patients are able to explore the reasons why a person has raised voluntary assisted dying and be able to address any concerns that may have encouraged the request without triggering a formal request process.

115 Kimsma, G (2010), 'Death by request in the Netherlands: facts, the legal context and effects on physicians, patients and families', *Medicine, Health Care & Philosophy*, vol. 13, no. 4, pp. 355–361, p. 359.

David considers his options

During a consultation a year later David's neurologist notices a decline in David's functioning and asks how he is coping. David says that he is now experiencing a steady decline in his muscle strength and that eating, drinking and clearing his airway has become increasingly difficult and distressing. He also has difficulty breathing when lying down.

David begins to have problems in coughing to clear his airway effectively. After discussion with his neurologist and his support group, he is referred to the Victorian Respiratory Support Service (VRSS), and over-night non-invasive ventilation through a facial mask is arranged. This measure provides David with better comfort at night.

While David's symptoms of respiratory failure are currently being relieved with non-invasive ventilation overnight, it is clear to his neurologist that David will soon need continuous ventilation. David is also provided with artificial nutrition through a feeding tube to assist with maintaining his health. David's neurologist explains that while this means David's nutrition is being maintained, his respiratory muscle weakness will continue to grow as his medical condition progresses. He tells David that these treatments may not continue to be effective and that he expects David has less than 12 months to live. They discuss what is likely to happen next.

David considers his options and talks at length with his neurologist. He also gets information from the VRSS and from MND Victoria and talks with other people with MND. At his next appointment, David states that he would like to continue tube feeding and ventilation for now. He also requests information about voluntary assisted dying. His neurologist discusses this with him and lets him know where he can get further information.

David's story continues below.

Ministerial Advisory Panel Recommendation 9

That a request for information about voluntary assisted dying does not constitute a first request.

Policy intent

To ensure a person who requests information about voluntary assisted dying is given the opportunity to consider that information without feeling pressured to commence the formal request and assessment process.

Withdrawing a request for voluntary assisted dying

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that a person may withdraw their request at any time. If withdrawn, the person's request becomes void and the primary and secondary medical practitioner must assess any subsequent request from the beginning.¹¹⁶

Discussion

The ability to easily withdraw a request for voluntary assisted dying is critical to ensuring the person is acting voluntarily. It must be clear that the person may withdraw their request at any time. This position was strongly supported throughout the consultation process. As with any medical treatment, a person must consent and they retain the right to withdraw their consent to medical treatment at any time.

The Panel affirms that it is of fundamental importance that the person feels free to withdraw from the voluntary assisted dying process at any time and does not feel under any pressure to proceed. For clarity, when a person withdraws their request for voluntary assisted dying and subsequently makes another request, they must commence the request and assessment process from the beginning. This is because a request for voluntary assisted dying should be enduring, and not a transitory or reactionary response.

¹¹⁶ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. 223, 238, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

The Panel anticipates that many people who begin the request and assessment process to access voluntary assisted dying will choose not to complete it. Some people will find the care and treatment options offered by their assessing medical practitioners are sufficient, while others may decide they do not want to continue the voluntary assisted dying process for other reasons.

International jurisdictions do not appear to publish data on the number of people who request voluntary assisted dying but withdraw before completing the process. The Panel notes that the reporting requirements it has recommended will ensure the Voluntary Assisted Dying Review Board (described in Part C) is able to capture this data.

During the consultation process some stakeholders suggested there could be a maximum timeframe within which the request and assessment process must be completed, and that failure to complete the process in this prescribed time would be taken as a withdrawal of the request for voluntary assisted dying. While the Panel considered such a time limitation, it was recognised that this may inadvertently place pressure on people to proceed with voluntary assisted dying and rush its completion. The request and assessment process should only ever proceed on the initiative of the person and should be completed within a timeframe decided by the person. Requiring the person to complete the request and assessment process within a maximum timeframe may rush the person's decisions and inhibit them from exploring alternatives.

Ministerial Advisory Panel Recommendation 10

That the person may withdraw from the voluntary assisted dying process at any time.

When the person withdraws from the voluntary assisted dying process, they must commence the process from the beginning if they decide to make a subsequent request for voluntary assisted dying.

Policy intent

To ensure a person's request for voluntary assisted dying remains voluntary, and that a person does not feel pressure to proceed with a request for voluntary assisted dying.

To ensure a person's request is enduring, and not a transient or reactionary response.

The role of interpreters

The Parliamentary Committee Inquiry

The Parliamentary Committee did not comment on the use of interpreters in its proposed voluntary assisted dying framework.

Discussion

Throughout the consultation process stakeholders recognised Victoria's diverse population and noted that people from culturally and linguistically diverse backgrounds should be able to access information in a way they can understand. Although this is an important matter, it is not unique to voluntary assisted dying. People from culturally and linguistically diverse backgrounds receive medical treatment in Victorian hospitals every day, and there are already processes in place to ensure accredited interpreters are available and through whom an informed consent process can occur. The *Medical Treatment Planning and Decisions Act 2016* recognises that a person may make an advance care directive through an interpreter and requires the interpreter to certify that the person appeared to understand the nature and effect of the document.¹¹⁷

In some forums, stakeholders expressed concern about family members interpreting information on behalf of a person in the context of voluntary assisted dying. In some international jurisdictions this is addressed by including accreditation requirements for interpreters in legislation. For example, in California an interpreter must meet qualification standards and sign a declaration that the person understood the information translated.¹¹⁸ In other international jurisdictions, such as Canada, voluntary assisted dying legislation is silent on the use of interpreters.

The Panel recognises the importance of ensuring people from culturally and linguistically diverse backgrounds are able to access voluntary assisted dying and are properly informed when they do choose to. The Panel recommends that appropriately accredited interpreters be allowed to assist people in making verbal and written requests for voluntary assisted dying. The use of accredited interpreters is an important safeguard in ensuring the interpretation is independent and that the person is acting voluntarily.

People who require other forms of communication assistance should also have the option to use an appropriately qualified interpreter to access voluntary assisted dying. Due to different capabilities, people communicate through a range of different methods that are clearly understood by those familiar with the method of communication. For example, people who do not communicate orally or in writing should not be prevented from accessing voluntary assisted dying when they meet all of the eligibility criteria. An appropriately accredited independent interpreter, who is familiar with the manner in which a person communicates, may assist the person to verbalise their request for voluntary assisted dying and prepare a written request.

¹¹⁷ *Medical Treatment Planning and Decisions Act 2016* (Vic), s. 99.

¹¹⁸ *End of Life Option Act* (California), s. 443.11.

A person who requires communication assistance should be able to access voluntary assisted dying and be able to seek assistance from a qualified interpreter to do so. People from diverse backgrounds, or who do not communicate orally or in writing should not be excluded from accessing voluntary assisted dying if they meet all the eligibility criteria. It is intended that the legislation will still require that a written request is made in English, so a person will be able to obtain assistance from an accredited and independent interpreter in preparing the request.

Ministerial Advisory Panel Recommendation 11

That the legislation support access to voluntary assisted dying for people who are from culturally and linguistically diverse backgrounds and people who require alternative means of communication, by allowing appropriately accredited, independent interpreters to assist them to make verbal and written requests for voluntary assisted dying.

Policy intent

To ensure equitable access to voluntary assisted dying through the use of appropriately accredited independent interpreters for people who fulfil the eligibility criteria.

Receiving a request for voluntary assisted dying

During the consultation process the Panel heard that most health practitioners providing end-of-life care have received requests for voluntary assisted dying from their patients. A range of factors motivate these requests and may often not be the result of a genuine desire to access voluntary assisted dying, but an attempt to raise concerns about something else. Health practitioners providing end-of-life care already have conversations with people about their hopes and fears and help them to tailor their care accordingly. Allowing voluntary assisted dying in very limited circumstances should not significantly alter this therapeutic relationship or the treatment and care provided. For example, the experience of establishing a voluntary assisted dying program within the Seattle Cancer Care Alliance was that voluntary assisted dying was incorporated into their existing treatment options, without seeming to impact on existing therapeutic relationships between patients and medical practitioners offering voluntary assisted dying.¹¹⁹ Voluntary assisted dying legislation will clarify the role of health practitioners in these situations and provide comfort for people who may raise voluntary assisted dying with their health practitioners as part of a broader end-of-life care discussion.

The Panel recognises the critical work of the wide range of health practitioners in providing end-of-life care and is confident this will continue. Voluntary assisted dying legislation is not intended to set out a separate model of care. While the legal process recommended by the Panel places obligations on medical practitioners, it is expected that multidisciplinary teams will continue to provide people with high-quality care. It is likely that other health practitioners, as well as medical practitioners, will receive requests for information about voluntary assisted dying, and it is important they are provided with guidance and support. Other health practitioners may also play an important role in supporting medical practitioners and the person who makes the request through the request and assessment process. The person may also ask them to be present when the person chooses to self-administer the lethal dose of medication. Guidelines about the role of health practitioners will need to be developed, but legislation is not the appropriate mechanism for providing this clinical guidance.

This section focuses on the voluntary assisted dying process from the perspective of medical practitioners and other health practitioners receiving requests and participating in the process.

The role of medical practitioners

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that both a primary medical practitioner and an independent secondary medical practitioner approve a request for voluntary assisted dying. The Parliamentary Committee noted that it is essential that the secondary medical practitioner is independent of both the patient and the primary medical practitioner.

¹¹⁹ Loggers, E et al (2013), 'Implementing a death with dignity program at a comprehensive cancer center', *New England Journal of Medicine*, vol. 368, no. 15, pp. 1417–1424.

The Parliamentary Committee recommended that the secondary medical practitioner must review the patient's record, examine them, and provide their assessment in writing. While both the primary and secondary medical practitioner have responsibilities under the proposed framework, the responsibility for ensuring compliance with procedural statutory requirements, including reporting requirements, lies with the primary medical practitioner. To this end, the primary medical practitioner must submit documentation on all formal written requests, whether approved or rejected.

Discussion

Medical practitioners necessarily play a central role in voluntary assisted dying because they have a lead role in providing treatment and care as well as stewardship of the medications that are appropriate for voluntary assisted dying. The role of medical practitioners could either be that of a gatekeeper in assessing eligibility for voluntary assisted dying, or a more holistic role of ensuring people are provided with appropriate care and have genuine choice at the end of their life. The Panel is of the view that voluntary assisted dying should not occur as a fringe medical practice and that people who decide to request voluntary assisted dying should continue to be provided high-quality treatment and care in accordance with expected standards.

The Panel notes that the Parliamentary Committee used the terms 'primary' and 'secondary' medical practitioner. The Panel uses the terms 'coordinating' and 'consulting' medical practitioner, as these more accurately describe the roles of the medical practitioners in the voluntary assisted dying process.

Most jurisdictions in which voluntary assisted dying has been legalised require the involvement of at least two medical practitioners – one to receive the request and undertake a first assessment and a second to undertake another independent assessment of the person. Some jurisdictions, such as Oregon, require the first assessment to be undertaken by a practitioner who has primary responsibility for the care of the person and the treatment of their terminal disease.¹²⁰ Other jurisdictions, such as Vermont, are less prescriptive and require only a 'bona fide physician-patient relationship'.¹²¹ During the consultation forums, medical practitioners expressed concerns about being expected to provide a lethal dose of medication to a person they did not have a relationship with, and most suggested they would need to undertake their own assessment of the person if they were going to participate.

The Panel recognises that the respective roles of the two assessing medical practitioners need to be clear. It is important that the process of assessment is well organised and structured and that therapeutic relationships between the person and their treating medical practitioners are maintained as the assessment process proceeds. The Panel notes stakeholder views that one of the assessing medical practitioners should be responsible for coordinating the assessment process for the person making the request. There are well-established procedures for obtaining independent clinical opinions that are applicable to the assessment process for voluntary assisted dying requests. The Panel is of the view that these referral procedures are appropriate and sufficient for voluntary assisted dying.

¹²⁰ *Death with Dignity Act (Oregon)*, s. 127.800(2).

¹²¹ *Patient Choice At End Of Life Act (Vermont)*, s. 5281.

The Panel's proposed framework provides two clear roles for the assessing medical practitioners to remove any uncertainty or ambiguity about their respective responsibilities under the legislation. The role of coordinating medical practitioner requires the medical practitioner to take responsibility for the process and to ensure all the legal requirements are met, as well as conducting an assessment of the person's eligibility for access to voluntary assisted dying. The consulting medical practitioner provides a second independent assessment to ensure the person meets the eligibility criteria for voluntary assisted dying and that the person is properly informed. The independence of this assessment provides the community with reassurance about the accuracy of the assessment and the validity of the process.

The coordinating medical practitioner will be responsible for managing both the clinical and the legal processes. The coordinating medical practitioner will need to agree to this at the commencement of the voluntary assisted dying process. The coordinating medical practitioner is responsible for:

- undertaking an assessment;
- referring to a consulting medical practitioner;
- being present when the written declaration of enduring request is witnessed;
- submitting documentation to the Voluntary Assisted Dying Review Board;
- applying for a permit to prescribe the lethal dose of medication;
- prescribing the lethal dose of medication;
- making the determination of whether a person can self-administer the lethal dose of medication or whether the coordinating medical practitioner will need to administer it; and
- administering the lethal dose of medication if this is necessary.

David requests voluntary assisted dying

David formally requests voluntary assisted dying from his neurologist. His neurologist agrees to support him through the voluntary assisted dying process and becomes David's coordinating medical practitioner. David's neurologist explains the formal process and what is involved.

As coordinating medical practitioner, David's neurologist will need to ensure all the requirements set out in the legislation are met, including that he is suitably qualified, and will send reports to the Voluntary Assisted Dying Review Board. Before undertaking David's first assessment, as this is the first time he has done this, he completes the required training.

David's neurologist assesses that David meets the eligibility criteria and makes sure he is properly informed about the process.

They discuss how David is feeling and how his suffering affects him. David says that given the likely breathing difficulties that are causing a lot of fear not only for himself, but also for his wife and children, he would like the local palliative care to provide support for him and his family.

David's neurologist talks to David about the effects and possible complications of the prescribed voluntary assisted dying medication and answers his questions. He makes it clear to David that he can withdraw his request at any time.

David's neurologist refers him to a consulting medical practitioner for a second independent assessment.

David's story continues below.

- The role of the consulting medical practitioner is to undertake the second independent assessment and to independently report their assessment to the Voluntary Assisted Dying Review Board.

If either the coordinating medical practitioner or the consulting medical practitioner is not satisfied that all of the eligibility criteria have been fulfilled, the person will not be able to access voluntary assisted dying.

The Panel recognises that medical practitioners have an existing duty of care to their patients and that this will continue to apply in relation to voluntary assisted dying. As the Medical Board of Australia's *Good medical practice: a code of conduct for medical practitioners in Australia* states: '[r]isk is inherent in healthcare' but medical practitioners have an obligation to minimise risk.¹²² A coordinating medical practitioner will have an ongoing therapeutic relationship with the person as they progress through the voluntary assisted dying process and will be required to identify, minimise and monitor any potential risks. While the consulting medical practitioner will not be engaged to the same extent, they will also be required to identify any potential risks. Potential risks may include an impending loss of decision-making capacity in relation to voluntary assisted dying or concern that a family member may not be trustworthy or is unreliable. Consistent with existing practice, the assessing medical practitioners would be expected to work through these risks with the person. For example, an impending loss of decision-making capacity may require an assessing medical practitioner to explain to the person that they may not be able to access the lethal dose of medication because they may no longer be able to make an informed decision.

Ministerial Advisory Panel Recommendation 12

That two medical practitioners must undertake independent assessments of a person's eligibility for voluntary assisted dying.

Ministerial Advisory Panel Recommendation 13

That the roles of the two assessing medical practitioners be clearly defined as:

- the coordinating medical practitioner; and
- the consulting medical practitioner.

Policy intent

To ensure the responsibilities and obligations of the two assessing medical practitioners are clearly defined to remove uncertainty and ambiguity.

¹²² Medical Board of Australia (2014), *Good medical practice: a code of conduct for doctors in Australia*, Australian Health Practitioner Regulation Agency, viewed 1 June 2017, <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>>.

International example

The case of Jeanette Hall in Oregon illustrates the importance of having two medical practitioners conduct independent assessments of a person's eligibility for voluntary assisted dying. While this case has been cited as an example of the dangers or flaws of voluntary assisted dying, the Panel is of the view that it demonstrates the effectiveness of a rigorous voluntary assisted dying process.

Ms Hall was diagnosed with terminal cancer and was informed by her medical practitioner that she had six months to live. Ms Hall decided that given this diagnosis she would like to access voluntary assisted dying. In Oregon a person must be independently assessed by another medical practitioner who confirms the diagnosis and prognosis before they can access voluntary assisted dying. The second medical practitioner Ms Hall consulted found that her cancer was treatable and Ms Hall has lived a further 15 years.¹²³

Diagnosis and prognosis can be complicated and medical practitioners must manage the associated uncertainty. The requirement that a second medical practitioner undertake an independent assessment of the person's eligibility for voluntary assisted dying ensures any mistakes are identified. It is to be expected that there will be instances in which the consulting medical practitioner disagrees with the coordinating medical practitioner's assessment. If this did not occur the voluntary assisted dying process would not be working effectively. This case study illustrates how a rigorous voluntary assisted dying process ensures people receive proper information and are accurately assessed.

The qualifications of the medical practitioner

The Parliamentary Committee Inquiry

The Parliamentary Committee stated that each medical practitioner must be properly qualified to make a professional diagnosis and prognosis regarding the specific condition of the person requesting voluntary assisted dying.¹²⁴

Discussion

During the consultation process it was generally considered that less experienced medical practitioners should not be involved in the conduct of voluntary assisted dying. This reflected concerns that discussions about death and dying are difficult and require a degree of professional maturity and experience. It was thought that medical practitioners should be appropriately skilled and experienced to have these discussions. There was also concern that medical practitioners have the necessary skills to conduct the assessment of the eligibility criteria and to identify other issues, such as the presence of a mental illness or cognitive impairment that may be impacting on

123 Mulino, D (2016), 'Minority Reports' in Legislative Council Legal and Social Issues Committee, *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, viewed 30 May 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

124 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxv, 225, 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

a person's decision-making capacity. These concerns have been addressed in other jurisdictions by requiring, for example, that the medical practitioner who conducts the second independent assessment 'is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease'.¹²⁵

The Panel notes that medical practitioners already have professional obligations to act within their scope of practice. Medical practitioners assess whether they have the necessary skills to assist or treat patients and, if they do not, they refer them to an appropriate specialist. This is part of standard medical practice, and a medical practitioner risks breaching their professional obligations if they act outside the scope of their practice.

Given that voluntary assisted dying will be a new practice, the Panel recognises the importance of ensuring that only appropriately qualified medical practitioners are involved. This is why the Panel recommends that the two assessing medical practitioners must be Fellows of a College or be vocationally registered, and that at least one of the assessing medical practitioners has at least five years' of post-fellowship experience. To be a Fellow of a College a medical practitioner must have completed a specialist qualification. This is completed after they have become a qualified medical practitioner and involves additional years of training and exams, as set out by their relevant College, while also working as a medical practitioner.

The Panel also recommends that at least one of the assessing medical practitioners has expertise in the person's disease, illness or medical condition. The Panel is of the view that it is not appropriate to require a particular type of specialist expertise. This is because each person requesting voluntary assisted dying will have a different condition, different co-morbidities and different needs. Requiring at least one of the assessing medical practitioners to have expertise in the person's disease, illness or medical condition allows flexibility and recognises that other medical practitioners may have relevant expertise, for example in palliative care. To have expertise in the person's disease, illness or medical condition the assessing medical practitioner would be required to have experience in treating the disease, illness or medical condition, or similar conditions, and training relevant to the condition. The Voluntary Assisted Dying Review Board will also be able to review the expertise of the assessing medical practitioner to ensure their involvement is appropriate.

The Panel is of the view that a high level of expertise is required to have sensitive discussions about death and dying and to identify the person's preferences and values in relation to the end of their life. The assessing medical practitioner must also have the appropriate expertise to conduct a complex assessment and to make a considered prognosis.

¹²⁵ *Death with Dignity Act* (Washington), s. 1(4).

Ministerial Advisory Panel Recommendation 14

That both the coordinating medical practitioner and the consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered); and

- **at least one of the medical practitioners must have at least five years post fellowship experience; and**
- **at least one of the medical practitioners must have expertise in the person's disease, illness or medical condition.**

Policy intent

To ensure there is a robust assessment process for a person who requests access to voluntary assisted dying.

Further training for medical practitioners

The Parliamentary Committee Inquiry

The Parliamentary Committee was silent on legislated training for medical practitioners and other health practitioners who may be involved in voluntary assisted dying. The Parliamentary Committee proposed the provision of education and training programs in end-of-life care for health practitioners as part of implementation.¹²⁶

Discussion

Voluntary assisted dying will require a range of new obligations for participating medical practitioners. It is important that medical practitioners provide voluntary assisted dying in accordance with best practice and their legal obligations. A medical practitioner already has an obligation to be up to date with new medical interventions in their particular field. Voluntary assisted dying will require medical practitioners to apply a statutory framework that will guide clinical practice and assessments. International jurisdictions do not provide explicit training requirements in their legislation. However, some, such as Canada, require 'reasonable knowledge, care and skill' but do not provide detail about what this means.¹²⁷

The Panel recommends clear eligibility criteria for voluntary assisted dying that a medical practitioner will need to assess to determine a person's eligibility for voluntary assisted dying. While medical practitioners assess people against criteria in other circumstances, the voluntary assisted dying eligibility criteria will be new to medical practitioners and there will be no established practice or experience to draw upon in assessing these criteria.

¹²⁶ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxviii, 230, 234, 240, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

¹²⁷ *Medical Assistance in Dying Act* (Canada), s. 241.2(7).

Medical practitioners already undertake significant amounts of ongoing training and professional development. Research suggests that training focused on person-centred care can improve patient satisfaction.¹²⁸ Voluntary assisted dying will place a range of new obligations on medical practitioners who participate. It is important that medical practitioners understand their obligations before they commence the voluntary assisted dying process with a person so they understand what they are agreeing to participate in. In the Netherlands the *Support and Consultation on Euthanasia in the Netherlands* program provides training to consulting medical practitioners. These specifically trained medical practitioners provide a second independent assessment of people requesting voluntary assisted dying to determine whether they meet the eligibility criteria in 80 per cent of cases.¹²⁹ In around 25 per cent of cases in the Netherlands, medical practitioners determine that the person does not meet the eligibility criteria.¹³⁰ A study of the assessments of consulting medical practitioners specifically trained under the program found consistency across the practitioners' assessments.¹³¹

There was strong support during the consultation process for voluntary assisted dying processes to be embedded in existing clinical practice and existing clinical relationships to help ensure people are given access to a full range of options. Requiring medical practitioners to be specifically trained prior to acting on a request for voluntary assisted dying may undermine this because the medical practitioners with whom a person has an existing relationship are unlikely to have undergone the specified training. Instead, there should be training readily available to medical practitioners who want to provide voluntary assisted dying when they receive a request.

The Panel recommends that medical practitioners be required to undertake training prior to conducting an assessment to determine whether a person is eligible for voluntary assisted dying. This means that a medical practitioner will be able to undertake the training after a request has been made and allows the therapeutic medical practitioner-patient relationship to be maintained. While the Netherlands provides training only to the consulting medical practitioner, the Panel recognises the importance of high-quality and consistent assessments of whether people meet the eligibility criteria for voluntary assisted dying at each step of the process. It is therefore important to ensure the assessments by both the coordinating and consulting medical practitioners are as accurate as possible.

128 Dwamena, F et al (2012), 'Interventions for providers to promote a patient-centred approach in clinical consultations (Review)', *Cochrane Database of Systematic Reviews*, no. 12, pp. 1–161, p. 12.

129 Brinkman-Stoppelenburg, A et al (2014), 'Obligatory consultation of an independent physician on euthanasia requests in the Netherlands: what influences the SCEN physicians judgment of the legal requirements of due care?', *Health Policy*, vol. 115, no. 1, pp. 75–81, p. 76.

130 Lewis, P & Black, I (2012), *The effectiveness of legal safeguards in jurisdictions that allow assisted dying*, The Commission on Assisted Dying: Briefing Paper, Demos, London, p. 66, viewed 10 May 2017, <<https://www.demos.co.uk/wp-content/uploads/2016/09/Penney-Lewis-briefing-paper.pdf>>.

131 Brinkman-Stoppelenburg, A et al (2014), 'Obligatory consultation of an independent physician on euthanasia requests in the Netherlands: what influences the SCEN physicians judgment of the legal requirements of due care?', *Health Policy*, vol. 115, no. 1, pp. 75–81, p. 80.

Obligatory training of participating medical practitioners will provide the community with reassurance that assessments will be undertaken consistently. Training obligations will also provide certainty to participating medical practitioners that they are acting appropriately in accordance with the new legislative framework. This is why the Panel recommends that both the coordinating and the consulting medical practitioners be required to complete training before undertaking an assessment of a person's eligibility for voluntary assisted dying.

Training that will help medical practitioners to understand their obligations under the voluntary assisted dying legislation should be developed as part of the implementation. If a medical practitioner has not previously undertaken the training, once a person had made their first request for voluntary assisted dying and the medical practitioner agrees to support them through the process, training should be easily accessible to ensure a person's assessment is not unduly delayed.

Ministerial Advisory Panel Recommendation 15

That both the coordinating medical practitioner and the consulting medical practitioner must complete specified training before undertaking an assessment of a person's eligibility for access to voluntary assisted dying.

Ministerial Advisory Panel Recommendation 16

That the specified training comprise of obligations and requirements under the legislation including:

- **assessing the eligibility criteria under the legislation;**
- **assessing decision-making capacity in relation to voluntary assisted dying and identifying when a referral may be required; and**
- **assessing the voluntariness of a person's decision to request voluntary assisted dying and identifying risk factors for abuse.**

Policy intent

To ensure medical practitioners understand their obligations under the voluntary assisted dying legislative framework and can undertake high-quality assessments of a person's eligibility for voluntary assisted dying.

Transferring the role of coordinating medical practitioner

The Parliamentary Committee Inquiry

The Parliamentary Committee was clear that assessments of a person's eligibility for voluntary assisted dying should be independent, but was silent on what should occur when the first medical practitioner is unable to continue the voluntary assisted dying process.

Discussion

In US jurisdictions such as Oregon, the medical practitioner providing voluntary assisted dying is required to be the practitioner 'who has primary responsibility for the care of the patient and treatment of the patient's terminal disease'.¹³² The legislation does not outline what should occur when that medical practitioner becomes unavailable. In Belgium a medical practitioner must have repeated conversations with a person over a reasonable period of time.¹³³ Again, the legislation does not state what should occur when that medical practitioner becomes unavailable.

It is important to ensure the voluntary assisted dying process is contained, but there must also be some flexibility. A coordinating medical practitioner may not always be available, or a person may prefer to proceed with their consulting medical practitioner. The Panel recognises that this need for flexibility must be balanced against the importance of providing continuity of care and clear accountability. As a consulting medical practitioner will already be engaged in the voluntary assisted dying process and will have conducted an assessment of the person's eligibility, they are the most appropriate person to take on the role of coordinating medical practitioner if the original coordinating medical practitioner can no longer perform this role. This transfer of role would be managed through a process of handover of the person's care. The Panel is of the view that it would not be appropriate for a medical practitioner who has not been part of the assessment process to subsequently prescribe a lethal dose of medication to a person, relying on the assessment undertaken by another medical practitioner.

In some circumstances either the coordinating medical practitioner or the person may wish that the continued process for voluntary assisted dying be handed over to the consulting medical practitioner. In these circumstances the coordinating medical practitioner should be able to refer the person to the consulting medical practitioner. This can occur at any point in the voluntary assisted dying process, however, the handover of the process can only be made to the consulting medical practitioner who undertook the second independent assessment of the person's eligibility for voluntary assisted dying. A transfer of role may also occur because a coordinating medical practitioner conscientiously objects to administering the lethal dose of medication, however, the Panel notes that ideally the medical practitioner would recognise the person's circumstances and conscientiously object when a first request is received. Both assessing medical practitioners should ensure the transfer of roles does not disrupt the person's care.

¹³² *Death with Dignity Act (Oregon)*, s. 127.800 (2).

¹³³ *Act on Euthanasia of 28 May 2002 (Belgium)*, s. 3(2)(2).

It is the responsibility of the coordinating medical practitioner to refer the person with all of the necessary documentation and medical history. Where the consulting medical practitioner agrees to take on the role of coordinating medical practitioner, they must accept responsibility for continuing to undertake the process with the person including prescribing the lethal dose of medication and reporting to the Voluntary Assisted Dying Review Board.

Ministerial Advisory Panel Recommendation 17

That the coordinating medical practitioner or the person may request that the role of coordinating medical practitioner for the voluntary assisted dying process be transferred to the consulting medical practitioner.

Policy intent

To ensure there is continuity of care for the person and their family throughout the voluntary assisted dying process.

International example

As described in the *New York Times* in May 2017, Mr Shields of Canada had been through the assessment process with his medical practitioner, but as he neared the point at which he wanted to end his life his medical practitioner informed him that she would be going on two week's leave. This left Mr Shields with the decision to proceed with voluntary assisted death immediately, or to wait another two weeks until his medical practitioner returned. Mr Shields opted to wait another two weeks. This required considerable rearranging of the existing plan for Mr Shields and his family.¹³⁴

This situation creates the risk that people will feel pressured to proceed immediately, and to die earlier than they intended. The ability to transfer the role of the coordinating medical practitioner to the consulting medical practitioner, as recommended by the Panel, will help to ensure these situations do not arise and that a person's preferences for their end-of-life care is prioritised.

¹³⁴ Porter, C (2017), 'At his own wake, celebrating life and the gift of death', *The New York Times* (online), 25 May, <<https://www.nytimes.com/2017/05/25/world/canada/euthanasia-bill-john-shields-death.html>>.

Conscientious objection

The Parliamentary Committee Inquiry

The Parliamentary Committee recognised the right of medical practitioners, other health practitioners and health services to conscientiously object to participating in voluntary assisted dying. The Parliamentary Committee appreciates the concerns expressed by providers of palliative care services that neither medical practitioners nor health services should be forced to participate in voluntary assisted dying. The Parliamentary Committee affirmed that no medical practitioner, other health practitioner or health service can be forced to participate in voluntary assisted dying.¹³⁵

Discussion

The Panel notes widely held stakeholder views that health practitioners (not just medical practitioners) should not be obliged to participate in voluntary assisted dying. Stakeholders also reasoned that if health practitioners object to participating in voluntary assisted dying, they should declare their objection early in the process to ensure they do not impede access for the person seeking assistance. The Panel also notes the Victorian *Charter of Human Rights and Responsibilities 2006*, which recognises that every person has the right to freedom of thought, conscience, religion and belief.¹³⁶

Health practitioners may conscientiously object to providing any medical treatment and voluntary assisted dying should not be treated any differently. The *Abortion Law Reform Act 2008* creates an explicit requirement that if a health practitioner conscientiously objects to providing an abortion they must refer a woman to another health practitioner who the practitioner knows does not have a conscientious objection.¹³⁷ There were a range of views expressed by stakeholders about whether a health practitioner who conscientiously objects should be required to refer a person to another health practitioner. While some thought that it was necessary to ensure people were able to access voluntary assisted dying, others suggested that it would be an inappropriate imposition on medical practitioners and that ordinary standards for conscientious objection should apply.

In the US jurisdictions it is recognised that a health practitioner may conscientiously object, but there is no obligation to refer to another health practitioner.¹³⁸ Other international jurisdictions do not discuss conscientious objection in their voluntary assisted dying legislation. It should be noted that in other jurisdictions there are different legislative frameworks, including a Bill of Rights in some, that dictate conscientious objection in those jurisdictions.

¹³⁵ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

¹³⁶ *Charter of Human Rights and Responsibilities Act 2006* (Vic), s. 14.

¹³⁷ *Abortion Law Reform Act 2008* (Vic), s. 8.

¹³⁸ *End of Life Option Act* (California), s. 443.14(e)(1); *Death with Dignity Act* (Oregon), s. 127.885(4); *Patient Choice At End of Life Act* (Vermont), s. 5285; *Death with Dignity Act* (Washington), s. 19(1)(d).



The Panel sees no reason to depart from the ordinary requirements for conscientious objection. If a health practitioner conscientiously objects to participating in voluntary assisted dying, the practitioner should inform their patient as soon as reasonably possible and ensure their conscientious objection does not impede that person's access to medical treatment.¹³⁹ The Panel is of the view that there are key differences between abortion and voluntary assisted dying, which make an obligation to refer unnecessary. First, those who will be eligible for voluntary assisted dying under the proposed framework will already be engaged with a range of medical practitioners on a regular basis, whereas women seeking abortions may often have only a general practitioner who they see regularly. Second, although both the need for abortion and voluntary assisted dying are time sensitive, a matter of days may make a significant difference to the type and significance of the procedure required to perform an abortion. Conversely, while voluntary assisted dying should not be unduly delayed, the recommended process recognises there is not the same level of urgency. For these reasons, the Panel is of the view that the provision on conscientious objection in the *Abortion Law Reform Act 2008* should not be replicated for voluntary assisted dying.

The Panel acknowledges access to health services in small rural communities will need to be carefully considered to reduce barriers to accessing voluntary assisted dying as much as possible. In these circumstances health practitioners should consider the limited access their patient may have to other health practitioners and that their conscientious objection should not impede their patient's access to lawful medical treatment.

The Panel recognises the importance of allowing all health practitioners to conscientiously object to participating in voluntary assisted dying, however, it is important to identify what health practitioners are conscientiously objecting to. The Panel is of the view that it would not be appropriate for a health practitioner to object to providing a person with other medical treatment because they have requested voluntary assisted dying. Instead, a health practitioner may conscientiously object to participating in the assessment of a person's eligibility for voluntary assisted dying, prescription of the lethal dose of medication and the provision or administration of the lethal dose of medication. A person's access to medical treatment should not depend on their personal choices or beliefs. During any implementation period, guidelines and support processes should be developed for health practitioners to conscientiously object to ensure there is a clear and consistent approach to managing requests for voluntary assisted dying in these circumstances.

The Panel notes that the Parliamentary Committee recommended that health services be given the ability to conscientiously object. The Panel recommends that only health practitioners may conscientiously object. This is because health services do not have the same professional obligations as health practitioners and do not conscientiously object to providing medical treatment. Instead, a health service will assess which medical treatments it can safely provide, and will make decisions, as an organisation, about whether to provide these medical treatments. A health service may choose not to provide voluntary assisted dying, in the same way that neurosurgery is not performed at many health services. If voluntary assisted dying is legalised, health services will be able

¹³⁹ Medical Board of Australia (2014), *Good medical practice: a code of conduct for doctors in Australia*, Australian Health Practitioner Regulation Agency, viewed 1 June 2017, <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>>.

to determine the extent of their involvement in voluntary assisted dying in accordance with the capabilities of the health service.

During the consultation process some stakeholders suggested that an objection to providing or participating in voluntary assisted dying should not be described as a 'conscientious objection'. If voluntary assisted dying is legalised and a health practitioner decides they do not want to participate because of their personal beliefs, this is a conscientious objection and should be described as such. It is important that people understand why their medical practitioner is objecting to providing voluntary assisted dying and the term 'conscientious objection' is widely understood. It must be clear to a person that their medical practitioner's objection is not because the person is not eligible for voluntary assisted dying, but because of the medical practitioner's personal views. Using the term 'conscientious objection' clearly conveys this message and is consistent with other laws in Victoria.¹⁴⁰

Ministerial Advisory Panel Recommendation 18

That a health practitioner may conscientiously object to participating in the provision of information, assessment of a person's eligibility, prescription, supply or administration of the lethal dose of medication for voluntary assisted dying.

Policy intent

To ensure a health practitioner has the opportunity to conscientiously object to participating in voluntary assisted dying.

¹⁴⁰ See, for example, *Abortion Law Reform Act 2008 (Vic)*, s. 8.

Making a request for voluntary assisted dying

The Panel is recommending a process for voluntary assisted dying that requires repeated requests and opportunities to demonstrate the request is voluntary, informed and enduring. The process may appear onerous, but the Panel recognises that it should be a rigorous process to access voluntary assisted dying. The Panel also notes that it is unusual to introduce entirely new clinical practice through a legal framework; instead, these processes are generally developed over time by medical practitioners to ensure safe and consistent practice. There are, however, some precedents overseas, and the Parliamentary Committee's recommendation closely follows the framework in US jurisdictions.

In considering the recommended process, the Panel looked at examples of existing assessment processes, such as the standard process for accessing elective surgery. Similar to the recommended process for requesting voluntary assisted dying, the process for accessing elective surgery also requires repeated consultations with multiple medical practitioners and repeated provision of information. The Panel does not view these processes as overly burdensome, and recognises that they are an important safeguard in ensuring voluntary decisions, and that they are consistent with other medical practices where significant risks must be managed.

At the same time, the Panel recognises that the person who has requested access to voluntary assisted dying is suffering from an incurable disease, illness or medical condition that is advanced, progressive and will cause death. The person hopes for a good life to the end, so the process should not create undue burden or anxiety or be a tick-box process. It should be undertaken in the spirit of person-centred care.

This section is written from the perspective of a person who is seeking to access voluntary assisted dying and explains the steps the Panel recommends the person be required to complete.

A three request process for voluntary assisted dying

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that a patient must make three requests before a medical practitioner can prescribe a lethal drug, or end a patient's life by administering the drug. The patient must:

- make an first verbal request
- complete a formal written request in a form outlined for that purpose
- make a final verbal request.¹⁴¹

¹⁴¹ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 222, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

Discussion

The three request process is used in the US jurisdictions and is viewed as a safeguard to ensure a request for voluntary assisted dying is voluntary, considered and enduring. The process requires an initial verbal request, followed by a written request, and then a final verbal request. Canada has a more simplified process, requiring only that the person provide a written request for voluntary assisted dying.¹⁴²

The three request process will help to ensure a person's decision is voluntary, considered and enduring by providing multiple opportunities for a person and their medical practitioner to discuss the person's request and circumstances. Lewis et al. concluded after a review of Oregon, the Netherlands, Belgium and Switzerland that the 'available data suggest that the requirement that a request precede the provision of lawful assistance to die is respected in all reported cases', although also note that if a person acted unlawfully they would be unlikely to report this to the authorities.¹⁴³ In other jurisdictions the three request process also appears to encourage people to reconsider their request. In Oregon, for example, between 1997 and 1999 only 18 per cent of people who made a first request for voluntary assisted dying received a prescription.¹⁴⁴

The Panel notes that during the consultations there was strong support for a staged process for making a request for voluntary assisted dying that includes an initial verbal request, a formal written request and a final verbal request. Stakeholder views that a distinction needs to be drawn between informal conversations about voluntary assisted dying and a formal verbal request are also noted. It needs to be clear that the process to access voluntary assisted dying commences formally with an initial verbal request. The Panel recognises that the process for formalising the initial verbal request, which commences the

Betty makes her first request for voluntary assisted dying

Betty and John attend Betty's general practitioner two weeks later. Betty says that she is in increasing pain and discomfort and formally requests voluntary assisted dying. She states that John and her adult children support her decision. Her general practitioner agrees to be her coordinating medical practitioner and support her through the process.

As the coordinating medical practitioner, Betty's general practitioner will need to ensure that all the requirements set out in the legislation are met, including sending reports to the Voluntary Assisted Dying Review Board. Betty's general practitioner is a qualified Fellow of a College, but as this will be the first time he complete an assessment for eligibility to access voluntary assisted dying he undertakes the required training.

Betty's general practitioner completes the first assessment to assess if Betty meets the eligibility criteria and makes sure she is properly informed. He goes over the information Betty already has, what she understands about her disease and its likely course and prognosis. They discuss how Betty is feeling and how her suffering affects her to see if there is more that can be done. They discuss what Betty understands about her remaining treatment and palliative care options.

Betty's story continued...

142 *Medical Assistance in Dying (Canada)*, s. 24.2(3).

143 Lewis, P & Black, I (2013), 'Adherence to the request criterion in jurisdictions where assisted dying is lawful? A review of the criteria and evidence in the Netherlands, Belgium, Oregon, and Switzerland', *Journal of Law, Medicine & Ethics*, vol. 41, no. 4 pp. 885–898, p. 892.

144 Ganzini, L et al (2000), 'Physicians' experiences with the Oregon Death with Dignity Act', *New England Journal of Medicine*, vol. 342, no. 8, pp. 557–565, p. 557.

process, must be clear. The Panel also notes that the requirement that a request must be repeated three times in various forms over a period of time makes it more likely that a request will be both enduring and carefully considered by the person themselves and the medical practitioners who are responsible for assessing the person's eligibility to access voluntary assisted dying.

To access voluntary assisted dying a person will need to make three requests and be assessed by two independent medical practitioners. The three request process creates a clear structure for assessments by the two independent medical practitioners to ensure a person meets all of the eligibility criteria for voluntary assisted dying. The process also ensures that a person's request is voluntary, considered and enduring and provides multiple opportunities for this to be re-assessed.

Betty's general practitioner confirms that she meets all of the eligibility criteria and that she is making a properly informed, voluntary and enduring decision to access voluntary assisted dying.

Betty's general practitioner makes sure she is properly informed on all of the relevant information about her disease, its prognosis, treatment and palliative care options.

He talks to Betty about the effects and possible complications of the medication and answers her question about this. Betty's general practitioner makes it clear to Betty that she can withdraw her request at any time.

Betty's general practitioner completes the required form certifying that Betty fulfils the eligibility criteria, and forwards it to the Voluntary Assisted Dying Review Board, also placing a copy in Betty's medical record. Betty's general practitioner refers her to a consulting medical practitioner for a second independent assessment.

Betty's story continues below.

Ministerial Advisory Panel Recommendation 19

That the person must make three separate requests to access voluntary assisted dying: a first request, followed by a written declaration of enduring request, and then a final request.

Policy intent

To ensure a person's request to access voluntary assisted dying is voluntary, considered and enduring.

Ministerial Advisory Panel Recommendation 20

That the formal process for requesting voluntary assisted dying proceeds for the person as follows:

- a. The person makes their first request to a medical practitioner.**
- b. The person undergoes a first assessment by the coordinating medical practitioner.**
- c. The person undergoes a second independent assessment by the consulting medical practitioner.**
- d. The person makes a witnessed written declaration of enduring request to the coordinating medical practitioner.**
- e. The person makes a final request to the coordinating medical practitioner.**

Policy intent

To ensure a person's request to access voluntary assisted dying is voluntary, considered and enduring.

To ensure a quality three request process for access to voluntary assisted dying that provides multiple opportunities for a person and their assessing medical practitioners to discuss the person's request.

Properly informed decision making

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that patients must be properly informed of certain medical and procedural information to make a valid request for voluntary assisted dying. They set out that patients requesting voluntary assisted dying must be properly informed:

- of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results;
- of palliative care and its benefits;
- that they are under no obligation to continue with a request for voluntary assisted dying, and may rescind their request at any time; and
- of the probable result and potential risks of taking the lethal dose of medication.

The Parliamentary Committee noted that it is the role of the primary and secondary medical practitioners to properly inform the patient of the information described above and that each medical practitioner must be independently and separately satisfied that the patient is properly informed.

The Parliamentary Committee highlighted the importance of explaining the role of palliative care to the person. As discussed previously, the Parliamentary Committee considered mere awareness of palliative care, its benefits and the relief it can provide is not a sufficient amount of information. There may be instances where palliative care will provide a patient with the relief they are seeking, and they need to be made aware of this option.

Betty's second independent assessment

Five days later, Betty and John see the consulting medical practitioner. The consulting medical practitioner is an oncologist with relevant expertise in the management of gastrointestinal cancer. She is a Fellow of a College, and has over five years of post-fellowship experience in her speciality. She agrees to act as Betty's consulting medical practitioner and to provide a second independent assessment of Betty's eligibility for access to voluntary assisted dying.

As Betty's consulting medical practitioner has not done an eligibility assessment for voluntary assisted dying previously, she completes the specified training before conducting Betty's second independent assessment.

The consulting medical practitioner assesses Betty's eligibility for voluntary assisted dying using the same criteria as Betty's coordinating medical practitioner and is satisfied that Betty meets all of the eligibility criteria.

The consulting medical practitioner makes sure she has properly informed Betty on all relevant information about her disease, its prognosis, treatment and palliative care options. They discuss how she is coping with her symptoms, which have become very distressing and difficult. She also talks to Betty about the effects and possible complications of the medication and answers all Betty's questions about this. She reiterates to Betty that she can withdraw from the process at any time. She affirms that Betty is making her request voluntarily.

Betty's story continued...

A patient must be properly informed of their diagnosis, prognosis and therapeutic treatment options, including palliative care and its benefits. The patient must also be informed of the probable result and potential risks in taking the lethal dose of medication, and that they are under no obligation to continue with a request for voluntary assisted dying, and may rescind their request at any time.¹⁴⁵

Discussion

To validly consent to or refuse any medical treatment, a person must be properly informed. This requires that the person be provided with information about the nature and effect of the treatment being offered, the risks, and any alternative treatments. The same requirements should apply to voluntary assisted dying.

A person must understand the nature and effect of voluntary assisted dying, including the possible risks and the possibility that it may not be effective. A person should also be provided with information about alternative treatment options, including palliative care. The introduction of voluntary assisted dying aims to give people genuine choice, therefore it is critical that people have all of the necessary information.

Medical practitioners already have an obligation to ensure a person is informed, in broad terms, about medical treatment and any risks or side effects that may be of specific importance to the person.¹⁴⁶

The Panel recognises that the requirements for medical practitioners to provide information are well established and notes that these continue to apply. Nonetheless, the Panel also acknowledges that as voluntary assisted dying will be a new practice, there should be explicit requirements about the minimum information that must be provided to a person to make clear the obligations of medical practitioners. This is consistent with jurisdictions in the US. For example, in Washington a person must be informed of:

- a. his or her medical diagnosis;
- b. his or her prognosis;
- c. the potential risks associated with taking the medication to be prescribed;
- d. the probable result of taking the medication to be prescribed;
- e. the feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.¹⁴⁷

The consulting medical practitioner completes the required form that certifies that Betty's circumstances satisfy all of the eligibility criteria. The consulting medical practitioner forwards the completed form to the coordinating medical practitioner, and submits a copy to the Voluntary Assisted Dying Review Board.

Both the coordinating medical practitioner and the consulting medical practitioner are satisfied that Betty has decision-making capacity in relation to voluntary assisted dying, and therefore a referral to a specialist for further advice is not necessary.

Betty's story continues below.

¹⁴⁵ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 222, 226-227, 238, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

¹⁴⁶ *Rogers v Whitaker* (1992) 175 CLR 479, 489-490.

¹⁴⁷ *Death with Dignity Act* (Washington), s. 1.

The Panel also recognises the importance of responding to any particular concerns the person may have or any further requests for information. Again, this is consistent with existing informed consent requirements.

Medical practitioners already have a duty of care that requires them to provide appropriate information. In the case of voluntary assisted dying, for the avoidance of doubt and to ensure both the coordinating and consulting medical practitioners provide consistent and complete information, the list as set out in Recommendation 21 should be included in legislation.

Ministerial Advisory Panel Recommendation 21

That the coordinating medical practitioner and the consulting medical practitioner must ensure that the person is properly informed of:

- **their diagnosis and prognosis;**
- **treatment options available to them and the likely outcomes of these treatments;**
- **palliative care and its likely outcomes;**
- **the expected outcome of taking the lethal dose of medication (that it will lead to death);**
- **the possible risks of taking the lethal dose of medication;**
- **that they are under no obligation to continue with their request for voluntary assisted dying, and that they may withdraw their request at any time; and**
- **any other information relevant to the person's needs.**

Policy intent

To ensure a person is able to provide informed consent to voluntary assisted dying.

To support person-centred care.

Assessment of eligibility

The Parliamentary Committee Inquiry

The view of the Parliamentary Committee is that medical practitioners, rather than a review board, are in the best position to assess whether a patient is eligible for voluntary assisted dying.

Each medical practitioner must independently judge whether the person is:

- at the end of life
- suffering from a serious and incurable condition that is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable
- making a voluntary decision, free from coercion
- making a properly informed decision (see section 8.7.2).¹⁴⁸

All these criteria must be met to the satisfaction of the primary and secondary medical practitioner for a patient to make a valid request for voluntary assisted dying.

Discussion

The assessments undertaken by the coordinating medical practitioner and the consulting medical practitioner provide an important safeguard. The Panel notes the strong stakeholder support for the assessment of a person's eligibility to access voluntary assisted dying to be carried out by two independent medical practitioners. Each medical practitioner will be expected to assess each of the eligibility criteria and satisfy themselves that the person has fulfilled all the criteria. It is anticipated that there will be circumstances in which the consulting medical practitioner's assessment is different to the assessment of the coordinating medical practitioner.

In the Netherlands, approximately 25 per cent of independent assessments determine that the person is ineligible for voluntary assisted dying.¹⁴⁹ While a coordinating medical practitioner will aim to provide an accurate assessment of the person's eligibility every time, experience in other jurisdictions suggests that the consulting medical practitioner will provide an important independent check on the coordinating medical practitioner's assessment. The fact that consulting medical practitioners in other jurisdictions identify errors in the coordinating medical practitioner's assessment or come to a different conclusion about the person's eligibility is evidence that the voluntary assisted dying process is working effectively and provides a clear justification for requiring two independent assessments.

¹⁴⁸ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 225, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

¹⁴⁹ Lewis, P & Black, I (2012), *The effectiveness of legal safeguards in jurisdictions that allow assisted dying*, The Commission on Assisted Dying: Briefing Paper, Demos, London, p. 66, viewed 10 May 2017, <<https://www.demos.co.uk/wp-content/uploads/2016/09/Penney-Lewis-briefing-paper.pdf>>.



The requirement that two medical practitioners independently assess a person's eligibility may be viewed as unnecessary repetition, but the Panel is of the view that it provides an important opportunity for a fulsome assessment of a person's condition and situation. The eligibility criteria require a diagnosis of an incurable disease, illness or medical condition that is advanced and progressive and will cause death as well as a prognosis of no longer than 12 months to live. The two assessments are important in ensuring that only those who are eligible gain access to voluntary assisted dying, but it ensures also that a person is given accurate information to make their decision about voluntary assisted dying. The two assessments also provide an important opportunity to assess voluntariness. Studies have recognised a well-established association between social isolation and vulnerability to elder abuse.¹⁵⁰ However, this association is not directly related to voluntary assisted dying or enticing a person to commit suicide. Greater engagement with a range of health practitioners may help to reduce the risks posed by social isolation, as well as a range of other risk factors, and medical practitioners will be required to identify the need for greater social supports and assist in organising these.

The person and the two assessing medical practitioners will discuss the required information during the two independent assessments. This may seem onerous, but the Panel is of the view that this will ensure the person receives all the information they need and will provide them with ample opportunity to ask questions and discuss the information. There may be occasions when the consulting medical practitioner is able to add new information because of their particular training or expertise. This will also allow assessing medical practitioners to ensure the person understands all the information they have been provided and have sought out themselves. The two eligibility assessments should be regarded as important

David's second independent assessment

David's consulting medical practitioner, who will undertake the second independent assessment, is a respiratory specialist with relevant expertise and experience in treating MND patients near the end of life. She is also a qualified Fellow of a College and has completed the required training.

The consulting medical practitioner, who David sees eight days later, undertakes her assessment using the same eligibility criteria as the coordinating medical practitioner. She also makes sure she has properly informed David on all relevant information about his disease, its prognosis, treatment and palliative care options. She talks to David about the effects and possible complications of the prescribed medication and answers all of his questions about this. She makes it clear to David that he can withdraw his request at any time.

As David's consulting medical practitioner has worked with many patients who have been diagnosed with MND and are near the end of life, she is mindful that the disease may impact on cognition. She refers David to a neuropsychologist for an assessment about David's decision-making capacity in relation to voluntary assisted dying. The advice from the neuropsychologist confirms that David does have this capacity. David's consulting medical practitioner confirms she is satisfied that David meets all of the eligibility criteria to access voluntary assisted dying.

Both David's coordinating medical practitioner and consulting medical practitioner are satisfied that David meets all of the eligibility criteria to access voluntary assisted dying.

David's story continues below.

¹⁵⁰ Kaspiew, R, Carson, R & Rhoades, H (2015), *Elder abuse: understanding issues, frameworks and responses. A report to the Australian Government Attorney-General's Department*, Australian Institute of Family Studies, Melbourne, p. 12, viewed 9 June 2017, <<https://aifs.gov.au/publications/elder-abuse>>.

therapeutic encounters, not only as a matter of ensuring compliance with legislation. In this respect, it will be expected that these assessments take the form of interactive communication. The assessing medical practitioners must be satisfied of all of these elements before the person is eligible to access voluntary assisted dying.

If either the coordinating or consulting medical practitioner assesses the person as ineligible, they will not be able to access voluntary assisted dying. The Panel notes, however, that obtaining second opinions is a standard part of medical practice and if a person disagrees with either medical practitioner's assessment, they may seek a second assessment. If a coordinating medical practitioner finds a person ineligible, they would need to recommence the process with a different medical practitioner. If the consulting medical practitioner finds the person ineligible, the coordinating medical practitioner may refer the person to another practitioner if they still believe the person is eligible. Some people may attempt to visit multiple medical practitioners to obtain a favourable assessment, but the Panel does not consider this creates a danger of misuse. The eligibility criteria are clear and the Voluntary Assisted Dying Review Board will review each assessment, regardless of the outcome. This means if a person is deemed ineligible by multiple medical practitioners, but one medical practitioner assesses the person as eligible, it will be clear to the Board that further investigation is required.

Ministerial Advisory Panel Recommendation 22

That the coordinating medical practitioner and the consulting medical practitioner undertake independent assessments to form a view as to whether:

- **the person meets the eligibility criteria;**
- **the person understands the information provided;**
- **the person is acting voluntarily and without coercion; and**
- **the person's request is enduring.**

Policy intent

To ensure there is a rigorous assessment process for voluntary assisted dying.

‘Doctor shopping’

In standard medical practice, people regularly seek and receive second opinions from another medical practitioner. People seek second opinions for a range of reasons, not just because they disagree with the conclusion of the assessment. Second opinions can ensure people receive accurate assessments and appropriate treatments, as well as ensuring that if a person’s concerns are not addressed by one medical practitioner, they are addressed by another, even if the outcome of the assessment remains the same.

The Panel recognises that people should also be able to seek a second opinion in relation to voluntary assisted dying. The eligibility criteria are clearly set out for both the person seeking voluntary assisted dying and the medical practitioner. If a medical practitioner certifies that a person is eligible when they are not or prescribes a lethal dose of medication when the person is not eligible, this may constitute either unprofessional conduct or a criminal offence. As the Voluntary Assisted Dying Review Board will be required to review each assessment for voluntary assisted dying, the Board will be able to identify unexplained patterns of ‘doctor shopping’ and refer medical practitioners who do not act in accordance with the law to the Australian Health Practitioner Regulation Agency or Victoria Police.

The Panel recommends a clear assessment process that requires two medical practitioners to independently assess a person as eligible. In addition, only the coordinating medical practitioner can write the prescription for the lethal medication and must receive a permit from the Department of Health and Human Services in order to do so. A pharmacist will not dispense the lethal dose of medication without a valid permit. This means that even if a person finds one medical practitioner willing to break the law by providing an assessment that a person meets the eligibility criteria even though they do not, this medical practitioner would also need to find another medical practitioner willing to collude with them. Even if they are able to do this, the Department and the Voluntary Assisted Dying Review Board would be able to identify irregularities or wrong doing before a permit for prescription is given.

Timing of requests

The Parliamentary Committee Inquiry

The Parliamentary Committee considered that the process set out in its report ensures the decision to request voluntary assisted dying is well-considered, and that the person has time to reflect on it and discuss it with family and friends.

The Parliamentary Committee recognised the need to guard against impulsive decisions by people experiencing extreme physical and emotional pain to ensure they are not accessing voluntary assisted dying without proper consideration. The Parliamentary Committee also believed that it is unreasonable to mandate an arbitrary coolingoff period that denies some people who would otherwise qualify to access this option at the end of life. Medical practitioners routinely assess whether medical treatment decisions are properly considered. As such, the Parliamentary Committee believed that the best approach is to allow medical practitioners to determine whether this criterion is established.

The primary medical practitioner is best placed to judge the enduring nature of the patient's request in the context of the trajectory of their condition. The independent secondary medical practitioner is best placed to act as a safeguard to ensure the judgement of the primary medical practitioner is reasonable. The Parliamentary Committee was of the view that these assessments, combined with the requirement that a patient be 'at the end of life', provide the necessary protection to ensure requests are properly considered, while also taking into account a patient's condition and likely deterioration.

The Parliamentary Committee recommended that the primary and secondary medical practitioners must be independently satisfied that the patient's request is enduring, and that a reasonable amount of time has passed between the patient's initial request, and the provision of a lethal drug. In making this judgement, the primary and secondary medical practitioners must have regard to the particular condition, and likely trajectory of the patient. An enduring request, by its very nature, requires an ongoing and sustained interest over time.¹⁵¹

Discussion

The Panel recognises that many people who request voluntary assisted dying will make this decision after a long period of consideration arising from their experience of their disease, illness or medical condition and perhaps a long-held view about their own death. Nevertheless, the Panel supports a process that incorporates time for reflection, provides the opportunity to discuss the decision to request voluntary assisted dying with family and friends, and confirm a person's enduring intent at the actual time of decision-making. The Panel notes the strong stakeholder support for specifying a particular time period between the initial request and the final request, although there were divergent opinions about the length of this time period. A formal time period is an important safeguard to ensure requests for voluntary assisted dying are enduring, well-considered and properly assessed.

¹⁵¹ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxvi, 222, 228, 238, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.



In other jurisdictions that have included a time period between requests, there is little evidence to suggest a particular time period creates a significant difference in the quality of people's decisions. For example, there is no evidence that demonstrates the 15-day period in Oregon ensures more considered decisions than the 10-day period in Canada. Despite this, a set period provides a framework to help people requesting voluntary assisted dying and assessing medical practitioners to understand what is expected and ensure consistent practice. During the consultation process stakeholders consistently advocated that decisions to access voluntary assisted dying should not be rushed; however, opinions varied about what constituted a rushed decision. A required time period will provide clarity that a person's decision to request voluntary assisted dying is well-considered. The 15-day period in Oregon may, however, be too long. Ganzini et al. found that 20 per cent of people who request voluntary assisted dying in Oregon die before they are able to complete the process.¹⁵² The Panel therefore recommends that a period of 10 days must pass between a person's initial verbal request and their final verbal request. This strikes an appropriate balance between the need to ensure a person's decision to request voluntary assisted dying is well-considered and not unnecessarily prolonging a person's suffering.

Practice should be consistent, but there may be exceptional circumstances in which a person's death is imminent and it would be unreasonable to require them to wait 10 days, as this will effectively preclude them from accessing voluntary assisted dying and will impose further days of intolerable suffering. The Panel considered other reasons for shortening the required time period, such as an imminent loss of decision-making capacity, however, determined that this would be inappropriate. In Canada, the 10-day time period may be waived when death or a loss of decision-making capacity to provide informed consent are imminent.¹⁵³ Concern about an imminent loss of decision-making capacity may pressure a person to make the decision to request voluntary assisted dying quickly, without fully considering their options and the possibility of continued enjoyment of life, whereas an imminent death within 10 days means that a person does not have the option of continued enjoyment of life. The 10-day time period should only be waived in very limited circumstances, where death is imminent and is expected to occur within the 10-day time period.

The Panel also recommends that the final verbal request cannot be made on the same day as the second independent assessment is completed. During the second independent assessment, the person will have a further opportunity to discuss and consider the required information and should have time to reflect. The final verbal request should not be a mere formality but should demonstrate the enduring nature of the person's request. The requirement that a final verbal request cannot be made on the same day that the second independent assessment is completed should never be waived. The requirement ensures that, no matter what the circumstances, a person cannot rush through the voluntary assisted dying process. In Oregon, the prescribed time period appears to be well understood and respected. There has been only one case in which a medical practitioner did not wait the required 48 hours between a

¹⁵² Ganzini, L et al (2000), 'Physicians' experiences with the Oregon Death with Dignity Act', *New England Journal of Medicine*, vol. 342, no. 8, pp. 557–563, p. 561.

¹⁵³ *Medical Assistance in Dying Act (Canada)*, s. 241.2(3)(g).

person's written request and writing a prescription.¹⁵⁴ This medical practitioner was referred to Oregon Medical Board.¹⁵⁵ A prescribed time period over which the request and assessment process must occur helps to ensure the person's decision to request voluntary assisted dying is enduring and well-considered.

Ministerial Advisory Panel Recommendation 23

That the final request may only be made after a period of at least 10 days has passed since the first request.

Ministerial Advisory Panel Recommendation 24

That there is an exception to the 10 day requirement when the coordinating medical practitioner believes that the person's death is likely to occur within 10 days and this is consistent with the prognosis provided by the consulting medical practitioner.

Ministerial Advisory Panel Recommendation 25

That the final request cannot be made on the same day that the second independent assessment is completed.

Policy intent

To ensure a person's decision to request voluntary assisted dying is enduring well considered.

Provide clear direction to medical practitioners about when the 10 day time period may be waived.

¹⁵⁴ Oregon Public Health Division (2011), *Oregon's Death with Dignity Act - 2010*, State of Oregon, Portland, p. 2, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

¹⁵⁵ Ibid.

Written declaration of enduring request

The Parliamentary Committee Inquiry

The Parliamentary Committee proposed that the two independent witnesses must sign the formal written request, with provisions for people who cannot physically sign a request.

Discussion

When a person makes a request for voluntary assisted dying, they are making an active and considered decision about the timing and manner of their death. A person's written declaration of enduring request represents their enduring decision and witnessing requirements may help ensure requests are voluntary and properly informed.

North American jurisdictions require that written requests for voluntary assisted dying be witnessed by independent witnesses. These jurisdictions include a range of exclusions to ensure two forms of independence. First, that the witnesses will not derive any material benefit from the person's death, which may motivate them to act maliciously. Second, that the witnesses not be a member of the person's healthcare team, which addresses the risk of collusion and impropriety among assessing medical practitioners and other members of a person's health care team. During the consultation process, stakeholders were generally more concerned with coercion or undue influence from families than from health practitioners. It is noted that the requirement for independent assessments by two medical practitioners also provides protection against undue influence from family members, as the assessing medical practitioners must be satisfied that the person is acting voluntarily. The Panel notes that in Oregon, 20 years of practice that requires two medical practitioners and two independent witnesses to certify that a person is acting voluntarily indicates that there is no evidence of coercion or undue influence of people who have proceeded with voluntary assisted

David makes a written declaration of enduring request

David is clear about his decision to request voluntary assisted dying and returns to his coordinating medical practitioner to make his written declaration of enduring request. He signs his written declaration of enduring request in the presence of his neurologist and this is witnessed by his sister and his next-door neighbour, who he has known for many years. David's next-door neighbour wants to check that he is eligible to act as a witness. David's neurologist is able to explain that two people, one of whom is not a family member and neither of whom will benefit from his death or are part of this treatment team can act as witnesses. David's neighbour now feels comfortable that he is able to act as a witness.

David's story continues below.

Betty makes a written declaration of enduring request

Betty is clear in her mind about her decision to request voluntary assisted dying and makes an appointment to see her coordinating medical practitioner the following week. John, her sister, Mary, and a close friend, Jenny, attend the appointment with her. Betty signs a written declaration of enduring request in the presence of her coordinating medical practitioner and it is witnessed by Mary and Jenny, neither of whom would benefit from her death.

Betty's story continues below.

dying. In Oregon there have been five cases out of 1,127 in which a person's written request was not properly witnessed.¹⁵⁶ In each of these cases the medical practitioner was referred to the Oregon Medical Board.

The requirement for two independent witnesses is an important safeguard to ensure requests are voluntary and free from abuse. This would necessarily exclude people who are involved in the treatment or care of the person or who might benefit financially from the death of a person making the request. The Panel recognises that while such requirements may make it more difficult for a person to find appropriate person to witness their written declaration of enduring request, the exclusions prevent conflicts of interest and provide further assurance of voluntariness.

Signing and witnessing the written declaration of enduring request in the presence of the coordinating medical practitioner, who has the required training, will mean that any questions the person or the witnesses may have can be explained by a medical practitioner who has undertaken the specific training about the obligations and requirements under the legislation.

The written declaration of enduring request will be the lasting documentation of a person's decision to access voluntary assisted dying. The Panel recommends that people have the opportunity to provide a written statement about their decision to access voluntary assisted dying. This requirement should not be compulsory, but for some people it will provide an important opportunity to explain their decision. This may help people to discuss their decision with others and will also provide further evidence of an enduring and well-considered request.

¹⁵⁶ Department of Human Services, Oregon Health Division, Center for Disease Prevention and Epidemiology (2001), *Oregon's Death with Dignity Act: three years of legalized physician-assisted suicide*, State of Oregon, Portland, p. 4, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>; Department of Human Services, Office of Disease Prevention and Epidemiology (2004), *Sixth annual report on Oregon's Death with Dignity Act*; State of Oregon, Portland, p. 13, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>; Department of Human Services, Office of Disease Prevention and Epidemiology (2005), *Seventh annual report on Oregon's Death with Dignity Act*, State of Oregon, Portland, p. 14, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>; Department of Human Services, Office of Disease Prevention and Epidemiology (2006), *Eighth annual report on Oregon's Death with Dignity Act*, State of Oregon, Portland, p. 13, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>; Oregon Public Health Division (2010), *2009 summary of Oregon's Death with Dignity Act*, State of Oregon, Portland, p. 2, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

Ministerial Advisory Panel Recommendation 26

That a person's written declaration of enduring request must be in writing, be signed by the person, and be witnessed by two persons in the presence of the coordinating medical practitioner. The two witnesses must certify that the person appears to be voluntarily signing the declaration, to have decision-making capacity, and to understand the nature and effect of making the declaration.

Ministerial Advisory Panel Recommendation 27

That the one of the witnesses to the written declaration of enduring request must not be a family member. The two witnesses must be 18 years and over and cannot be:

- a person who knows or believes that they are a beneficiary under the will of the person making the written declaration of enduring request, or a recipient, in any other way, of a financial or other material benefit resulting from the person's death; or
- an owner or operator of any health care or accommodation facility at which the person making the written declaration of enduring request is being treated or any facility in which the person resides; or
- directly involved in providing health or professional care services to the person making the written declaration of enduring request.

Ministerial Advisory Panel Recommendation 28

That the written declaration of enduring request allows the person to make a personal statement about their decision to access voluntary assisted dying.

Policy intent

To ensure a person making a written declaration of enduring request is acting voluntarily and has been properly informed.

To ensure the two witnesses to the written declaration of enduring request are independent.

To provide a person with the opportunity to explain their decision to access voluntary assisted dying in writing.

Completing the voluntary assisted dying process

The Panel's recommendations provide for an extensive framework for ensuring a person's request to access voluntary assisted dying is voluntary, properly informed and enduring. The final stage of the voluntary assisted dying process provides an opportunity to confirm this and also provides an independent check of compliance with the process. The final stage also requires measures to be put in place to ensure the safe storage, use and potential return of the lethal dose of medication. Other jurisdictions that have legalised voluntary assisted dying do not provide such a prescriptive process for the safe management and return of the lethal dose of medication. The Panel has taken into account the concern expressed by a range of stakeholders during the consultation process about lethal doses of medication being in the community and is recommending a tightly controlled process to address this.

This section is written from the perspective of both a person who is seeking to access voluntary assisted dying and the relevant health practitioners. It explains the steps the Panel recommends that each relevant person be required to undertake to complete the process.

Monitoring the lethal dose of medication

The Parliamentary Committee Inquiry

The Parliamentary Committee did not provide guidance on how to monitor or return the lethal dose of medication. However, the Parliamentary Committee did propose that the implementation taskforce investigate and recommend an accountability system for tracking the lethal dose of medication once it has been prescribed to patients.

Discussion

The Panel recognises stakeholder concerns about storage and retrieval of the lethal dose of medication. Stakeholders had divergent views about the safeguards that should be in place. There was also acknowledgement that people are responsible in keeping potentially lethal medications safely at home and that the imposition of additional requirements may create unrealistic and unnecessary burdens for people who are suffering at the end of their lives. There needs to be recognition of an individual's autonomy in safely storing and administering their medication in their own home. Nevertheless, the Panel recognises that specific measures to ensure the safe storage and retrieval of unused lethal doses of medication designed for this purpose are necessary.

Other jurisdictions that provide for self-administration of a lethal dose of medication generally rely on existing laws for the safe disposal of the medication. For example, in California, a person who has custody or control of an unused lethal dose of medication must dispose of it in accordance with existing drug take-back programs.¹⁵⁷ In Vermont unused medications must be sent to a disposal centre in accordance with existing drug take-back programs, mixed with another substance such as ground coffee beans or cat litter to make it unusable, or disposed of in accordance with any other instructions on the label.¹⁵⁸ While these jurisdictions have established drug take-back programs, a study

¹⁵⁷ *End of Life Option Act* (California), s. 443.20.

¹⁵⁸ *Patient Choice At End of Life Act* (Vermont), s. 5291; Vermont Department of Health (2014), *Chapter 2, subchapter 6 - rule governing the safe disposal of unused drugs*, viewed 1 June 2017, <http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_safe-disposal-unused-drugs.pdf>.

in the US suggests that only a small percentage of unused medications are properly disposed of through these programs.¹⁵⁹

The Parliamentary Committee proposed that a solution be developed during the 18-month implementation period. While the Panel recognises that practical issues will need to be addressed with key stakeholders during the implementation period, it also supports the incorporation of clear requirements that safeguard the community in legislation. The Panel recognises that there are existing mechanisms in place for retrieving unused medications in Victoria, as well as penalties for unauthorised possession of prescription medication.¹⁶⁰

The Panel received strong feedback from stakeholders that additional safeguards are required for medication that is deliberately formulated as a lethal dose. The Panel considered a range of options in light of the need to avoid overly intrusive steps or the creation of unreasonable administrative burdens for a person at the end of life. While some stakeholders suggested regular check-ups on people who have been prescribed the lethal dose of medication, this may inadvertently place pressure on them to self-administer the medication, as regular questions may be interpreted as a suggestion that they should have administered the medication.

Some stakeholders also suggested technological solutions, such as GPS devices and finger-print-coded lock boxes. The Panel considers these suggestions to be impractical and unlikely to provide any additional safety. GPS tracking is unlikely to assist because anyone wanting to misuse the medication could remove the tracking device. It is also noted that to be effective some form of 24-hour monitoring would be required, and even then it is not clear that knowing where the lethal dose of medication is would do anything to prevent its misuse.

Appointing a contact person

To deal with this complex issue, the Panel recommends that before a person is prescribed the lethal dose of medication they must appoint a contact person, who will be responsible for returning any unused medication after the person has died. The Panel is of the view that this will ensure there is a clear line of accountability that makes it possible for the Voluntary Assisted Dying Review Board to monitor lethal doses of medication in the community. The contact person will need to agree to their appointment and confirm that they understand they will be required to return any unused medication to the dispensing pharmacist after a person has died. The person will need to explain to the contact person where they are storing the lethal dose of medication, and after the person dies, the contact person will be required to check whether the lethal dose has been self-administered.

¹⁵⁹ Egan, K et al (2017), 'From dispensed to disposed: evaluating the effectiveness of disposal programs through a comparison with prescription drug monitoring program data', *American Journal of Drug & Alcohol Abuse*, vol. 43, no. 1, pp. 69–77.

¹⁶⁰ *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s. 36B(2).

It is therefore proposed that the contact person play two roles:

- to return any unused lethal medication to the dispensing pharmacist after the person's death; and
- To act as a point of contact for the Voluntary Assisted Dying Review Board to ask any follow up questions to support quality and service improvement initiatives. This would be an 'opt in' role for the contact person.

The appointment of a contact person, and the acceptance of the role by the appointed person, should occur before prescribing the lethal dose of medication. The Panel recommends this measure to ensure the safe retrieval of unused lethal medication in recognition of the widespread stakeholder concern about unused lethal medication in the community.

Ministerial Advisory Panel Recommendation 29

That the person appoint a contact person who will take responsibility for the return of any unused lethal medication to the dispensing pharmacist within 30 days after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board.

Policy intent

To ensure the safe retrieval of unused lethal medication.

To provide a clear contact point for the Voluntary Assisted Dying Review Board

Certification for authorisation

The Parliamentary Committee Inquiry

The Parliamentary Committee did not make any recommendation about the conclusion of the assessment process.

Discussion

Jurisdictions in the US require medical practitioners to complete a range of forms when participating in voluntary assisted dying. These forms are generally focused on ensuring the person fulfils the eligibility criteria and, in some jurisdictions, also include recording in the medical record that each of the steps in the process has been completed.¹⁶¹ It is common in existing medical practice in Victoria to pause prior to commencing a medical procedure to conduct one final check that all the necessary steps to prepare for the procedure have been undertaken. For example, surgical safety checklists (which require these pauses) improve morbidity and mortality rates and increase compliance with safety measures.¹⁶² While such forms may seem overly bureaucratic, they do provide an important prompt for medical practitioners to stop and reconsider every step of the process.

¹⁶¹ See, for example, *Death with Dignity Act* (Washington), s. 25-48-111.

¹⁶² Lyons, V & Popejoy, L (2014), 'Meta-analysis of surgical safety checklist effects on teamwork, communication, morbidity, mortality and safety', *Western Journal of Nursing Research*, vol. 36, no. 2, pp. 245-261; Collins, S et al (2014) 'Effectiveness of the surgical safety checklist in correcting errors: a literature review applying reason's Swiss cheese model', *Association of Operating Room Nurses Journal*, vol. 100, no. 1, pp. 65-79.

The Panel is recommending that the coordinating medical practitioner be required to complete a final check before applying for a permit to prescribe the lethal dose of medication. This final check will not require the coordinating medical practitioner to reassess the person's eligibility for voluntary assisted dying.

The Panel also notes stakeholder concerns that access to voluntary assisted dying should be based explicitly on the eligibility criteria that are agreed rather than a general, subjective opinion of the reasonableness of the request by a medical practitioner. The final check will ensure every step in the voluntary assisted dying process has been undertaken, and it is this process that will ensure people are making voluntary and informed decisions to access voluntary assisted dying.

The Parliamentary Committee recommended that medical practitioners assess the 'reasonableness' of the request. While this would appear to allow practitioners to reject a request on the basis that they believe it to be unreasonable, the Parliamentary Committee suggested that this is to 'ensure that the patient truly understands and appreciates the nature and consequences of the decision to request assisted dying, as well as the alternatives to assisted dying, and that the patient's request is not ambivalent'. The Panel agrees that the coordinating medical practitioner should conduct a final check but does not see how a medical practitioner can assess the 'reasonableness' of a person's request. Making judgements about 'reasonableness' is subjective and would be influenced by a medical practitioner's own views about suffering and a life worth living. The Panel is of the view that it would not be appropriate to introduce such arbitrary decision making into the process. The Panel is also concerned that allowing a medical practitioner to override a person's decision based on their values undermines the person's autonomy.

The final check, as set out in the assessment process, will confirm that every step has been completed and that all of the eligibility criteria have been fulfilled before the coordinating medical practitioner applies for a permit to prescribe the lethal dose of medication.

Ministerial Advisory Panel Recommendation 30

That, to conclude the assessment process, the coordinating medical practitioner complete a certification for authorisation to confirm in writing that they are satisfied that all of the procedural requirements have been met.

Policy intent

To ensure every step in the voluntary assisted dying process has been completed and that all of the eligibility criteria have been fulfilled before the coordinating medical practitioner applies for a permit to prescribe the lethal dose of medication.

Authorising the lethal dose of medication

The Parliamentary Committee Inquiry

The Parliamentary Committee did not make a recommendation about assessing compliance with the voluntary assisted dying process prior to prescribing the lethal dose of medication.

Discussion

Throughout the consultation process a range of stakeholders raised concerns about the need to ensure compliance with the process before prescribing the lethal dose of medication. These stakeholders cited concerns that a review after the fact may produce evidence of wrongdoing, but that voluntary assisted dying is irreversible. Some stakeholders suggested that a medical practitioner should be required to obtain approval in order to prescribe the lethal dose of medication.

No other jurisdiction requires approval or review by an independent body of the medical practitioners' assessments prior to prescribing a lethal dose of medication. Instead, other jurisdictions recognise that medical practitioners will comply with their professional obligations and ensure this will occur through various processes of review of voluntary assisted dying. In these jurisdictions there is very little evidence of wrongdoing, which is consistent with the experience in Victoria that medical practitioners comply with their professional obligations. In the Netherlands in 2015 there were 5,516 cases of voluntary assisted dying. Of these, there were four cases in which the due care criteria were not complied with.¹⁶³ In Oregon in 2015 no referrals were made to the Oregon Medical Board for a failure to comply with voluntary assisted dying legislative requirements.¹⁶⁴ While the Panel is confident that medical practitioners will comply with their professional obligations and act in the interests of their patients, an independent authorisation process will ensure the voluntary assisted dying process has been correctly completed. In Victoria there are existing processes that can be adapted for voluntary assisted dying. The *Drugs, Poisons and Controlled Substances Act 1981* requires medical practitioners who consider it necessary to prescribe a Schedule 8 medication to a drug dependent person to apply to the Secretary to the Department of Health and Human Services for a permit to do so.¹⁶⁵ A similar process for voluntary assisted dying will ensure the coordinating medical practitioner had completed every step of the process before the medical practitioner can receive an authorisation to prescribe the lethal dose of medication. The data from this process will also provide an independent source of information for the Voluntary Assisted Dying Review Board to monitor lethal doses of medication in the community.

¹⁶³ Regional Euthanasia Review Committees (2016), *Annual report 2015*, viewed 26 May 2017, <<https://www.euthanasiecommissie.nl/de-toetsingscommissies/jaarverslagen>>.

¹⁶⁴ Oregon Public Health Division, Oregon Health Authority (2016), *Oregon's Death with Dignity Act: 2015 data summary*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

¹⁶⁵ *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s. 34.

The Panel notes that if voluntary assisted dying is legalised it will not occur in isolation and that there are already stringent checks on prescribed medications. The purpose of the medications prescribed will be clear from the medication and dosage, and this will be easily identified by medical practitioners and pharmacists. There is no other legitimate medical purpose for a lethal dose of medication. This means that if a medical practitioner attempts to prescribe a lethal dose of medication without a permit, a pharmacist will be easily able to identify that this is unlawful and notify the Australian Health Practitioner Regulation Agency.

The medical practitioner should be required to obtain a permit from the Department of Health and Human Services before prescribing the lethal dose of medication. To obtain this permit the coordinating medical practitioner will need to report that all of the requirements under the legislation have been met by submitting the final check form. It is suggested that the authorisation process be consistent with existing authorisation processes in Victoria, such as the permit process for a range of Schedule 8 medications. The Panel recommends that a specific permit be issued on the rare occasions where a person requires the lethal dose of medication to be administered by the coordinating medical practitioner. This will ensure clarity of roles and responsibilities in relation to the administration of the medication and will ensure transparency during the review of the process. It will also identify to the Voluntary Assisted Dying Review Board that additional reporting and monitoring processes are required.

In response to consultation feedback, the Panel considered the creation of an independent body to assess eligibility for voluntary assisted dying or to confirm the assessments of the medical practitioners. The Panel rejected this option and is of the view that a review of the process by the Department of Health and Human Services prior to prescription provides a more effective safeguard. Independent bodies would have limited opportunity to undertake a clinical assessment and would not have an existing therapeutic relationship with the person, making it unlikely that they would be able to give a more accurate diagnosis and prognosis. Such a process would also be stressful and burdensome for an extremely unwell person. The Panel's recommended process requires two independent assessments already, and the permit application process ensures there is an independent assessment of the process by the Department prior to prescription of the lethal dose of medication.

The Panel is of the view that, at the point at which they prescribe the lethal dose of medication, the coordinating medical practitioner must inform the person about how to self-administer the medication, the effects of the medication and the person's obligation to store the medication in a locked box. This is consistent with good medical practice.

Ministerial Advisory Panel Recommendation 31

That the prescription of the lethal dose of medication requires an authorisation process.

Policy intent

To establish clear monitoring and accountability for the safe prescription of the lethal dose of medication for voluntary assisted dying.

Dispensing the lethal dose of medication

The Parliamentary Committee Inquiry

The Parliamentary Committee did not recommend a process for the pharmacist to dispense the lethal dose of medication.

Discussion

The involvement of a pharmacist is an important safeguard because it provides additional independent input from another health practitioner. The Panel recommends that the pharmacist only be able to dispense the lethal dose of medication in accordance with a prescription and valid permit. As the dose of medication is intended to be lethal, there is no other purpose for which the prescribed dose could be used, so it will be clear to a pharmacist what the prescription is for.

In other jurisdictions there is minimal recognition of the role of pharmacists. In Oregon, any health practitioner who dispenses the medication must provide a copy of the dispensing record to the Oregon Health Authority.¹⁶⁶ In Canada, the dispensing pharmacist must also report on this.¹⁶⁷ Other jurisdictions do not discuss the role of pharmacists in providing information to people at the time the medication is dispensed.

In Victoria, pharmacists provide important education when medications are dispensed. This includes guidance on taking medications and the safe handling and storage of medications. Pharmacists also ensure medications are appropriately labelled, making them easily identifiable. The Panel recommends that pharmacists continue to perform this role in relation to voluntary assisted dying. The legislation should require pharmacists to attach clear labels to the medication to indicate that it is a lethal dose. Pharmacists should also be required to explain to people that they are responsible for the medication and must store it in a locked box. The pharmacist should also provide information about the return of the medication when it is unused. This information may also be provided to the contact person when they are present, or the pharmacist may provide information that is to be given to the contact person.

The dispensing pharmacist must also provide information to a person about how to take the lethal dose of medication, including any necessary premedication. When dispensing the medication the pharmacist should be required to provide the person with information about its safe storage and the role of the contact person in returning any unused medication after a person has died.

¹⁶⁶ *Death with Dignity Act (Oregon)*, s.127.865.

¹⁶⁷ *Medical Assistance in Dying Act (Canada)*, s. 241.31(2).

Ministerial Advisory Panel Recommendation 32

That at the point of dispensing the lethal dose of medication, the dispensing pharmacist must:

- **attach labels clearly stating the use, safe handling, storage and return of the medication; and**
- **provide the person with information about the administration of the medication and the likely outcome.**

Policy intent

To ensure safe dispensing, use, handling, storage and return of the lethal dose of medication and that a person is provided with adequate information about the medication.

Storing the lethal dose of medication

The Parliamentary Committee Inquiry

The Parliamentary Committee did not recommend storage requirements for the lethal dose of medication.

Discussion

During the consultation process many stakeholders raised concerns about the safe storage of the lethal dose of medication. Although many of these stakeholders acknowledged the range of dangerous medications already in the community, they thought that a medication dosage prepared to cause death should be treated differently. Other stakeholders suggested people could be trusted to act responsibly and that opportunities for misuse or accidents were limited. It is noted that the lethal dose of medication will not be a single pill and will require a series of medications to be ingested in a particular order and in large enough volumes that it could not be ingested inadvertently.

Other jurisdictions do not include specific storage requirements. The Panel is of the view that a requirement that a person store their lethal dose of medication in a locked box will provide comfort to the community and will also assist the contact person. The locked box will ensure the contact person can easily identify where the lethal dose of medication is stored and may return the box to the pharmacist to destroy the medication if the person dies without using it.

Ministerial Advisory Panel Recommendation 33

That the person be required to store the lethal dose of medication in a locked box.

Policy intent

To ensure the lethal dose of medication is safely stored to avoid misuse.

Medication Monitoring

Part C also provides an overview of the roles, responsibilities and process for the monitoring of medication prescribed for the purpose of voluntary assisted dying.

When the lethal dose of medication is self-administered

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that in the vast majority of cases voluntary assisted dying should involve a medical practitioner prescribing a lethal dose of medication, which the patient may take without further assistance.¹⁶⁸

Discussion

People accessing voluntary assisted dying are likely to be engaged with a range of health practitioners and, in many circumstances, will have formed a close relationship with these practitioners. Some people may feel comforted by the presence of a health practitioner when they ingest the lethal dose of medication. In Oregon in 2016, health practitioners reported being present 41 per cent of the time when the lethal dose of medication was self-administered.¹⁶⁹ In Washington in 2015 there was a medical practitioner present in 75 per cent of cases.¹⁷⁰ Many people may like to have a health practitioner present at the time they self-administer the medication, and the legislation should not preclude this. It is, however, important that the obligations of health practitioners are clear so that they are reassured that it is appropriate for them to be present if the person wishes. Unless the person is physically unable

Betty makes her final request

Three days later Betty makes her final request to her coordinating medical practitioner. Betty has thought a lot about this and discussed with family and friends who she wants to be with her when she dies. Betty also decides she wants to die at home.

Betty appoints her partner, John, as her contact person. Betty's medical practitioner confirms that John understands his obligations for the return of any unused medication after Betty has died. Betty, John and her coordinating medical practitioner discuss the practicalities including: who will be with Betty; whether Betty would like him to be present; how the medication will take effect; and what to do if something unexpected happens. They discuss how to manage the prescription and the medication.

Betty's coordinating medical practitioner undertakes a final check to confirm that all the procedural requirements have been met. Before prescribing the medication Betty will require, he applies for an authorisation permit to the Department of Health and Human Services. The final checklist is emailed through to the Department and a permit number is issued. Betty's coordinating

Betty's story continued...

168 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxv, 220, 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.

169 Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

170 Washington State Department of Health (2016), *Washington State Department of Health 2015 Death with Dignity Act report*, Washington State, viewed 7 May 2017, <<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>>.

to self-administer or digest the medication, the medical practitioner cannot be authorised to administer the lethal dose of medication to the person.

A health practitioner should not be required to provide life-sustaining treatment to a person who has made a voluntary decision in accordance with the legislation to administer the lethal dose of medication. If a person has made an autonomous decision to access voluntary assisted dying and to self-administer the lethal dose of medication, it would clearly be contrary to that person's wishes to attempt to revive them. At the same time, a health practitioner should not be prevented from providing assistance if something goes wrong or from continuing to provide treatment to ensure a person is comfortable. Legislation in Vermont explicitly provides that a person shall face no liability for being present and is not required to take any action to prevent self-administration of the lethal dose of medication.¹⁷¹ In Washington, people are similarly protected from liability for being present at the time the person self-administers the lethal dose of medication.¹⁷²

While other jurisdictions provide broad protection for people who are present when a person self-administers the lethal dose of medication, they do not describe the expectations on health practitioners when the medication is regurgitated or a family member calls an ambulance after the person has administered the medication.

medical practitioner confirms once again that Betty is under no obligation to take the medication and that she can withdraw at any time. He writes the prescription for Betty.

John accompanies Betty to a pharmacy. The pharmacist checks the authorisation permit and informs Betty and John about the effects and risks of taking the lethal dose of medication, its administration and the requirement to store the medication in a locked box. The pharmacist attaches a label to the medication clearly stating its use, safe handling and safe storage, and the need to return it, if unused. The pharmacist reports to the Voluntary Assisted Dying Review Board that she had dispensed the medication to Betty.

Betty is relieved and comforted to have the medication available and in safe storage at her home. Betty's disease continues to progress over the next few weeks and she becomes more fatigued. With the assistance of the palliative care service, her daily care needs are met, including the management of her pain and other symptoms and Betty adapts to the changes of her disease. She has thought a lot about who she wants to be with her when she dies. She arranges this with her children, her sister Mary and friend, Jenny. In their presence, 10 days later, Betty takes lethal dose of medication. She dies an hour and a half later.

Betty's story continues in Part C.

¹⁷¹ *Patient Choice At End of Life Act* (Vermont), s. 5284.

¹⁷² *Death with Dignity Act* (Washington), s. 19(1)(a).

The Panel recognises that this will rarely occur. In Oregon there have only been 6 cases out of 1,127 over 20 years in which a person has regained consciousness after administering the medication.¹⁷³ Nonetheless the Panel recognises the importance of providing health practitioners with guidance and certainty in the unlikely event of these unusual cases. Given that a person who self-administered the lethal dose of medication has a clear intention to end their life, a health practitioner should not be under any obligation to attempt to revive the person. If the person is experiencing pain and distress, a health practitioner should provide symptom relief in the manner they ordinarily would to a dying person. This must not, however, include intentionally hastening the person's death. The framework for voluntary assisted dying clearly outlines the circumstances in which a medical practitioner may administer a lethal dose of medication to a person, and a failed self-administration is not one of those circumstances. It is important to make and uphold this distinction to ensure there is clarity and transparency around what has occurred.

Health practitioners who are present at the time the person self-administers the lethal dose of medication or health practitioners and paramedics who are called after a person self-administers should be under no obligation to provide life-sustaining treatment. However, they should not be prevented from providing palliative care or general assistance to a person for the purpose of ensuring their comfort. Paramedics who are called to attend following the administration of the lethal dose of medication should also have no obligation to provide life-sustaining treatment, if they are aware that this is what has occurred, as it would be contrary to the intent of the person. It is important to clarify the obligations of health practitioners because they have professional obligations to provide medical treatment to their patients.

David makes his final request

10 days after his first request David makes his final request. David appoints his wife as his contact person. David's neurologist confirms that David's wife understands her obligation to return any unused medication after David has died. David's neurologist discusses the practicalities, and how the medication will take effect. They discuss how to manage the prescription and the medication. David requests that his neurologist be present at the time he takes to medication as this would provide comfort to him and his family. His neurologist agrees and explains what his role will be and that he will not participate in assisting with the medication, but that he will be able to provide comfort care to David if this is required.

David's neurologist undertakes a final check to make sure all of the requirements have been met and applies for an authorisation permit from the Department of Health and Human Services to prescribe the medication for David. He emails the checklist through to the Department, which issues a permit number. David's neurologist confirms to David that he is under no obligation to take the medication and can change his mind at any time. He writes the prescription for David.

A week later after spending some good time with his family and a few friends, David decides it is time to self-administer the medication. He arranges a time with his wife, children and neurologist, who he has asked to be present to support him and his family. David self-administers the medication and dies an hour later.

This concludes David's story.

¹⁷³ Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

Ministerial Advisory Panel Recommendation 34

That the legislation not preclude health practitioners from being present when a person self-administers the lethal dose of medication if this is the preference of the person.

Ministerial Advisory Panel Recommendation 35

That there be protection in the legislation for health practitioners who are present at the time a person self-administers the lethal dose of medication, including that the health practitioner is under no obligation to provide life-sustaining treatment.

Policy intent

To allow for person-centred care.

To ensure there is clear protections for health practitioners who are present when a person self-administers the lethal dose of medication.

When the lethal dose of medication is administered by a medical practitioner

The Parliamentary Committee Inquiry

The Parliamentary Committee set out a singular exception to self-administration where people are physically unable to self-administer the lethal dose of medication. In this case, a medical practitioner should be able to assist the person to die by administering the drug.¹⁷⁴

Discussion

Canada and the European jurisdictions allow a person to decide whether they would like to self-administer the lethal dose of medication or to have a medical practitioner administer the medication. Jurisdictions in the US only provide for self-administration of the lethal dose of medication.

The Panel recognises that people who are physically unable to self-administer the lethal dose of medication should not be discriminated against and that it is reasonable for them to request assistance. The Panel also notes that for some people the issue may not be physically placing the medication in their mouth, but actually absorbing and digesting it. These people should not be excluded from accessing voluntary assisted dying, but medical practitioners should only be able to administer a lethal dose of medication in very limited circumstances and, where this occurs, it should be closely monitored.

¹⁷⁴ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxxv, 220, 222, 225, 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lisic/inquiry/402>>.

In the majority of cases, a person who is eligible for voluntary assisted dying will self-administer the lethal dose of medication. The Panel notes the general view among stakeholders that self-administration of a lethal dose of medication is a powerful safeguard to ensure voluntary assisted dying is in fact voluntary. The Panel acknowledges that stakeholders generally supported medical practitioners administering the lethal dose of medication for people who voluntarily request assistance when they are physically unable to self-administer. Stakeholders were concerned that it would be unfair and discriminatory not to allow this.

It is noted that the voluntary assisted dying framework is intended primarily for self-administration and that instances of where the lethal dose of medication is not self-administered are expected to be a very rare exception. To ensure clear accountability, only a coordinating medical practitioner should be authorised to administer a lethal dose of medication (noting that the role of coordinating medical practitioner may be transferred to a consulting medical practitioner). The coordinating medical practitioner is responsible for ensuring every step of the voluntary assisted dying process is completed, and it would not be appropriate for another medical practitioner to rely on the assessment of the coordinating medical practitioner. This is consistent with other jurisdictions that allow medical practitioners to administer a lethal dose of medication. In Canada, for a medical practitioner to administer the lethal dose of medication they must have conducted an assessment of the eligibility criteria.¹⁷⁵ Similarly, the Netherlands has a series of 'requirements of due care' that a medical practitioner must complete before administering the lethal dose of medication, which include conducting an assessment and ensuring the person's request is voluntary.¹⁷⁶

The Panel recommends that a coordinating medical practitioner be required to apply for a specific permit to administer the medication. This process will ensure it is clear who is administering the lethal dose of medication and who is responsible for the medication. In these cases, the medical practitioner will hold the medication at all times. This will also indicate to the Board the Voluntary Assisted Dying Review Board that there are additional steps that must be completed. This means that a coordinating medical practitioner will either apply for a self-administration permit or a coordinating medical practitioner administration permit from the Department of Health and Human Services.

The Panel acknowledges that, while allowing administration of a lethal dose of medication by a medical practitioner ensures voluntary assisted dying is not discriminatory, it creates other risks that must be addressed. When a person self-administers a lethal dose of medication it is a final indication that their decision is voluntary. When a medical practitioner administers a lethal dose of medication there must be a similar final affirmation that the person's decision is voluntary. This concern must be weighed against the need to ensure the process is not too onerous for people who are extremely unwell and suffering at the end of their life.

¹⁷⁵ *Medical Assistance in Dying Act (Canada)*, s. 241.2(3)(a).

¹⁷⁶ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands)*, art 2.



The Panel recommends that a witness, who is independent of the medical practitioner, must be present at the time the lethal dose of the medication is administered. The presence of this witness will protect both the person and the medical practitioner. The witness will be required to certify that the person appeared to have decision-making capacity and that their decision to be administered a lethal dose of medication was voluntary and at their request. The presence of an independent witness ensures a medical practitioner cannot pressure a person into receiving the lethal dose of medication. It also ensures that if a medical practitioner is subsequently accused of wrongdoing, there is an independent witness who is able to attest to whether the medical practitioner acted reasonably and in good faith.

The Panel considered requiring another independent medical practitioner to be present or another witness independent of the person. But given the extensive process that must be completed before a person may even reach this point, the involvement of further witnesses is unnecessary. It would also be insensitive and onerous to require a person to arrange for a number of others to observe their death, and this could be extremely confronting for family members. The certification of the medical practitioner and the witness that the person had decision-making capacity and that their decision remained voluntary is a sufficient additional safeguard because the person's decision-making capacity and the voluntariness of their request will already have been independently assessed by two medical practitioners.

Only the coordinating medical practitioner should be authorised to administer the lethal dose of medication. It is noted that they may transfer the role of coordinating medical practitioner to the consulting medical practitioner if this is required or requested by the person. The Panel notes that medical practitioners considering whether or not to accept the role of coordinating medical practitioner should make this decision in light of the particular circumstances of the person making the request. If the person is unlikely to be able to self-administer the medication, the medical practitioner should consider whether they are willing to administer the lethal dose of medication if this may be required. In the unlikely event that both the coordinating medical practitioner and the consulting medical practitioner conscientiously object to administering the lethal dose of medication, a coordinating medical practitioner may identify another medical practitioner willing to administer the medication. This medical practitioner may then become the consulting medical practitioner after they have conducted their own assessment of the person. The coordinating medical practitioner may then transfer the role of coordinating medical practitioner to the willing medical practitioner, who may then administer the lethal dose of medication.

The coordinating medical practitioner should certify in a scheduled form that:

- the person understands the nature and effect of administering the lethal dose of medication;
- the person's request appears to be voluntary; and
- the person wants to continue with the administration of the lethal dose of medication.

As an additional safeguard, when the coordinating medical practitioner is administering the lethal dose of medication, an independent witness must be present to ensure and certify that the person's decision is voluntary and enduring. The same standards will apply as for the assessment process in that an appropriately accredited interpreter may assist when necessary.

The presence of an independent witness provides an additional safeguard to ensure medical practitioners act appropriately and protects the medical practitioner from claims of impropriety.

If a person becomes physically unable to self-administer the lethal dose of medication after they have been prescribed the medication, they will need to request this from their coordinating medical practitioner. A medication is only prescribed to the person to self-administer; if anyone administers the medication to the person, this will be a crime. The Panel anticipates that a loss of physical capacity to self-administer the medication after the medication has been prescribed will be extremely rare. In Oregon the median time between a first request and death is 48 days, so it is unlikely there would be an unforeseen loss of physical capacity in that time.¹⁷⁷ The Panel recognises that there must be a process to account for these unlikely circumstances arising.

In order to administer the medication, the coordinating medical practitioner will need to complete the process for administering the lethal dose of medication to the person. This will require the coordinating medical practitioner to apply to the Department of Health and Human Services for a permit to administer the lethal dose of medication. To obtain this permit, the coordinating medical practitioner should be satisfied that any prescription or medication for self-administration has been returned. Once the coordinating medical practitioner is satisfied of this, the process may proceed in the same way as any other process for administration by a medical practitioner.

¹⁷⁷ Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

Ministerial Advisory Panel Recommendation 36

That not being able to self-administer is defined as being physically unable to self-administer or digest the lethal dose of medication.

Ministerial Advisory Panel Recommendation 37

That if the person is not able to self-administer, the coordinating medical practitioner may administer the lethal dose of medication.

Ministerial Advisory Panel Recommendation 38

That, in the rare circumstance the person loses the capacity to self-administer the medication after it has been prescribed, they must return to their coordinating medical practitioner if they wish to proceed with voluntary assisted dying. After the previously prescribed medication has been returned to the pharmacist, the coordinating medical practitioner may undertake the process to administer the medication.

Ministerial Advisory Panel Recommendation 39

That, in the rare circumstance where both the coordinating and consulting medical practitioners conscientiously object to administering the lethal dose of medication, the coordinating medical practitioner can refer the person to a new consulting medical practitioner willing to administer the medication. The new consulting medical practitioner must conduct their own independent assessment, after which the coordinating medical practitioner may transfer the role of coordinating doctor to them.

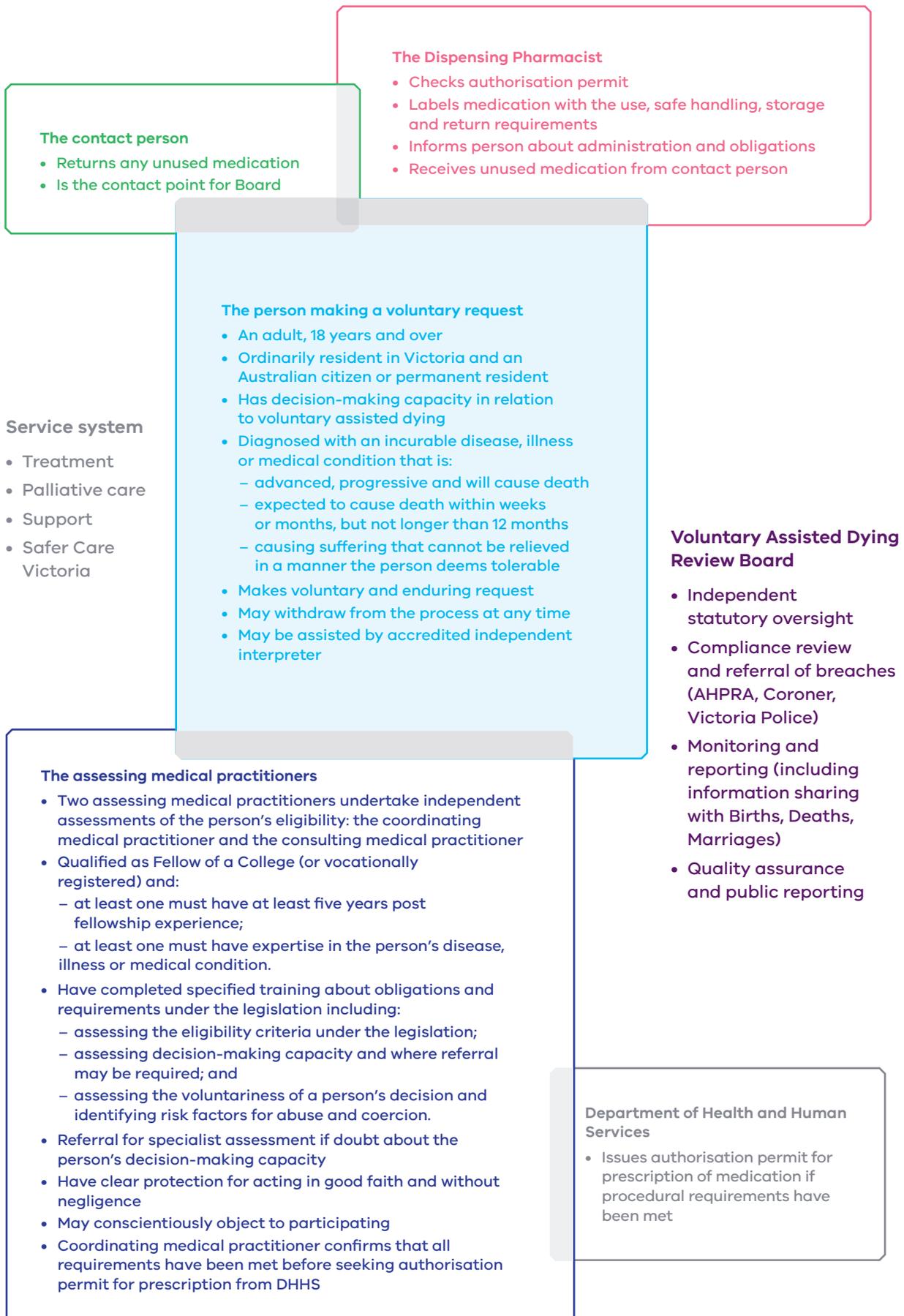
Ministerial Advisory Panel Recommendation 40

That, if the coordinating medical practitioner administers the lethal dose of medication, a witness who is independent of the coordinating medical practitioner must be present. The coordinating medical practitioner and the witness must certify that the person's request appears to be voluntary and enduring.

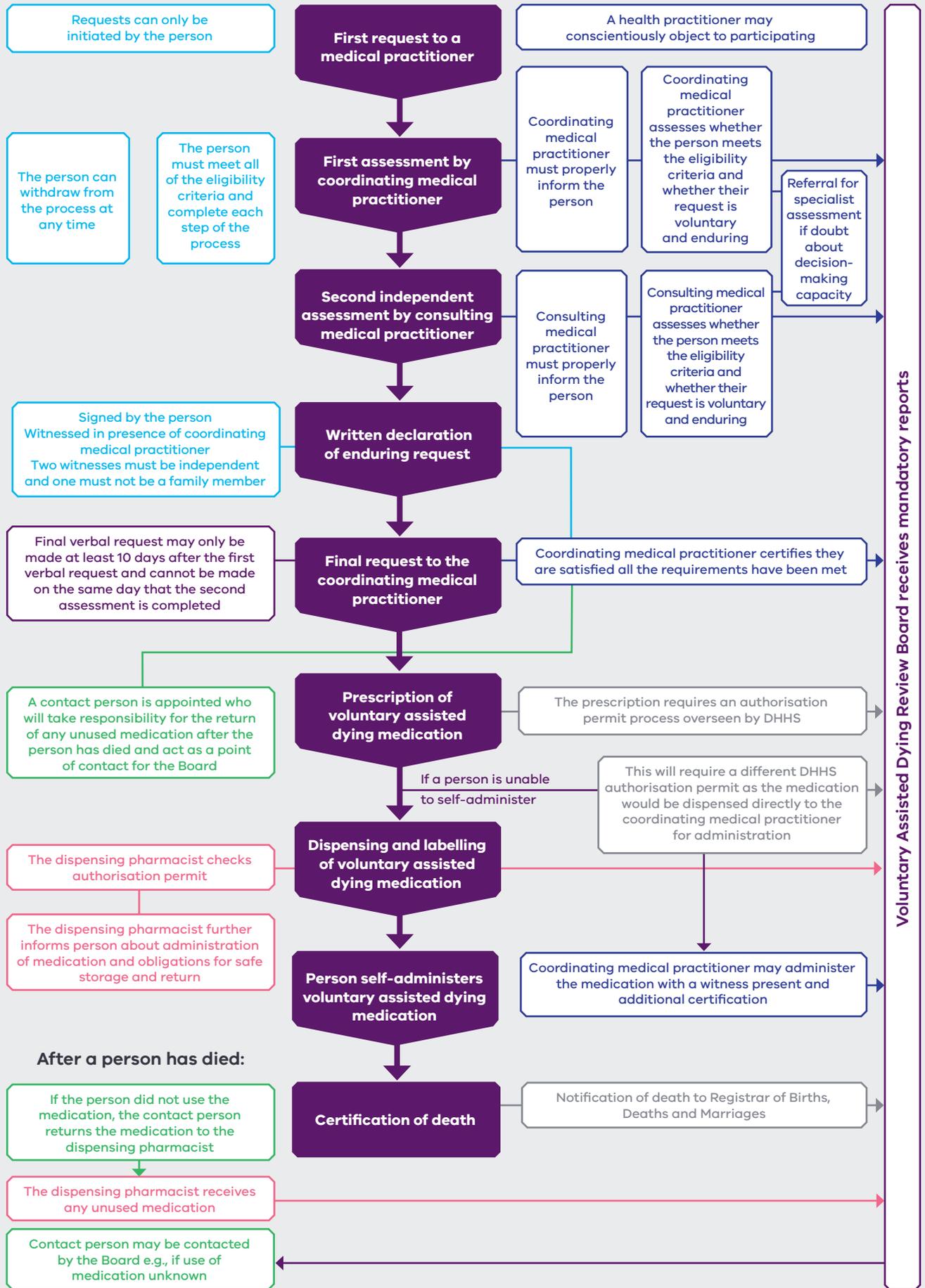
Policy intent

To ensure safeguards are in place to protect a person and the coordinating medication practitioner when a person is physically unable to self-administer or digest the lethal dose of medication.

Who is involved in voluntary assisted dying



The voluntary assisted dying process: an overview



Voluntary Assisted Dying Review Board receives mandatory reports





Part C: Oversight

In addition to providing a clear and compassionate framework for the operation and monitoring of voluntary assisted dying, the Panel recognises that the framework must also establish protections to protect people from abuse. This Part considers the practical monitoring of what happens after a person has died, as well as how the lethal dose of medication will be monitored at every stage of the process. It also sets out the establishment of the Voluntary Assisted Dying Review Board and its functions, and the proposed legislative protections and offences. The Panel has undertaken a detailed examination of the operating frameworks in various parts of the health system and for voluntary assisted dying in other jurisdictions to determine the most effective safeguards for Victoria. The Panel is confident that its comprehensive approach will ensure close oversight of the system to support the safe operation of voluntary assisted dying in Victoria and allay any community anxiety.

Monitoring after death

Much of the focus of the discussions and debates in both the consultation process and the deliberations of the Panel have centred on clearly defining the eligibility criteria and establishing the request and assessment process. However, in addition, the remit of the Panel has been to consider some further practical matters of implementation. One of the key considerations for the Panel is the question of what monitoring should occur after a person has died. This may be a particularly challenging time for family members and others who have been involved and needs to be handled sensitively and with compassion. The Panel recognises the importance of ensuring support for families and friends of people who choose voluntary assisted dying, and notes there are also a number of practical issues to be considered.

Cause of death

The Parliamentary Committee Inquiry

The Parliamentary Committee did not comment on how cause of death as a result of voluntary assisted dying should be recorded, nor what should be reported as the cause of death by a medical practitioner.

Discussion

Throughout the Panel's consultation process, there was much discussion about what should be recorded as the cause of death for those who access voluntary assisted dying. Most stakeholders recognised the need to balance the desire to collect information about voluntary assisted dying against the preservation of individual privacy. Collection of information about people who access voluntary assisted dying is important; however, the person and their family may not want voluntary assisted dying to be recorded on the death certificate as the cause of death.

In Victoria the death of a person is notified to the Registrar of Births, Deaths and Marriages. This notification is made by a medical practitioner, and includes information about the cause of death.¹⁷⁸ This information is collected under provisions of the *Births, Deaths and Marriages Registration Act 1996* and forms the basis for the registration of a death and the issuing of a death certificate. Death certificates may be required for legal and other official purposes, such as the settlement of the deceased's estate or the closing of bank and utility accounts. The notification of death made by a medical practitioner is a different document from the death certificate provided by the Registrar of Births, Deaths and Marriages.

¹⁷⁸ *Births, Deaths and Marriages Registration Act 1996* (Vic), s. 37.

In Washington and Colorado the cause of death is recorded as the underlying illness.¹⁷⁹ In Oregon the legislation is silent on the matter; however the Department of Human Services suggests that physicians record the underlying illness as the cause of death on the death certificate rather than stating that the person self-administered a lethal dose of medication prescribed under their legislation.¹⁸⁰ Canada provides for the Minister for Health to establish guidelines on the information to be included on death certificates, which may include both the manner of death and the underlying illness.¹⁸¹ In Switzerland, death certificates identify assisted suicide as the immediate cause of death, whereas Switzerland's Federal Office of Statistics records the underlying illness.¹⁸²

The Panel notes that the predominant stakeholder view was that death certificates should record the underlying condition as the cause of death. It was frequently noted that the person would not be accessing voluntary assisted dying without the underlying condition, which would inevitably cause their death in the immediate future. There was concern raised that those who accessed voluntary assisted dying should not be discriminated against on the basis of their choice for the purpose of benefits such as insurance.

The Panel notes that the proposed legislation provides access to voluntary assisted dying under limited circumstances for those people at the end of their life. They would die from that condition even if they did not choose voluntary assisted dying. Other medical treatments or actions taken that may hasten death or prolong life are not included on death certificates currently. The Panel considers it would be inconsistent to include voluntary assisted dying on a death certificate when other interventions are not recorded. The Panel also notes that identifying voluntary assisted dying on death certificates may inadvertently compromise the privacy of the clinical relationship between a medical practitioner and their patient. Therefore it is appropriate for the death certificate to identify the underlying condition as the cause of death. Other reporting requirements set out data collection points in a way that reduces the need to report voluntary assisted dying on a public document. The approach proposed for data reporting on the death of a person is discussed below.

As the person is already at the end of their life, the Panel recommends that accessing voluntary assisted dying should not affect insurance payments or other annuities. The person has not made a decision to end their life prematurely, they have made a decision about the manner of their death and they should not be punished for this. The person's underlying disease, illness or medical condition will inevitably cause their death, and, for the purposes of insurance and other annuities, their death as a result of voluntary assisted dying should be treated as though they died as a result of the disease, illness, or medical condition. This is consistent with approach taken in US jurisdictions.¹⁸³

179 *Death with Dignity Act* (Washington), s. 4(2); *End-of-Life Options Act* (Colorado), s. 25-48-109(2).

180 The Task Force to Improve the Care of Terminally-Ill Oregonians Center for Ethics in Health Care, Oregon Health & Science University (2008), *The Oregon Death with Dignity Act: a guidebook for health care professionals*, The Greenwall Foundation, 14. Oregon Department of Human Services Reporting, viewed 11 May 2017, <<https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>>.

181 *Medical Assistance in Dying Act* (Canada), s. 241.31(3.1).

182 External Panel on Options for Legislative Response to *Carter v. Canada* (2015), *Consultations on physician-assisted dying: summary of results and key findings: final report*, Government of Canada, Ontario, p. 118, viewed 1 May 2017, <<http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html>>.

183 *Death with Dignity Act* (Oregon), s. 127.875; *Death with Dignity Act* (Washington), s. 7; *End of Life Options Act* (California) s. 443.13(2); *End of Life Options Act* (Colorado), s. 25-48-115; *Patient Choice At End of Life* (Vermont), s. 5287

Ministerial Advisory Panel Recommendation 41

That the death certificate of a person who has accessed voluntary assisted dying identifies the underlying disease, illness or medical condition as the cause of death.

Ministerial Advisory Panel Recommendation 42

That accessing voluntary assisted dying should not affect insurance payments or other annuities.

Policy intent

To preserve privacy for the person and their family.

To preserve the privacy of the medical practitioner and their therapeutic relationship with the person.

To recognise that people accessing voluntary assisted dying are already at the end of their life and have an underlying disease, illness or medical condition that will cause death.

Notification of death

The Parliamentary Committee Inquiry

The Parliamentary Committee did not comment on the notification of death to the Victorian Registry of Births, Deaths and Marriages.

Discussion

As noted above, in Victoria, a notification of death is completed by a medical practitioner and submitted to the Registry of Births, Deaths and Marriages. The Registry provides a form that must be completed and submitted to the Registry within 48 hours following the death. This form is required under section 37(1) of the *Births, Deaths and Marriages Registration Act* and is used where a death is not required to be reviewed or reported to the Coroner. The information collected is held in the Register and is the basis for issuing of the death certificate. The Register may also be used for statistical purposes, medical research, community planning, law enforcement and other uses provided by law. Access to the Register for approved purposes may be granted to certain government and authorised non-government agencies.

The Panel views it as important that information about whether a person who has died has accessed voluntary assisted dying. To ensure information about the use of lethal dose of medication is collected, the Panel proposes that the medical practitioner who completes the notification of a person's death should be required to indicate on the notification if the practitioner is aware that the person has been prescribed a lethal dose of medication and whether the lethal dose has been administered. It is recognised that sometimes the medical practitioner who certifies death may not be the coordinating medical practitioner who prescribed the lethal dose of medication. It is also recognised

that there may be occasions in which it is not clear to the medical practitioner whether the person has administered the lethal dose of medication. For example, in Oregon in 2016 around 5 per cent of people who were prescribed the lethal dose of medication died without the Oregon Health Authority knowing whether or not they administered the medication.¹⁸⁴

The Panel accepts that there will be some uncertainty in a small number of cases. The Panel's recommendation that the person must appoint a contact person will help address this issue. If there is uncertainty about whether the person has administered the lethal dose of medication the Voluntary Assisted Dying Review Board will be able seek information from the contact person. It is important to note that the notification of death and the death certificate are separate documents and that all the information included in a notification of death is not necessarily stated in the death certificate. In this way, the person's privacy is still preserved.

The notification of the death of each person who is prescribed the lethal dose of medication is to be shared by the Registrar of Births, Deaths and Marriages with the Voluntary Assisted Dying Review Board. This will ensure that deaths under the voluntary assisted dying framework are identified, and avoid placing a further burden on medical practitioners to report to the Voluntary Assisted Dying Review Board in addition to the Registrar. This is consistent with the manner in which the Registrar of Births, Deaths and Marriages is currently authorised to share information for particular purposes under legislation. The privacy of this information is protected under existing legislative requirements such as the *Health Records Act 2001*, which regulates the collection, use and disclosure of personal and health information.

After Betty has died

Having confirmed Betty's death, the coordinating medical practitioner completes a death notification stating the cause of her death as cancer of the colon, and forwards this to the Registrar of Births, Deaths and Marriages together with a statement that Betty has self-administered a lethal dose of medication under the legislation. The coordinating medical practitioner forwards the completed set of required forms to the Voluntary Assisted Dying Review Board.

Betty's care team visit John and his family, and offer an opportunity for him to attend a bereavement group. John declines saying he already keeps in touch with members of the Cancer Support Group whom he and Betty were linked into at the time when she was diagnosed and he feels comfortable to talk with this group as he has developed a strong and shared bond with its members.

This concludes Betty's story.

¹⁸⁴ Oregon Public Health Division, Oregon Health Authority (2016), *Oregon's Death with Dignity Act: 2015 data summary*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

Ministerial Advisory Panel Recommendation 43

That the medical practitioner who certifies death must notify the Registrar of Births, Deaths and Marriages if they are aware that the person has been prescribed a lethal dose of medication or if they are aware that the person self-administered a lethal dose of medication under the voluntary assisted dying legislation.

Ministerial Advisory Panel Recommendation 44

That the Registrar of Births, Deaths and Marriages and the Voluntary Assisted Dying Review Board share information relating to voluntary assisted dying.

Policy intent

To establish a central location where information about the administration of the lethal dose of medication is collected after a person has died.

To ensure all deaths under the voluntary assisted dying framework are identified.

Coronial involvement

The Parliamentary Committee Inquiry

The Parliamentary Committee considered requiring that the Coroner examine each case of voluntary assisted dying but believed this would be unnecessary because such a death would be reasonably expected and lawful, and therefore not qualify as a reportable death under the *Coroners Act 2008*.

Discussion

In the Netherlands, the attending physician must notify the municipal autopsyist if the death was the result of voluntary assisted dying under their legislation.¹⁸⁵ They are the only jurisdiction where voluntary assisted dying is legalised that requires this level of review. These requirements are not replicated in North American jurisdictions, where the review of voluntary assisted dying occurs through reports provided by medical practitioners.

In Victoria, special categories of death must be reported to the Coroners Court of Victoria; these are called 'reportable deaths'. The *Coroners Act* sets out that a reportable death includes:

- a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or

¹⁸⁵ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 8.

- a death that occurs—(i) during a medical procedure; or (ii) following a medical procedure where the death is or may be causally related to the medical procedure—and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.¹⁸⁶

The Coroners Court of Victoria is a specialist court established to investigate certain types of deaths, including reportable deaths. The purpose of these investigations is to identify the cause of death and consider ways to prevent similar deaths in the future.

While coronial investigations may add additional oversight, the purpose of conducting an investigation in a case of voluntary assisted dying is not clear. The cause of death would be known, legal and expected. The one exception may be to undertake an examination of the deceased to confirm beyond any doubt that the person had died by administering the lethal dose of medication. However, it is anticipated that the cause of death would generally be known and expected. As voluntary assisted dying would be legal, there would be no reason for the Coroner to make recommendations about how similar deaths could be avoided. If there were any suggestion of impropriety, or a failure to comply with the legislative requirement for voluntary assisted dying, the Coroner could still conduct an investigation. In the case of any impropriety or suspicious deaths, the Coroner and Victoria Police maintain their usual jurisdiction and powers to investigate and the proposed Voluntary Assisted Dying Board would refer any suspected breaches to the relevant investigatory agency.

A number of stakeholders stated that the involvement of the Coroner would not be in keeping with the intention of the voluntary assisted dying framework, which is to provide a peaceful and controlled death for the person and their family, minimising potential distress at that time. A coronial investigation would create processes and interventions that are unnecessary and burdensome for the family during a time of grief. A coronial investigation can be invasive, prolonged and disruptive for family members trying to continue their lives. The Panel notes that the position adopted by the Parliamentary Committee supports stakeholders' views that it is not necessary for the Coroner to review each voluntarily assisted death.

The Panel weighed up the possible merits of providing further certainty after a death about the use of the lethal dose of medication in a very limited number of circumstances against the risk of interference and intrusion on the person's family and friends. The Panel noted that in the majority of other jurisdictions, coronial involvement is not imposed and this had not been an issue for the safe operation of voluntary assisted dying. On balance, the Panel affirmed that the needs of the person must be central and that mandating coronial involvement would not support the intent of the legislation to provide a compassionate framework to reduce suffering at the end of life.

¹⁸⁶ *Coroners Act 2008 (Vic)*, s. 4(2)(a)-(b).

Ministerial Advisory Panel Recommendation 45

That a death by means of voluntary assisted dying in accordance with the legislative requirements not be considered a reportable death for the purpose of the Coroners Act.

Policy intent

It is important that the Coroner investigates improper action and it is intended that the Coroner maintains jurisdiction to investigate a suspicious death. However, the Panel agrees with the position of the Parliamentary Committee that it would be unnecessary and burdensome as well as intrusive for grieving families the Coroner to review each voluntary assisted death.

Medication monitoring

Roles and responsibilities

This is a summary of how the lethal dose of medication will be managed and monitored at every stage of the process, cross-referenced with the relevant recommendations.

The Panel has deliberated at length on the complex issue of the safe management of the lethal dose of medication. The Panel was particularly cognisant of developing a framework that would work in the Victorian context and not impose undue administrative burden.

Voluntary assisted dying medication can only be prescribed after the person has undertaken a rigorous request and assessment process as set out in Part B.

Coordinating medical practitioner

- Includes an appointment of contact person form within the certification for authorisation report to the Voluntary Assisted Dying Review Board
- Requests an authorisation permit for the prescription after certification that all requirements have been met

Department of Health and Human Services

- Provides an independent point of assessment of compliance prior to authorisation to prescribe
- Issues a permit using an authorisation process under the *Drugs, Poisons and Controlled Substances Act 1981*
- Provides a mandatory report to the Voluntary Assisted Dying Review Board on the issuing of a permit

Recommendation 31: That the prescription of the lethal dose of medication requires an authorisation process.

Dispensing pharmacist

- Provides additional independent monitoring of the lethal dose of medication by another health practitioner
- Dispenses only with a prescription and a valid permit
- Labels the lethal dose of medication stating its use, safe handling, storage and return

Recommendation 32: That at the point of dispensing the lethal dose of medication, the dispensing pharmacist must:

- attach labels clearly stating the use, safe handling, storage and return of the medication; and
 - provide the person with information about the administration of the medication and the likely outcome.
- Communicates with the person or contact person about their obligations for safe storage and arrangements for return of the lethal dose of medication if unused
 - Provides a mandatory report to the Voluntary Assisted Dying Review Board at the point of dispensing (Recommendation 49)

- Receives from the contact person any unused medication for disposal
- Provides a mandatory report to the Voluntary Assisted Dying Review Board when a contact person returns unused medication (Recommendation 49)

Person who has been prescribed the lethal dose of medication

- Nominates a contact person

Recommendation 29: That the person appoints a contact person who will take responsibility for the return of any unused lethal medication to the dispensing pharmacist within 30 days after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board.

- Stores medication safely in a locked box

Recommendation 33: That the person be required to store the lethal dose of medication in a locked box.

Contact person (Recommendation 29)

- Provides a clear line of accountability for the return of any unused medication
- Accepts responsibility to know where the medical is safely stored, to check whether the lethal dose of medication has been used after a person's death, and to return any unused medication
- Provides a follow up contact point for the Voluntary Assisted Dying Review Board

Voluntary Assisted Dying Review Board

The roles and functions of the Voluntary Assisted Dying Review Board are set out in Recommendation 47. The specific roles the Board has in relation to the monitoring of voluntary assisted dying medication are:

- Receives mandatory reports from the assessing medical practitioners confirming the person's eligibility to be prescribed the lethal dose of medication (Recommendation 49)
- Receives a mandatory report from the coordinating medical practitioner who provides the final check that includes the contact person's details (Recommendation 49)

Recommendation 49: That, in order to monitor the lethal dose of medication, there is mandatory reporting to the Voluntary Assisted Dying Review Board:

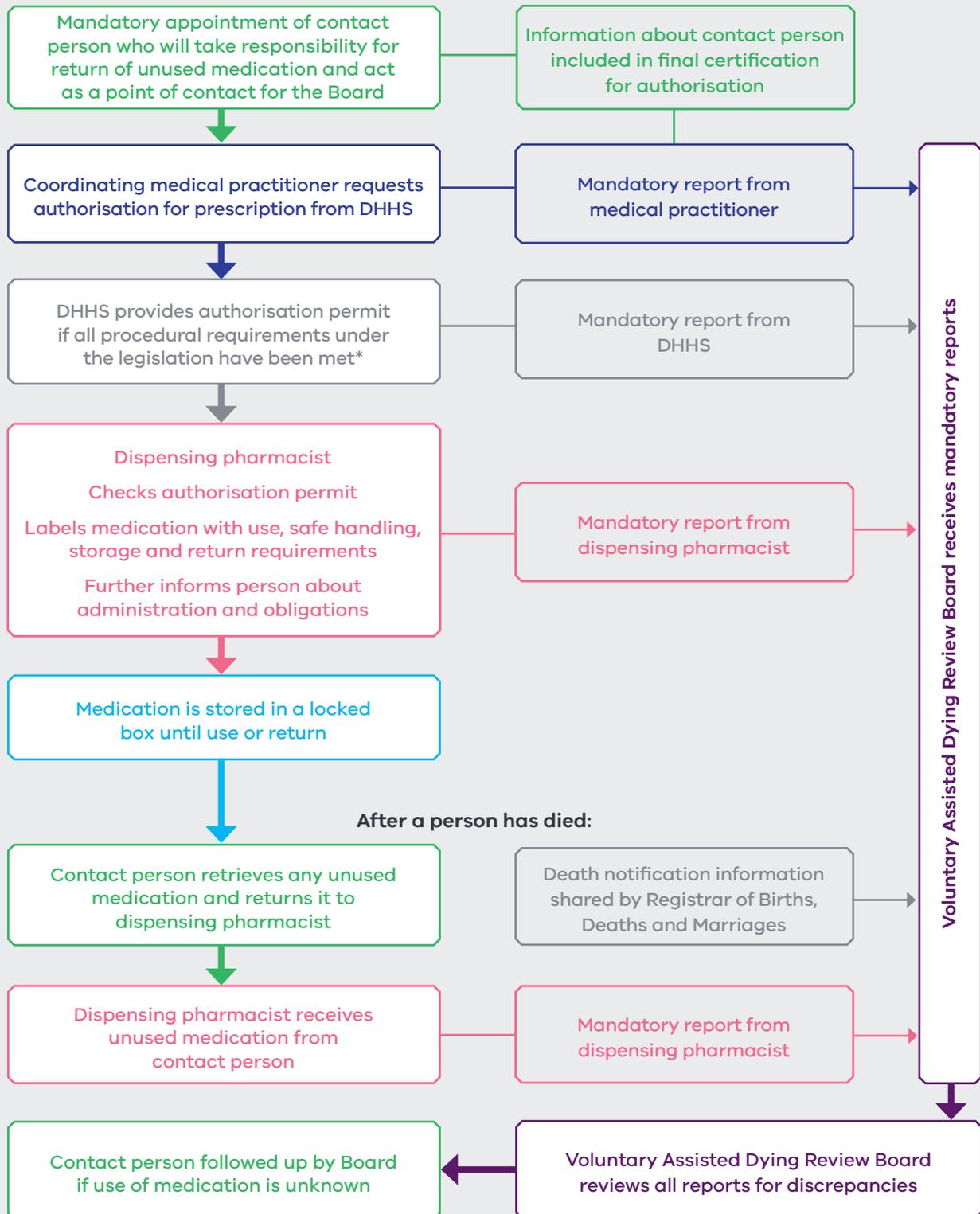
- by the Department of Health and Human Services when the prescription is authorised;
- by the pharmacist when the prescription is dispensed;
- by the pharmacist if unused lethal medication is returned by the contact person.
- Receives a mandatory report from the Department of Health and Human Services at the point an authorisation permit is issued
- Receives a mandatory report from the dispensing pharmacist at the point of dispensing
- Receives a mandatory report from dispensing pharmacist if unused medication is returned
- Receives death notification information from the Registrar of Births, Deaths and Marriages (Recommendations 43 and 44)
- Follows up with the contact person if the use of lethal dose of medication is unknown (Recommendation 29)
- Reviews all reports to check for compliance and discrepancies (Recommendation 47)

The process for safely monitoring the lethal dose of medication is set out in a diagram on the following page

Process for the safe monitoring of voluntary assisted dying medication

Voluntary assisted dying medication can only be prescribed after the person has undertaken a rigorous request and assessment process.

After a person has been assessed as meeting all of the eligibility criteria:



* Note: If a person loses physical capacity to self-administer after they have received the medication it will need to be returned and a new authorisation permit will be required for the coordinating medical practitioner to administer the medication; no one else may administer the lethal dose of medication.

Voluntary Assisted Dying Review Board

In this section the Panel sets out the establishment of an oversight body, the Voluntary Assisted Dying Review Board (the Board), to serve as the principal point of governance and administration for the new voluntary assisted dying framework. A central body can provide leadership and expert guidance to support safety and improve quality. It is best able to serve as the repository for reporting and data collection so it can monitor activity, compliance, trends and any other system risks. It will provide a clear and transparent point of accountability for health practitioners and will provide reassurance to the Victorian community that voluntary assisted dying will be carefully monitored and reviewed.

Establishment as a statutory entity

The Parliamentary Committee Inquiry

The Parliamentary Committee's investigations showed that many voluntary assisted dying frameworks include an entity responsible for reviewing cases. Exactly how the entity is constituted and what its role is differs between each jurisdiction. The Parliamentary Committee considered case-by-case review necessary to ensure a robust voluntary assisted dying framework in Victoria and recommended the establishment of a state-wide review entity, the Assisted Dying Review Board.

Discussion

The North American jurisdictions that have legalised voluntary assisted dying rely on existing entities to oversee voluntary assisted dying. This is primarily by means of reporting to a health authority, equivalent to the Victorian Department of Health and Human Services. In both Belgium and Luxemburg the relevant legislation establishes a form of national commission focusing on monitoring and evaluation. In the Netherlands the legislation establishes Regional Review Committees for the Termination of Life on Request and Assisted Suicide.

Throughout the consultation process there was wide support for an oversight body; stakeholders felt it was a sensible way to ensure the framework operates properly and is closely monitored.

The Panel considered the options and affirmed that a statutory entity is the preferred model for establishing an oversight body. Statutory models of governance provide a strong relationship with the legislative framework under which an oversight body operates. The independence of a statutory body ensures transparency with respect to its operations.

The Panel also reviewed the range of existing statutory bodies in Victoria that have a role in health governance to consider how they are established and operate. The Panel formed the view that the consultative council model is appropriate for the proposed Board. For example, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reviews all cases of maternal, perinatal and paediatric mortality and morbidity, and advises the Minister for Health and the Department of Health and Human Services on strategies to improve clinical performance and avoid preventable deaths. The functions of the Voluntary Assisted Dying Review Board could mirror this, in reviewing all cases of voluntary assisted dying and seek to improve care and avoid

harm. This alignment suggests a natural fit with the consultative council model, which has its role, functions and operations set out in legislation. Consultative councils also identify potential impropriety and provide information to the relevant health practitioner National Board and to the Coroner.¹⁸⁷ The Voluntary Assisted Dying Review Board would similarly identify potential failures to comply with the statutory requirements and refer matters to appropriate investigatory agencies.

In addition, the Panel noted that consultative councils are independent statutory bodies that operate within a broader quality and safety system within Safer Care Victoria.¹⁸⁸ Safer Care Victoria is a lead government agency that is independent and separate from the Department of Health and Human Services, but works in close collaboration to improve healthcare safety and quality at the levels of the individual health practitioner, health service and system. The Panel noted that its recommended oversight framework would therefore provide the strength of both independence and clear links and collaboration with government and the health care system. Just as voluntary assisted dying should not be provided in isolation, improving quality and safety should occur in accordance with other improvements in end-of-life care.

The Panel notes that the Board would need to be established up to a year before the legislation comes into effect in order to determine its processes and its operational model, and to set out and disseminate its reporting requirements so that it is ready to undertake its functions as soon as the legislation commences.

Ministerial Advisory Panel Recommendation 46

That a Voluntary Assisted Dying Review Board be established under statute to review every case of voluntary assisted dying and report on the operation of voluntary assisted dying in Victoria.

Policy intent

To provide a clear link between the Board and the voluntary assisted dying legislative framework.

To identify potential issues and inform system-wide quality and safety improvements.

¹⁸⁷ *Public Health and Wellbeing Act 2008 (Vic)*, s. 41.

¹⁸⁸ Safer Care Victoria is the peak state authority for leading quality and safety improvement in healthcare. Staffed and led by clinicians and researchers, Safer Care Victoria oversees and supports health services to provide safe, high-quality care to patients. It was created in response to the recommendations within the report by Duckett, S, Cuddihy, M & Newnham, H (2016), *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: report of the review of hospital safety and quality assurance in Victoria*, State of Victoria, Melbourne, viewed 11 May 2017, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>>.

Role and functions

The Parliamentary Committee Inquiry

The Parliamentary Committee proposed that the function of the Board would not be to approve or reject requests to access voluntary assisted dying from patients – that is the role of the primary doctor and independent secondary doctor in each case. Neither would the Board hear appeals from patients whose requests to access voluntary assisted dying have been rejected. The purpose of the Board would be to ensure that medical practitioners are complying with requirements of the voluntary assisted dying framework by reviewing cases of approved requests following the patient's death.

The Parliamentary Committee proposed that the Board reviews each instance where a patient's request to access voluntary assisted dying has been approved, including:

- patients who take the lethal drug prescribed to them, and subsequently die
- patients who are administered a legal drug by a medical practitioner, and subsequently die
- patients who receive a prescription for a lethal drug, but do not take the drug, for whatever reason
- patients whose request to access voluntary assisted dying is approved, but die before their medical practitioner is able to prescribe the lethal drug.

In the case of administrative, clerical, or minor procedural errors on the part of either medical practitioner, the Parliamentary Committee proposed that the Board would provide feedback to ensure the medical practitioners involved follow proper procedure in the future. In the case of breaches, the Board would forward its report to the appropriate authority. Depending on the nature of the breach this may be Victoria Police, the Coroner, and/or or the Australian Health Practitioner Regulation Agency. Those bodies would then determine whether to investigate the case further.

Discussion

The Panel notes the strong stakeholder support for the establishment of a review board to monitor voluntary assisted dying in Victoria. There was support expressed during the consultation process for such a body to collect information about requests for voluntary assisted dying, including those that had been rejected. The proposed Board would oversee activity under the legislation and be able to analyse data about voluntary assisted dying. This would include reviewing compliance with the requirements of the legislation, referring breaches to the appropriate authority, and reporting on voluntary assisted dying. Feedback from the consultation process supported these key functions and also placed strong emphasis on the role of a Board in improving quality and safety and promoting research on good practice. Consistent with the recommendation of the Parliamentary Committee, the role of the Board would not be to approve or reject requests for access or to hear appeals if a person is refused access to voluntary assisted dying. It should be noted that no other jurisdiction has specified provisions within voluntary assisted dying legislation for appealing eligibility decisions.

In the US, the relevant jurisdiction's Health Authority or Department of Health is responsible for collecting and monitoring the reported information on voluntary assisted dying.¹⁸⁹ In California their existing Medical Board is assigned the responsibility to update forms and their Department of Public Health publishes them, while in Canada the Minister for Health makes regulations and establishes guidelines about medical assistance in dying.¹⁹⁰ In Oregon the voluntary assisted dying legislation is silent on obligations in relation to non-compliance and enforcement, but the Oregon Department of Human Services identifies reporting problems with the physicians and reports violation of the Act to the licensing board.¹⁹¹ In the Netherlands the Review Committee reviews all cases for compliance and refers cases to the public prosecutor and regional healthcare inspector if medical practitioners do not act in accordance with the statutory due care requirements.¹⁹² Similarly, the role of the Belgian Commission is to review all reported cases of voluntary assisted dying for compliance with the conditions in the legislation, and if they have not been fulfilled, to refer the case to the public prosecutor.¹⁹³

The Panel recommends that the Voluntary Assisted Dying Review Board not have the power to veto requests or arbitrate appeals. No other jurisdiction has an independent body that makes contemporaneous rulings about the potential legality of particular cases of voluntary assisted dying. The Panel recognises that such a process would be extremely traumatic for participants and that the most appropriate person to provide a diagnosis and prognosis is the person's medical practitioner. Eligibility assessment for voluntary assisted dying is determined through clinical judgement embedded in a therapeutic relationship, and is not a legal matter. The Panel notes that the Victorian Civil and Administrative Tribunal (VCAT) presently reviews legal matters, so it may be appropriate for VCAT to arbitrate if there are appeals relating to residency, capacity or procedural matters. The Panel also recommends that the Voluntary Assisted Dying Review Board not act as a complaints body, provide clinical oversight or act as a professional disciplinary body. Victoria already has a range of bodies that perform these roles and there is no reason to duplicate the functions of these bodies for voluntary assisted dying.

One of the core functions of the Board should be to review each case of voluntary assisted dying, as well as each assessment for voluntary assisted dying, to ensure there has been compliance with the statutory requirements. Researchers have noted that examining both granted and refused requests is important to be able to assess

189 California Department of Public Health; Colorado Department of Public Health and Environment; Oregon Health Authority; Vermont Department of Health; Washington State Department of Health.

190 *End of Life Option Act* (California), ss. 443.22, 443.19(c), *Medical Assistance in Dying Act* (Canada), s. 241.31(3).

191 Lewis, P & Black, I (2013), 'Reporting and scrutiny of reported cases in four jurisdictions where assisted dying is lawful: a review of the evidence in the Netherlands, Belgium, Oregon and Switzerland', *Medical Law International*, vol. 13, no. 4, pp. 221–239; The Task Force to Improve the Care of Terminally-Ill Oregonians Center for Ethics in Health Care, Oregon Health & Science University (2008), *The Oregon Death with Dignity Act: a guidebook for health care professionals*, The Greenwall Foundation, viewed 11 May 2017, <<https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>>.

192 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 9(2).

193 *Act on Euthanasia of 28 May 2002* (Belgium), s. 8.

adherence to the eligibility criteria.¹⁹⁴ Ensuring compliance with procedural safeguards is an important safeguard in and of itself.¹⁹⁵

In keeping with the views of the Parliamentary Committee and practice in other jurisdictions, it is not intended that the Board would have an investigatory role. It would not be appropriate for the Board to investigate potential breaches of the statutory requirements because the Board participates in the process, and potential breaches should be investigated by an independent body with no interest in the outcome. Existing investigatory bodies, such as Victoria Police, also already have practices and procedures in place to ensure procedural fairness. Given the Board's involvement in the process and the existence of other appropriate investigatory bodies, the Board should not conduct investigations. It is intended that the Board would be able to refer suspected breaches of the statutory requirements to the appropriate authority to investigate the matter, such as Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency.

As noted above, the Panel favours an oversight approach that maintains independence from government and has its role clearly set out in legislation. The Panel considers that one of the strengths of the proposed Board model is that it would function as an independent statutory authority. As such, the Panel recommends that one of the Board's functions would be to collect and monitor data so that it can oversee the operation of the legislative framework directly, rather than having this data reported through the Department of Health and Human Services or another body. The Panel recognises that as the Board establishes its operations for ongoing implementation it would form a view about additional data that may be required to oversee voluntary assisted dying in Victoria. Therefore it is intended that the Board be able to request further reports and information to supplement what is set out in the legislation so it can perform its functions.

The role of the Board should include monitoring, analysing, considering, referring and reporting on matters relating to voluntary assisted dying. The Panel considers that the establishment of voluntary assisted dying in Victoria creates a new set of monitoring and reporting requirements. The Board would need to have sufficient data and oversight to be certain of the overall safety and quality outcomes and to provide necessary assurance to the community that all providers are consistently providing high-quality care.

It would also be important for the Board to have a focus on identifying opportunities for quality improvement. A recent review of hospital safety and quality assurance in Victoria has highlighted the importance of safety and quality improvement being a core goal of the Department of Health and Human Services and the health system.¹⁹⁶

194 Lewis, P & Black, I (2013), 'Adherence to the request criterion in jurisdictions where assisted dying is lawful? A review of the criteria and evidence in the Netherlands, Belgium, Oregon, and Switzerland', *Journal of Law, Medicine & Ethics*, vol. 41, no. 4 pp. 885–898.

195 External Panel on Options for Legislative Response to *Carter v. Canada* (2015), *Consultations on physician-assisted dying: summary of results and key findings: final report*, Government of Canada, Ontario, pp. 103–104, viewed 1 May 2017, <<http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html>>.

196 Duckett, S, Cuddihy, M & Newnham, H (2016), *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: report of the review of hospital safety and quality assurance in Victoria*, State of Victoria, Melbourne, viewed 11 May 2017, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>>.

The Panel concurs with this and therefore considers that the Voluntary Assisted Dying Review Board should have a strong focus on quality and safety. One of the key functions of the Board should be to provide transparency and accountability on the operation of the framework by reporting publicly on and identifying trends and recommendations for improvement.

The Panel also proposes that the Board, as custodian of the data that is collected and monitored under this framework, should have a role in facilitating research. In this way the Board would be able to identify opportunities for quality improvement and disseminate guidance based on the analysis of the data collected. This is consistent with the activities currently performed by the consultative councils, which produce guidelines for quality improvement.

Ministerial Advisory Panel Recommendation 47

That the role and functions of the Voluntary Assisted Dying Review Board be:

- **reviewing each case of voluntary assisted dying and each assessment for voluntary assisted dying to ensure the statutory requirements have been complied with;**
- **referring breaches of the statutory requirements to the appropriate authority to investigate the matter such as Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency;**
- **collecting information and data, setting out additional data to be reported and requesting additional information from medical practitioners or health services, for the purpose of performing its functions;**
- **monitoring, analysing, considering and reporting on matters relating to voluntary assisted dying;**
- **supporting improvement by facilitating and conducting research relating to voluntary assisted dying and maintaining and disseminating guidelines to support the operation of the legislation, in collaboration with other agencies and professional bodies and services; and**
- **any other functions necessary to promote good practice.**

Policy intent

To ensure a strong framework for overseeing and monitoring voluntary assisted dying in Victoria.

To provide quality assurance at the individual level and identify quality improvement opportunities at the system level.

Membership

The Parliamentary Committee Inquiry

The Parliamentary Committee proposed that the Assisted Dying Review Board have its membership detailed in legislation, appointed by the Minister for Health. It recommended that the membership consist of a representative of End of Life Care Victoria (a new entity proposed by the Parliamentary Committee), a doctor, a nurse, a legal professional, and a community member.

Discussion

In North American jurisdictions, voluntary assisted dying is reviewed in existing organisations and there are no statutory requirements that reviews be conducted by people with particular expertise. The Dutch Review Committees comprise an uneven number of members and include a legal specialist who is the Chair, a physician, and an expert on ethical or philosophical issues.¹⁹⁷ Luxembourg has nine members in its Commission, appointed based on their knowledge and experience. Three of the members must be medical doctors, one of whom has expertise in pain management; three are lawyers, including a barrister, a magistrate and a law professor; two members represent patient rights and the remaining member is a health practitioner.¹⁹⁸ In Belgium the 16-member Commission has eight doctors of medicine, of whom at least four are professors, four professors of law or practising lawyers, and four members who are from groups responsible for terminally ill patients.¹⁹⁹

During the consultation process it was suggested that the membership proposed by the Parliamentary Committee needed to be more multidisciplinary to reflect mainstream models of care for people who are dying. An ethicist, nurse, pharmacist and psychologist were among the additional expertise suggested to support the work of the Board. Feedback from the consultation process suggested there could be specialised health practitioners available to review specific matters, however it was recognised that wider and stable membership was necessary to support consistent and robust decision-making. This could be achieved by including more than one community member, a broader range of experts, and additional specialist health practitioners, such as psychiatrists and palliative care nurses. Feedback from participants at the forums strongly supported a Board with multidisciplinary membership. The Panel notes that the membership for consultative councils is extensive, which ensures the relevant expertise is available and that there is appropriate flexibility.²⁰⁰

197 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 3.

198 *Law of 16 March 2009 on euthanasia and assisted suicide* (Luxembourg), art 6.

199 *Act on Euthanasia of 28 May 2002* (Belgium), s. 6.

200 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity currently has 15 members on its Council and an additional wider membership in its sub-committees.

The Panel notes that the membership proposed by the Parliamentary Committee excludes a number of providers with expertise that would be necessary to support the functions of the Board. The Panel considers that the Board should reflect broader representation from the community and professionals and should include more than one community member and multidisciplinary professional representation. Rather than specifying and hence limiting the membership, the Panel considers that an appointment process and membership comparable to a consultative council would be appropriate for the Board. As such, the Panel agrees with the Parliamentary Committee that the membership should be appointed by the Minister for Health, and further proposes that the appointments reflect the knowledge and experience that would be necessary for the work of the Board.

Ministerial Advisory Panel Recommendation 48

That the membership of the Voluntary Assisted Dying Review Board be appointed by the Minister for Health, and that the appointments reflect the appropriate knowledge and experience required for the Board to perform its functions.

Policy intent

To ensure multidisciplinary membership with knowledge and experience required for the Board to perform its functions.

Monitoring of voluntary assisted dying

The importance and value of closely monitoring activity, compliance, trends and any other system risks is accepted. Collecting information would support the Voluntary Assisted Dying Review Board in its oversight role and enable it to fulfil its functions. In addition, clear accountability obligations provide surety to health practitioners and offer transparency to the Victorian community about the operation of voluntary assisted dying. The reports required under this framework will serve to identify issues with compliance and inform priorities for improvement. Monitoring enables the system to be evaluated and reviewed and this in turn can allay concerns about the impact and scope of the new legislation.

Data reporting

The Parliamentary Committee Inquiry

The Parliamentary Committee noted that the responsibility for ensuring compliance with procedural statutory requirements, including reporting requirements, lies with the primary doctor. The written assessment of the second doctor would also form part of the official record. The Parliamentary Committee proposed that the primary doctor would submit documentation on all formal written requests, whether approved or rejected, to the proposed body, End of Life Care Victoria. For approved requests, this would occur after the patient has died. Approved requests would be reviewed by the Assisted Dying Review Board and data on approved and rejected requests would be reported publicly by End of Life Care Victoria.

Discussion

Mandatory reporting is routine in medical practice and very familiar to medical practitioners in Victoria. For example, medical practitioners have obligations to report a range of notifiable conditions under the *Public Health and Wellbeing Act 2008* and there are criminal penalties for a failure to report.²⁰¹ Likewise, mandatory reporting of cancer screening or cancer diagnosis is required under the *Improving Cancer Outcomes Act 2014*, with the reporting details and requirements set out in regulations.²⁰² The Panel is mindful of the need not to impose too onerous or complex an administrative burden, but recommends that reporting be mandated to provide clear obligations on medical practitioners operating under the framework. The Panel notes that mandatory reporting ensures adherence to procedural requirements of the framework, but also recognises that reporting supports quality assurance and the oversight role of the Board.

The Parliamentary Committee recommended that the Board review cases where only voluntary assisted dying has occurred. While this is important, the Panel is of the view that there are a range of other circumstances in which information should be gathered. It is critical to assess circumstances of requests and assessments where a person has been deemed ineligible for, or have opted not to proceed with, voluntary assisted dying. Collecting this information will assist in monitoring patterns of access, and the Panel is of the view that reporting should occur at the completion of each assessment. This would allow the Voluntary Assisted Dying Review Board to identify not only who is requesting voluntary assisted dying but also those whose requests have been refused

²⁰¹ *Public Health and Wellbeing Act 2008 (Vic)*, s. 127.

²⁰² *Improving Cancer Outcomes Act 2014 (Vic)*, ss. 8, 9.

and who may be struggling to complete the process to access voluntary assisted dying and inform system improvements.

The additional reporting requirements recommended by the Panel would also allow the Board to identify potential cases of 'doctor shopping' and medical practitioners providing inconsistent assessments. Ordinarily people may choose their own medical practitioner and may seek a second opinion if they disagree with the assessment of their medical practitioner, so the Panel is of the view that people should have similar choice in relation to voluntary assisted dying. While the eligibility criteria are clear and the Panel expects the assessments of medical practitioners will generally be consistent, there may be cases in which medical practitioners arrive at a different conclusion. The requirement that medical practitioners report on every assessment to the Voluntary Assisted Dying Review Board ensures the Board can identify any inconsistency and assess whether the medical practitioners are complying with the statutory requirements.

Where the process to access voluntary assisted dying has been completed, it will be important for the Board to receive a full report of the final certification for authorisation. This should include the person's witnessed declaration of enduring request and the form appointing a contact person. This form will ensure the procedural requirements of the framework have been adhered to and provide important information about the operation of voluntary assisted dying.²⁰³ If the lethal dose of medication is to be administered by a medical practitioner, an additional reporting requirement at this stage provides a further safeguard and an additional opportunity for the Board to ensure compliance with the statutory requirements.

Researchers have noted that reporting all cases of voluntary assisted dying is important to safeguard the quality of the process.²⁰⁴ It has been suggested that reporting is not a strong safeguard because in other jurisdictions there have been failures to report or a lack of knowledge about obligations to report.²⁰⁵ Setting out reporting requirements in the legislation together with clear guidelines will ensure there is a clear understanding of the reporting obligations for medical practitioners. In addition, the legislation should be implemented with an effective education campaign for health practitioners about their obligations.

The Panel also notes that a failure to report in accordance with the legislative requirements will be a criminal offence. There is an equivalent offence for failing to report conditions under the *Public Health and Wellbeing Act*.²⁰⁶ A medical practitioner should be required to report within seven days of completing the relevant step in the process. This will ensure the Voluntary Assisted Dying Review Board will be provided information contemporaneously and will enable the Board to identify issues promptly.

203 It has been noted that ensuring compliance with procedural safeguards is an important safeguard in and of itself. See External Panel on Options for Legislative Response to *Carter v. Canada* (2015), *Consultations on physician-assisted dying: summary of results and key findings: final report*, Government of Canada, Ontario, p. 103, viewed 1 May 2017, <<http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html>>.

204 See, for example, Smets, T et al (2010), 'Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases', *British Medical Journal*, doi: 10.1136/bmj.c5174.

205 Mulino, D (2016), 'Minority Reports' in Legislative Council Legal and Social Issues Committee, *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, viewed 30 May 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

206 *Public Health and Wellbeing Act 2008* (Vic), s 127.

There are numerous points in which a failure to report may be identified. The coordinating medical practitioner must submit all the documentation. The consulting medical practitioner is also required to lodge their independent assessment to the review board as well as submit it to the coordinating medical practitioner. The pharmacist who dispenses the lethal dose of medication must also provide an independent report. These reporting points will provide the Board with the ability to continuously monitor and identify any apparent failures to report, which trigger a compliance check. The dispensing pharmacist will also be able to identify and report if there is an attempt to obtain a lethal dose of medication without the required permit.

In making these recommendations about mandatory reporting the Panel also acknowledges the strong support from stakeholders for monitoring and reporting and the need to clearly define the points in the process where reporting should occur.

The Panel is of the view that it is critical to delivering person-centred care to assess when people have requested access and been assessed for voluntary assisted dying. In this way, information can be captured about when people have been refused access to voluntary assisted dying or when they have withdrawn from the process. The Panel notes that mandatory reporting ensures adherence to procedural requirements of the framework as proposed by the Parliamentary Committee, but also recognises that reporting supports quality assurance and the oversight role of the Board.

As already noted as consistent with existing practice, a medical practitioner would notify a death to the Registrar of Births Deaths and Marriages. Where this death pertains to voluntary assisted dying it is intended that this information would be shared with the Board (Recommendations 43 and 44).

Ministerial Advisory Panel Recommendation 49

That there is mandatory reporting by medical practitioners to the Voluntary Assisted Dying Review Board within seven days of:

- **completing the first assessment (regardless of the outcome);**
- **completing the second independent assessment (regardless of the outcome);**
- **completing the certification for authorisation (which will incorporate the written declaration of enduring request and appointment of contact person forms); and**
- **when the lethal dose of medication is administered by a medical practitioner.**

Policy intent

To ensure adherence to procedural requirements of the framework and support quality assurance and the oversight role of the Board.

Medication reporting

The Parliamentary Committee Inquiry

The Parliamentary Committee did not comment on reporting on the lethal dose of medication. The Parliamentary Committee suggested that a proposed Implementation Taskforce investigate and recommend:

- guidelines for pharmacies and pharmacists in storing, transporting, and filling prescriptions involving drugs for voluntary assisted dying; and
- an accountability system for tracking voluntary assisted dying medication that has been prescribed to patients.

Discussion

The Panel recognises there are significant concerns about the safe handling of the lethal medication dispensed for self-administration and its retrieval if not used.

In Washington the legislation states that ‘any medication dispensed...that was not self-administered shall be disposed of by lawful means’.²⁰⁷ Whereas Vermont sets out that the Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed.²⁰⁸ In California the legislation specifies that a person who has custody or control of any unused medication arrange for its return or disposal.²⁰⁹ Colorado has a similar provision.²¹⁰

The consultation process affirmed the view that imposing undue administrative burden should be avoided. All stakeholders in the consultation forums dismissed the Californian requirement that a person complete a form within 48 hours prior to self-administering the lethal dose of medication. The Panel acknowledges that it is important not to unduly intrude into the life of a person who is dying. Concerns about monitoring the medication cannot result in requirements that inadvertently pressure people to administer the lethal dose of medication.

To support appropriate community safety the Panel considered that monitoring the prescription, dispensing and return of the lethal medication would be a practical safeguard. Oregon similarly requires the prescription and dispensing record to be submitted to the Health Authority.²¹¹ Collection of this information will assist in tracking the lethal medication and its use and as such the Panel recommends that there be a mandatory reporting requirement. Separate reporting by the Department of Health and Human Services when the prescription is authorised, and by the pharmacist when the prescription is dispensed, provides a strong safeguard. The Panel notes that a dose of medication intended to cause death could not be prescribed for any other purpose and so it will be immediately clear to a pharmacist what the prescription is for.

²⁰⁷ *Death with Dignity Act* (Washington), s. 14.

²⁰⁸ *Patient Choice At End Of Life Act* (Vermont), s. 5291.

²⁰⁹ “Shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.” See *End of Life Option Act* (California), s. 443.20.

²¹⁰ *End-of-life Options Act* (Colorado), s. 25-48-120.

²¹¹ *Death with Dignity Act* (Oregon), s. 127.865.

Furthermore, if the medication is unused it is expected that the contact person will arrange for its safe return to the dispensing pharmacist (refer also Recommendation 29). Additional reporting by the pharmacist at this point will further support the monitoring and oversight role of the Board.

Ministerial Advisory Panel Recommendation 50

That, in order to monitor the lethal dose of medication, there is mandatory reporting within seven days to the Voluntary Assisted Dying Review Board:

- **by the Department of Health and Human Services when the prescription is authorised;**
- **by the pharmacist when the prescription is dispensed; and**
- **by the pharmacist when unused lethal medication is returned by the contact person.**

Policy intent

To ensure monitoring of the lethal dose of medication and clearly set out mandatory reporting requirements for the authorisation, dispensing and return of medication.

Scheduled forms

The Parliamentary Committee Inquiry

The Parliamentary Committee did not comment on the inclusion of forms in legislation but proposed that the Implementation Taskforce would recommend the procedures for recording data on voluntary assisted dying requests, whether granted or not.

Discussion

Both the Oregon and Washington legislation set out the request for medication form and these forms are completed by the person making the request.²¹² Similarly, California sets out in legislation the form of a request for medication, but also includes three scheduled forms: attending physician checklist and compliance form, a consulting physician compliance form, and an attending physician follow-up form.²¹³ These forms may be updated by the Californian medical board.²¹⁴

Belgium and Luxembourg adopt a less prescriptive approach, instead setting out the types of information that must be completed by the medical practitioner for submission to their Commission.²¹⁵ The information includes the person's details, the nature of their condition and suffering, an assurance the request was voluntary, and the qualifications of and procedures used by the medical practitioner. Canadian legislation requires that

²¹² *Death with Dignity Act* (Oregon), s. 27.897; *Death with Dignity Act* (Washington), s. 22.

²¹³ *End of Life Option Act* (California), ss. 443.11, 443.22(b).

²¹⁴ *End of Life Option Act* (California), s. 443.22(a).

²¹⁵ *Act on Euthanasia of 28 May 2002* (Belgium), s. 7; *Law of 16 March 2009 on euthanasia and assisted suicide* (Luxembourg), art 7.

the Minister of Health make regulations that detail the information to be provided at various stages as well as the form, manner and timing of the provision of information.²¹⁶ In the Netherlands the forms of the notification and the report are laid down by order in council.²¹⁷

The Panel considers that setting out in legislation the information that will be collected provides transparency and clarity about the intended operation of the legislative framework. The Panel recommends that the forms be included in the legislation. This will ensure clarity and transparency when the legislation is debated by Parliament. Setting out the compliance requirements in forms included in the legislation will also ensure that these forms are not altered unless Parliament considers and passes an amendment to the legislation. The Panel also notes that once the Board is established, it may identify further information that will help improve quality and safety and the Board will be able to require this. The Board should also be able to request information from participating health practitioners in order to fulfil its functions.

Ministerial Advisory Panel Recommendation 51

That reporting forms are set out in the legislation to provide certainty and transparency about the information that is collected. That these forms include a:

- **first assessment report (which includes record of first request);**
- **second assessment report;**
- **written declaration of enduring request;**
- **appointment of contact person;**
- **certification for authorisation;**
- **dispensing pharmacist report;**
- **administration by medical practitioner report; and**
- **return of medication notification.**

Policy intent

The Panel is of the view that setting out the information that will be collected provides certainty and transparency about the intended operation of the voluntary assisted dying framework.

²¹⁶ *Medical Assistance in Dying Act* (Canada), s. 241.31 (3)

²¹⁷ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 9 (amendment to the *Burial and Cremation Act*).

Annual reporting and review of the framework

The Parliamentary Committee Inquiry

The Parliamentary Committee proposed that the Board report to Parliament on the operation of the voluntary assisted dying framework, including any trends it identifies and recommendations for improvement. For the purposes of increased transparency and accountability during the initial operation of the voluntary assisted dying framework, the Board would report every six months in the first two years of the framework's operation, and thereafter annually.

The Parliamentary Committee recommended that a select committee of Parliament comprising members of the Legislative Council and the Legislative Assembly be established to review any Act regulating voluntary assisted dying. The review should occur five years after the legislation commences operation.

Discussion

The Oregon Health Authority publishes an annual statistical report of activity under their legislation, as does the California Department of Health, the Colorado Department of Public Health and Environment and the Washington State Department of Health.²¹⁸ Similarly, Vermont has a biennial statistical report published by its Department of Health.²¹⁹ The Canadian legislation includes a provision for a review of the Act after five years but does not prescribe annual reporting.²²⁰ The Dutch Regional Committees provide a joint annual report on their operations.²²¹ Belgium and Luxembourg report every two years.²²²

There was strong support expressed by stakeholders for regular reporting on the implementation of voluntary assisted dying to the Victorian Parliament to ensure accountability. The Panel recognises that regular reporting provides reassurance and transparency about the operation of the legislative framework and supports the Parliamentary Committee's recommendation that this occurs every six months in the first two years and thereafter annually. The Panel concurs that the report should present data on the operation of the legislative framework, and identify trends and recommendations for improvement. Based on levels of access in existing jurisdictions, the Panel envisages that the number of people who access voluntary assisted dying in Victoria may be quite small, particularly in the early stages.²²³ If de-identified data

218 *Death with Dignity Act* (Oregon), s. 127.865; *End of Life Option Act* (California), s. 443.19(b); *End-of-life Options Act* (Colorado), s. 25-48-111(2)(a); *Death with Dignity Act* (Washington), s. 15 (3).

219 *Patient Choice At End Of Life Act* (Vermont), s. 5293(b).

220 *Medical Assistance in Dying Act* (Canada), s. 10.

221 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), art 17.

222 *Act on Euthanasia of 28 May 2002* (Belgium), s. 9; *Law of 16 March 2009 on euthanasia and assisted suicide* (Luxembourg), art 9.

223 This is also the view of the Parliamentary Committee. See Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, pp. xxviii, 8, 212, 213, 235, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsc/inquiry/402>>.

cannot be statistically reported due to low numbers, a narrative report may be more appropriate.²²⁴ These public reports will provide a clear and transparent picture of how the legislation is working, help to understand the impact of the legislation, and build public trust.

The Panel also acknowledges that this is a new legislative framework that governs a sensitive issue, and therefore, in addition to regular monitoring through annual reports, also recommends the evaluation of the operation of the legislation. There are provisions for a five-year review of the appropriateness and the effectiveness of an Act in other Victorian legislation.²²⁵ The consultation process identified strong support for the evaluation of the implementation of voluntary assisted dying, and stakeholders were of the view that the suggested review process combining annual reporting and a five-year review was appropriate for a new framework.

The Panel recognises that a five-year review of the legislation would provide reassurance to stakeholders that the operation of the legislation will be subject to public scrutiny. As such, the Panel proposes that the five-year review includes an evaluation of:

- the effectiveness of the legislation in allowing appropriate access for those people it intended to provide for;
- the effectiveness of the legislation in providing for the safeguards and protections for individuals and the community generally;
- the effectiveness of the implementation of voluntary assisted dying from a clinical, patient and family perspective;
- the effectiveness of the Voluntary Assisted Dying Review Board in monitoring, reporting and promoting improvements; and
- a review of the costs of voluntary assisted dying to the sector and parts of the community.

The Panel supports the Parliamentary Committee's recommendation that the Board report every six months during the first two years of operation, and thereafter annually. There is a possibility that the number of people accessing the framework will be too small to allow de-identified data to be statistically reported six monthly in the first two years. If this is the case, the Panel recommends that the Board provides a narrative report on the general issues and patterns identified. The Panel also proposes that the requirement to review the legislation be included in the voluntary assisted dying legislation to ensure that this is undertaken.

224 For example, Health Canada in its interim report on MAiD chose not to include this data in its report. See Government of Canada (31 May 2017), Interim update on medical assistance in dying in Canada June 17 to December 31, 2016, viewed 6 June 2017, <<https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html>>.

225 See, for example, *Severe Substance Dependence Treatment Act 2010* (Vic), s. 41.

Ministerial Advisory Panel Recommendation 52

That the Voluntary Assisted Dying Review Board report to Parliament: every six months in the first two years after commencement, and thereafter annually.

Policy intent

To ensure transparency and accountability of voluntary assisted dying.

To promote community confidence in the monitoring process.

Ministerial Advisory Panel Recommendation 53

That the voluntary assisted dying legislation be subject to review five years after commencement.

Policy intent

The Panel supports the recommended review of the legislation after five years of operation to ensure it is evaluated.

Protections and offences

The Panel is cognisant of the concern that exists in the community in relation to the establishment of a new legislative framework. It is of paramount importance to establish clear protections and offences in the legislation. For those who choose to participate, these parameters offer certainty about the scope of the law within which they must operate. For the broader public these well-defined constraints provide reassurance about the limited scope of voluntary assisted dying. This section of the report addresses acting within professional standards and then sets out the establishment of new criminal offences in the legislation. The Panel also recognises that the vast majority of Victorian health practitioners, as well as the community, can be relied upon to act lawfully.

Protection from liability

The Parliamentary Committee Inquiry

The Parliamentary Committee commented that the proposed voluntary assisted dying framework would conflict with current aspects of Victoria's common law and criminal statute, particularly in the *Crimes Act 1958*. In order to accommodate the voluntary assisted dying framework the Parliamentary Committee stated it would be necessary to include an exemption to certain offences. The Parliamentary Committee recommended that voluntary assisted dying legislation include consequential amendments to existing legislation to ensure no health practitioner would be criminally liable for participating in voluntary assisted dying in accordance with the legislation.

Discussion

The Panel recognises the importance of protecting health practitioners who participate in voluntary assisted dying in good faith and without negligence from civil and criminal liability. In other jurisdictions that provide for voluntary assisted dying, the legislation includes a specific provision to protect health practitioners who are acting lawfully within the constraints of the framework. Oregon sets out that 'no person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance'.²²⁶ This immunity is similarly reflected in California, Colorado, Vermont and Washington.²²⁷ The Canadian legislation sets out a series of amendments to its criminal code to ensure exemptions for those acting in accordance with their medical assistance in dying law.²²⁸

The *Crimes Act* sets out that any person who aids or abets any other person in the commission of suicide or in an attempt to commit suicide is guilty of an indictable offence.²²⁹ Currently, there are also a range of common law offences, such as homicide, of which a medical practitioner may be guilty if they assist their patient to die. The Panel defers to the judgement of the legislators as to what is required to achieve protection for health practitioners and notes that this is of prime importance to provide surety for health practitioners to operate confidently in accordance with the framework.

²²⁶ *Death with Dignity Act* (Oregon), s. 127.885(1).

²²⁷ *End Of Life Option Act* (California), s. 443.14; *End-of-life Options Act* (Colorado), s. 25-48-116; *Patient Choice At End Of Life Act* (Vermont), s. 5283; *Death with Dignity Act* (Washington), s. 19(1)(a).

²²⁸ *Medical Assistance in Dying Act* (Canada), s. 227(1) amending *Criminal Code* (Canada), s. 14.

²²⁹ *Crimes Act 1958* (Vic), s. 6B(2).

The Panel also recommends that, like protections from liability in other legislation, if a health practitioner acts reasonably, without negligence and in good faith in a manner they believe is in accordance with the legislation, they should not face criminal or civil liability.²³⁰

Ministerial Advisory Panel Recommendation 54

That the legislation provides clear protection for health practitioners who act in good faith and without negligence to facilitate access to voluntary assisted dying under the legislation.

Policy intent

The Panel considers it important that health practitioners who facilitate access to voluntary assisted dying in accordance with the strict terms of the legislative framework are protected from criminal or civil liability. The legislation needs to provide clear protection that where a health practitioner who, in good faith and without negligence, participates in voluntary assisted dying under the legislation and believes on reasonable grounds that they have complied with the legislation, should not face criminal, civil or professional liability. While the Parliamentary Committee specifically suggested amending the Crimes Act, the Panel defers to the judgement of the legislators as to what is required to achieve this protection.

Professional standards

The Parliamentary Committee Inquiry

The Parliamentary Committee suggested that the Board review the doctor's compliance with procedural requirements of the framework, and that in the case of breaches, the Board should forward its report to the appropriate authority, which may be the Australian Health Practitioner Regulation Agency.

Discussion

The Panel agrees with the Parliamentary Committee that the proposed Voluntary Assisted Dying Review Board review the compliance of medical practitioners with procedural requirements, noting that this is not intended to be a punitive approach to correctly ticking boxes, but quality assurance oversight. For substantive concerns that relate to practising outside the legislative framework, as noted by the Parliamentary Committee, there are existing authorities and mechanisms for investigating and addressing wrong-doing.

²³⁰ *Medical Treatment Planning and Decisions Act 2016 (Vic)*, s. 52.

During the consultation process there was some discussion about who should respond if a health practitioner or member of the public had concerns about a medical practitioner or another health practitioner acting outside of the legislative framework. The Australian Health Practitioner Regulation Agency promotes public safety by ensuring only those health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. The Agency has the power to receive and investigate complaints, restrict or remove the right to practice, and refer matters to the relevant medical or other health practitioner boards under the National Health Practitioner Regulation Law ('the National Law').

In addition, the National Law provides for the notification of conduct by a health practitioner that does not meet reasonably expected standards. There is a provision for mandatory notification by another health practitioner as well as a provision for voluntary notification by a member of the public or entity.²³¹ The Panel is of the view that this approach should be reflected in the legislation to further highlight that any departures from accepted professional standards will not be tolerated under the voluntary assisted dying legislation.

The Panel agrees with the Parliamentary Committee that the role of the Board should not be to act as a professional disciplinary body or provide clinical oversight, because other bodies and professional organisations already undertake this role. In order to respond to the community concern that a health practitioner may act outside the legal framework, the Panel believes that notification to the Australian Health Practitioner Regulation Agency should be clearly provided for in the legislation. The Agency and the relevant Board will then be responsible for taking appropriate action to determine whether a health practitioner has acted appropriately and, if not, to determine an appropriate sanction.

Ministerial Advisory Panel Recommendation 55

That a health practitioner must notify the Australian Health Practitioner Regulation Agency if they believe that another health practitioner is acting outside the legislative framework.

Ministerial Advisory Panel Recommendation 56

That any other person may notify the Australian Health Practitioner Regulation Agency if they believe that a health practitioner is acting outside the legislative framework.

Policy intent

That there is a clear avenue for referring concerns about health practitioners who act outside the legislative framework.

²³¹ *Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic)*, ss. 141, 145.

Criminal offences

The Parliamentary Committee Inquiry

The Parliamentary Committee did not recommend any new offences to safeguard their recommended voluntary assisted dying framework.

Discussion

The Panel notes that there are a range of existing criminal offences that will protect people under a voluntary assisted dying framework. For example, the crimes of murder and aiding and abetting suicide will continue to apply to those who act outside of the framework provided for in the legislation. In addition, it is already a criminal offence to possess prescription medication without authorisation. The Panel also notes that if the Voluntary Assisted Dying Review Board or the Australian Health Practitioner Regulation Agency became aware of potential criminal conduct, they would be required to refer the matter to Victoria Police for investigation.

As voluntary assisted dying will introduce new instruments and new roles and responsibilities, the Panel supports the creation of new criminal offences to ensure people are protected. Offences have been created in other jurisdictions with the introduction of voluntary assisted dying legislation. Most of the North American jurisdictions criminalise the alteration or forgery of a request for voluntary assisted dying, or concealing or destroying a withdrawal of a request.²³² These jurisdictions also set out a clear offence for a person who coerces or exerts undue influence on a person to request or self-administer the medication.²³³ The Panel proposes that the Victorian legislation reflect the clear protections that are provided in the US jurisdictions that ensure a person who requests voluntary assisted dying has not been coerced nor had their request interfered with.

The Panel recommends that the legislation create the offence of falsifying records related to voluntary assisted dying. This will also ensure accurate records are available for the Voluntary Assisted Dying Review Board to monitor the operation of the framework. The Panel also recommends that the legislation creates a new offence of inducing a person, through dishonesty or undue influence, to request voluntary assisted dying or to self-administer the lethal dose of medication. While there are a very limited number of prosecutions for these offences in other jurisdictions, the importance of the deterrent effect of these clear offences should not be downplayed.

²³² See, for example, *End of Life Option Act* (California), s. 443.17(a); *End-of-life Options Act* (Colorado), s. 25-48-119(1)(a); *Death with Dignity Act* (Oregon), s. 127.890(1); *Death with Dignity Act* (Washington), s. 20(1); *Medical Assistance in Dying Act* (Canada), s. 241.4.

²³³ See, for example, *End of Life Option Act* (California), s. 443.17(b); *End-of-life Options Act* (Colorado), s. 25-48-119(2); *Death with Dignity Act* (Oregon), s. 127.890(2); *Death with Dignity Act* (Washington), s. 20(2).

It should also be clear that it would be an offence to administer the lethal dose of medication to a person who does not have decision-making capacity. This will protect people who may complete the process and obtain the medication but may subsequently lose decision-making capacity. The lethal dose of medication should only ever be self-administered or administered by the coordinating medical practitioner on request. If a person does not have decision-making capacity, no other person may administer the lethal dose. Just because a person has the lethal dose of medication in their possession, it is not acceptable for a family member or a friend to make the final decision to end the person's life. The Panel notes that there has been concern expressed by some in the community about the possibility that people may be vulnerable to elder abuse at the end of life and has accordingly established a series of safeguards throughout the process.

The new criminal offences in the legislation and existing criminal offences will provide a strong deterrent and ensure there are harsh penalties for anyone who intentionally attempts to act outside the scope of the legislation.

Ministerial Advisory Panel Recommendation 57

That there be offences for:

- **inducing a person, through dishonesty or undue influence, to request voluntary assisted dying;**
- **inducing a person, through dishonesty or undue influence, to self-administer the lethal dose of medication;**
- **falsifying records related to voluntary assisted dying; and**
- **administering a lethal dose of medication to a person who does not have decision-making capacity.**

Policy intent

The Panel is of the view that offences related specifically to voluntary assisted dying should be set out to ensure people are protected and that there are clear penalties for anyone who intentionally attempts to act outside the scope of the legislation. The creation of a new legal framework requires specific offences that clearly relate to the activity being governed by the legislation.

Safeguard summary

A summary of the legislative safeguards included in this framework is provided below. Appendix 3 also provides an overview that compares these safeguards with other jurisdictions that have created a voluntary assisted dying framework through an act of parliament. The Panel has considered in detail the existing legislative frameworks that support voluntary assisted dying in other jurisdictions to more fully inform its deliberations and recommendations.

Safeguards proposed for Victoria’s voluntary assisted dying framework

Access

1. Voluntary	✓
2. Limited to 18 years and over	✓
3. Residency requirement [Victorian resident and Australian citizen or permanent resident]	✓
4. Limited to those with decision-making capacity	✓
5. Must be diagnosed with condition that meets restrictive set of criteria [advanced, progressive and will cause death]	✓
6. End of life is clearly defined [death expected within weeks or months, not more than 12 months]	✓
7. End of life condition combined with requirement for suffering	✓
8. All of the eligibility criteria must be met	✓
9. Mental illness alone does not satisfy the eligibility criteria	✓
10. Disability alone does not satisfy the eligibility criteria	✓

Request

11. Must be initiated by the person themselves	✓
12. No substitute decision makers allowed	✓
13. Cannot be included as part of an advance directive	✓
14. Health practitioner prohibited from raising voluntary assisted dying	✓
15. Person must make three separate requests	✓
16. Must have written request [witnessed in the presence of a medical practitioner]	✓
17. Two independent witnesses to request [exclusions for family members, beneficiaries, paid providers]	✓
18. Specified time must elapse between requests [first and third requests must be at least 10 days apart with exception when death imminent]	✓
19. Additional time required to elapse between steps of completing process [second assessment and third request must be at least one day apart]	✓
20. Must use independent accredited interpreter [if an interpreter is required]	✓
21. No obligation to proceed, may withdraw at any time	✓

Assessment

22. Eligibility and voluntariness assessed by medical practitioners	✓
23. Must be two separate and independent assessments by medical practitioners	✓
24. Assessing medical practitioners must have high level of training/experience	✓
25. Assessing medical practitioners must have undertaken prescribed training [to identify capacity and abuse issues]	✓
26. Requirement to properly inform person of diagnosis, prognosis and treatment options, Wpalliative care etc [by both assessing medical practitioners]	✓
27. Referral for further independent assessment if there is doubt about decision-making capacity	✓
28. Coordinating medical practitioner must confirm in writing that they are satisfied that all of the requirements have been met	✓

Medication management

29. Person required to appoint contact person who will return medication if unused	✓
30. Medical practitioner must obtain a permit to prescribe the medication to the person	✓
31. Medication must be labelled for use, safe handling, storage and disposal	✓
32. Pharmacist also required to inform the person about administration and obligations	✓
33. Medication must be stored in a locked box	✓

Administration

34. Medication must be self-administered [except in exceptional circumstances]	✓
35. If physical incapacity medical practitioner may administer	✓
36. Additional certification required if administered by medical practitioner	✓
37. Witness present if medical practitioner administers	✓

Practitioner protections

38. Health practitioner may conscientiously object to participating	✓
39. Explicit protection for health practitioners who are present at time of person self-administering	✓
40. Explicit protection for health practitioners acting in good faith without negligence within the legislation	✓
41. Mandatory notification by any health practitioner if another health practitioner acting outside legislation	✓
42. Voluntary notification by a member of the public of a health practitioner acting outside legislation	✓

Mandatory reporting

43. Reporting forms set out in legislation	✓
44. Reporting mandated at a range of points and from a range of participants to support accuracy	✓
45. First assessment reported [to Board]	✓

Mandatory reporting (cont.)

46. Second assessment reported [to Board]	✓
47. Final certification for authorisation reported [to Board, incorporates written declaration and contact person nomination]	✓
48. Additional form reported [to Board] if medication administered by medical practitioner	✓
49. Prescription authorisation reported by DHHS [to Board]	✓
50. Dispensing of medication reported [to Board]	✓
51. Return of unused medication to pharmacist reported [to Board]	✓
52. Death notification data reported [to BDM and collected by Board]	✓

Offences

53. New offence to induce a person, through dishonesty or undue influence, to request voluntary assisted dying	✓
54. New offence to induce a person, through dishonesty or undue influence, to self-administer the lethal dose of medication	✓
55. New offence to falsify records related to voluntary assisted dying	✓
56. New offence of failing to report on voluntary assisted dying	✓
57. Existing criminal offences for the crimes of murder and aiding and abetting suicide continue to apply to those who act outside the legislation	✓

Oversight

58. Guiding principles included in legislation	✓
59. Board is an independent statutory body	✓
60. Board functions described in legislation	✓
61. Board reviews compliance	✓
62. Board reviews all cases of [and each attempt to access] voluntary assisted dying	✓
63. Board has referral powers for breaches	✓
64. Board also has quality assurance and improvement functions	✓
65. Board has expanded multidisciplinary membership	✓
66. Board reports to publicly [to Parliament every six months for first two years, thereafter annually]	✓
67. Five year review of the legislation	✓
68. Guidelines to be developed for supporting implementation	✓



Part D: Implementation

Throughout its deliberations the Panel has been cognisant of the potential implications for the implementation of voluntary assisted dying legislation. Key issues need to be considered in the early stages of implementation planning if Parliament passes voluntary assisted dying legislation. In this Part the Panel highlights some of the key issues raised during the consultation process to support effective implementation of the legislation.

Voluntary assisted dying in the context of existing care options

The Parliamentary Committee Inquiry

As part of its recommendation for a voluntary assisted dying framework for Victoria, the Parliamentary Committee concluded that voluntary assisted dying should be incorporated into existing end-of-life care processes in order to protect and support patients and ensure sound medical practice. The Parliamentary Committee notes that ensuring high standards of patient care requires health practitioners and regulatory authorities to work together in implementing a voluntary assisted dying framework.

Discussion

Voluntary assisted dying is relatively rare in all jurisdictions where it is legal, and these jurisdictions generally embed voluntary assisted dying in existing end-of-life care. Over the past 20 years there have been 1,127 instances of voluntary assisted dying in Oregon, which represents 0.37 per cent of all deaths.²³⁴ The experience of the Seattle Cancer Care Alliance in Washington and the UHN in Toronto, Canada, also reflect the infrequent nature of voluntary assisted dying. The UHN consists of four tertiary hospitals that collectively provide care to nearly 40,000 inpatients and 1.1 million ambulatory care visits per year.²³⁵ From 8 March 2016 to 8 March 2017 there were 74 voluntary assisted dying enquires to UHN.²³⁶ In Seattle the experience of the Cancer Care Alliance has been similarly infrequent, with 114 patients enquiring about voluntary assisted dying between 5 March 2009 and 31 December 2011.²³⁷ The Seattle Cancer Care Alliance treats more than 7,000 patients per year.²³⁸ The infrequent nature of voluntary assisted dying also seems to be reflected in the percentage of requests for voluntary assisted dying in Australia, with less than one per cent of people with advanced illness referred to hospital palliative care services expressing an enduring desire for voluntary assisted dying.²³⁹

Given the likely small number of cases of voluntary assisted dying, the Panel considered the feedback from the consultation process that voluntary assisted dying assessments and administration should be conducted by an independent or separate 'panel'. This approach was sometimes raised as a way to address access issues for independent medical assessments in rural areas. It was also suggested as an approach to providing voluntary assisted dying by those organisations who expressed opposition to participating and suggested an entirely separate service, based on Dignitas in Switzerland.

234 Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), Oregon Death with Dignity Act: data summary 2016, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

235 Li, M et al (2017), 'Medical assistance in dying: implementing a hospital-based program in Canada', *New England Journal of Medicine*, vol. 376, no. 21, pp. 2082–2088.

236 Ibid.

237 Loggers, E et al (2013), 'Implementing a death with dignity program at a comprehensive cancer center', *New England Journal of Medicine*, vol. 368, no. 15, pp. 1417–1424.

238 Seattle Cancer Centre Alliance (2016), *2015 annual report*, Fred Hutch, Seattle Children's Hospital, UW Medicine, viewed 13 June 2017, <<https://www.seattlecca.org/about/annual-reports>>.

239 Hudson, P et al (2015), 'Legalizing physician-assisted suicide and/or euthanasia: pragmatic implications', *Palliative & Supportive Care*, vol. 13, no. 5, pp. 1399–1409.

The Panel considered these proposals, noting that organisations opposed to voluntary assisted dying will not be compelled to participate. The Panel supports the view of the Parliamentary Committee that voluntary assisted dying should be incorporated into existing care processes to protect and support patients and therapeutic relationships and to ensure sound medical practice. Voluntary assisted dying must be provided within the context of existing care in order to ensure continuity of care across a range of treatment options based on clinical needs and care goals. Creating a separate service for people wanting to access voluntary assisted dying would risk limiting access to other treatment options, such as palliative care and potentially inhibit continuity of care.

The Panel has concluded that establishing independent or separate panels to provide voluntary assisted dying create unacceptable risks including the possibility of fracturing existing therapeutic relationships and concentrating skill and expertise among a few medical practitioners. This would negatively impact on the patient's experience. The Panel rejects this approach.

The Parliamentary Committee also proposed that trained case support workers are provided for all patients whose voluntary assisted dying requests are approved, in addition to existing support in the medical system.²⁴⁰ The Panel is concerned that introducing a new position specifically for those whose request for voluntary assisted dying has been approved has the potential to create a two-tiered system driven by an approval process rather than a clinical assessment taking into account a person's overall care needs and available supports. Some people may need additional supports at the end of life, but the Panel suggests that this should be based on clinical need, and not as a routine practice, following the approval of a request for voluntary assisted dying. The suggested new position also introduces another worker into the life of a person at a time when existing personal and professional relationships become more important for support. The role of the coordinating medical practitioner, as set out by the Panel, mitigates the need for additional case support workers.

The Panel recommends that voluntary assisted dying implementation be considered in the context of existing care options available to people at the end of life. This will support existing therapeutic relationships, and allow voluntary assisted dying to be reviewed as part of overall safety and quality monitoring and review processes.

Ministerial Advisory Panel Recommendation 58

That the implementation of voluntary assisted dying should occur within the context of existing care available to people at the end of life, and ensure voluntary assisted dying activity is embedded into existing safety and quality processes.

Policy intent

To supporting therapeutic relationships, ensure safe and high-quality voluntary assisted dying activity, and provide an opportunity to build on existing professional support programs.

240 Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 218, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lsic/inquiry/402>>.

Implementation planning and governance

The Parliamentary Committee Inquiry

In its report the Parliamentary Committee identified four key components for a voluntary assisted dying framework: the core elements (the activity being undertaken); legislative safeguards; additional guidance for health practitioners and services; and oversight, review and reporting mechanisms, including education. It is the last two components that have greatest relevance for this Part in considering implementation planning if Parliament passes a voluntary assisted dying legislation.

In its implementation considerations, the Parliamentary Committee also recommended the establishment of:

- a Voluntary Assisted Dying Review Board to provide oversight, review and reporting;
- End of Life Care Victoria to provide policy and strategic direction on all end-of-life care issues and provide information and education on all aspects of end-of-life care including palliative care, advance care planning and voluntary assisted dying;
- an end-of-life care chairperson, to be based at a Victorian university; and
- an Implementation Taskforce to oversee the implementation of voluntary assisted dying delivery for Victoria, with a focus on investigating and advising on the clinical and practical implementation issues.

The issues relating to the establishment, functions and membership of the Voluntary Assisted Dying Review Board are discussed in Part C.

The Parliamentary Committee set out the role of the Implementation Taskforce in investigating and recommending the clinical and practical guidelines necessary for implementing voluntary assisted dying. The Parliamentary Committee also gives the Implementation Taskforce a number of responsibilities including: developing data recording procedures; guidelines for medical practitioners and pharmacists; accountability systems for monitoring the medication; and establishing a range of procedures.

Discussion

The Panel recognises that establishing an Implementation Taskforce is essential in order to provide the expertise, focus and leadership to develop the necessary resources, processes and systems over the period leading up to the commencement of any voluntary assisted dying legislation.

The Parliamentary Committee also set out in its report a structure for voluntary assisted dying oversight that includes proposed functions for the Voluntary Assisted Dying Review Board and End of Life Care Victoria. The Panel is of the view that the types of functions proposed for these new entities need to be more clearly defined and allocated. Further consideration should take into account the functions of existing entities such as the Department of Health and Human Services and Safer Care Victoria, which was established on 1 January 2017 to improve health system safety and quality.



The Panel recommends that the Implementation Taskforce play a pivotal role in focusing and coordinating the work that will need to be completed to prepare for any new legislation. This should include reviewing the functions proposed in the Parliamentary Committee's report for the new agencies to clarify roles and responsibilities in relation to the agencies that currently exist. In particular, the Implementation Taskforce should undertake a gap analysis of the existing entities and functions against the functions proposed for End of Life Care Victoria to identify what role such a new agency could effectively play in end-of-life care taking into account the following issues:

- the existing arrangements for end of life, palliative care and advance care planning information and how information about voluntary assisted dying would be incorporated into these arrangements;
- the interaction between the existing policy and planning functions of the Department of Health and Human Services and the policy direction set out in *Victoria's End of life and palliative care framework*;
- the existing functions of Safer Care Victoria in quality assurance and improvement and the incorporation of voluntary assisted dying activity and reporting; and
- the possible overlap and confusion about the functions of the proposed End of life Care Victoria and the Voluntary Assisted Dying Review Board, particularly the role played by each in data reporting, research and analysis.

The Panel is of the view that the Department of Health and Human Services should establish and provide the necessary support to the Implementation Taskforce in order to ensure it has the resources required to undertake its work in the period leading up to the commencement of any legislation. The Implementation Taskforce must engage with key stakeholders over the planning period to develop effective implementation strategies and resources. These strategies and resources should be evidence-based.

Early planning and development of associated resources and training for the implementation of voluntary assisted dying will give health practitioners and services a period in which to build capabilities, models of care and organisational responses. This can be supported by the promulgation of evidence-based resources and guidelines that will build a safe and compassionate voluntary assisted dying service system. This includes developing the specified training course as outlined in Recommendation 16, as well as clinical guidelines for medical practitioners and dispensing pharmacists, which should be done in consultation with the Voluntary Assisted Dying Review Board.

Ministerial Advisory Panel Recommendation 59

That work to establish the Voluntary Assisted Dying Review Board begin at least 12 months before the commencement of the legislation and is supported to develop a clear work plan to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engaging and sharing information with other partners (such as the Department of Health and Human Services, Safer Care Victoria, and services and providers) for quality improvement purposes.

Ministerial Advisory Panel Recommendation 60

That the Department of Health and Human Services establish and support an Implementation Taskforce to investigate and advise on the development of voluntary assisted dying. The Implementation Taskforce should have the coordinating role in overseeing and facilitating these work set out in the implementation recommendations.

Ministerial Advisory Panel Recommendation 61

That the functions proposed by the Parliamentary Committee for End of Life Care Victoria be subject to a gap analysis in relation to existing entities and their functions to determine a clear role for the proposed agency.

Policy intent

To provide targeted focus, leadership and accountability for developing the necessary resources for implementing voluntary assisted dying.

Implementation support

The Parliamentary Committee Inquiry

The Parliamentary Committee recommended that practical, clinical and medical guidelines be developed separately to legislation, or in subordinate legislation, with the aim of ensuring best practice among health practitioners providing voluntary assisted dying. It was recommended these be developed in consultation with regulatory authorities, medical experts and professional bodies.

Discussion

Many stakeholders raised and discussed a range of practical implementation considerations during the Panel's consultation process.



Regardless of how people felt about their own participation in voluntary assisted dying, there was almost universal agreement that stakeholders should be consulted about, and involved in, the practical planning for its implementation. This included engagement with health practitioners and professional bodies, health services executive management, patients, carers, and the community.

Supporting health practitioners

The Panel is of the view that, wherever possible, voluntary assisted dying should be accommodated in existing therapeutic relationships. This will not only support safe and quality practices, but will also provide appropriate professional support for health practitioners.

The Panel advocates that support for health practitioners, whether they choose to participate in voluntary assisted dying or conscientiously object to participating, should be developed within existing professional support structures. Working with existing health practitioner support services such as doctor health advisory services and nursing support services will facilitate integrated and evidence-based support for health practitioners who choose to participate in voluntary assisted dying as part of their broader clinical practice. Health service boards and executives should also play a leadership role in facilitating considerations about service involvement in voluntary assisted dying. This would include matters of staff support and establishing governance arrangements at the clinical and organisational levels. Given that 52 per cent of Australians die in hospitals, it will be important that the implementation process supports health services contemplating participating in voluntary assisted dying and how it is provided within broader end of life programs offered by health services.²⁴¹

In developing its Medical Aid in Dying Program, the UHN in Toronto, Canada, noted that the development of the institutional program and the accompanying hospital-wide education process brought voluntary assisted dying more prominently into the public space of medical care. This has resulted in enhanced transparency and accountability regarding the range of medical practices at the end of life and has encouraged more open conversations about patient wishes, fears and preferences.²⁴²

Consistency in governance approaches and staff support may best be facilitated in partnership with professional colleges and bodies such as the Australian Medical Association, the Australian Nursing and Midwifery Federation, palliative care and pharmacy organisations, relevant professional colleges and the Victorian Healthcare Association.

The support needs of the broader workforce, both for those who do and for those who do not participate in voluntary assisted dying, should be addressed through guidance and protocols as well as access to professional support. The proposed Implementation Taskforce should play a central role in facilitating a consistent state-wide approach for guiding and supporting health practitioners.

²⁴¹ Swerissen, H & Duckett, S (2014), *Dying well*, Grattan Institute, <<https://grattan.edu.au/report/dying-well/>>.

²⁴² Li, M et al (2017), 'Medical assistance in dying: implementing a hospital-based program in Canada', *New England Journal of Medicine*, vol. 376, no. 21, pp. 2082–2088.

International example

In Toronto, Canada, the UHN's Medical Assistance in Dying (MAiD) program is guided by a framework that establishes clear roles for how clinical teams respond to a patient's request for voluntary assisted dying. The framework covers the role of the assessment team and the role of the intervention team. MAiD is overseen by a multidisciplinary quality committee that provides oversight, reports MAiD performance metrics to the medical advisory committee, and employs MAiD data for use in quality assessment and research (with Research Ethics Board approval).

For the full discussion please see:

Li M, et al (2017), 'Medical assistance in dying: implementing a hospital-based program in Canada, *New England Journal of Medicine*, vol. 376, no. 21, pp. 2082–2088.

Supporting patient and clinician communication

A systematic review looking at patient and clinician communication suggests that the use of multi-pronged approaches is required to support good communication between health practitioners and patients.²⁴³ Good communication can promote healing, while sub-standard communication may have negative effects.²⁴⁴ The evidence-based approaches identified in this review should be considered as part of the development of the training and guidance tools for voluntary assisted dying. The effective approaches identified include:

- ensuring the provision and delivery of good-quality information through structured processes such as role plays, scripts and communication guides;
- supporting health practitioners to improve interpersonal and relational dimensions of care through training about mindfulness, active listening and self-reflection techniques; and
- supporting health practitioners to manage communication in complex disease trajectories, such as chronic diseases, through the use of consultation and advice from colleagues and linking in with multidisciplinary teams.

The Panel is of the view that, as part of implementation, existing communication skills training resources should be identified and employed in supporting quality voluntary assisted dying discussions. The focus should be on approaches that have been shown to be effective. Victoria is a leader in developing resources and training that supports high-quality communication in end-of-life care.²⁴⁵ Resources developed for end-of-life care, palliative care, goals of care and advance care planning discussions should be reviewed as part of the implementation preparation for voluntary assisted dying.

243 Iedema, R & Manidis, M (2013), *Patient-clinician communication: an overview of relevant research and policy literatures*, Australian Commission on Safety and Quality in Health Care and UTS Centre for Health Communication, Sydney, viewed 7 June 2017, <<https://www.safetyandquality.gov.au/our-work/clinical-communications/patient-clinician-communication/>>.

244 Ibid.

245 See, for example, Hudson L et al (2006), 'Responding to desire to die statements from patients with advanced disease: recommendations for health professionals' *20 Palliative Medicine*, vol. 20, no. 7, pp. 703–710.

Informing the community

One of the issues that will need to be dealt with in implementation is how people in the community are made aware of their option to request voluntary assisted dying, who may be eligible, and how they would access and complete the process. Both the Parliamentary Committee and the Panel support the recommendation that voluntary assisted dying not be raised by a person's health practitioner and that the person themselves must initiate the request.

While a person's medical practitioner will be a critical source of information in discussions with the person, there is likely to be value in independent sources of advice and accurate information that is presented in a way that makes it easy for a range of people to understand the voluntary assisted dying process, which might include what the person needs to consider in making a request or coming to a decision about voluntary assisted dying.

Access to good-quality, reliable end-of-life care information for the community and health consumers will be critical in order for a person to make informed decisions about voluntary assisted dying. The Panel strongly supports a communication strategy that focuses on end-of-life care options and choices broadly, and should include identifying community organisations where people are likely to go to find out information about voluntary assisted dying. These organisations may need to be supported with good consumer-oriented material in a variety of formats. The Implementation Taskforce needs to take this into account when considering the role End of Life Care Victoria may play in providing information. Any information should be developed in collaboration with community, consumer groups and health practitioners.

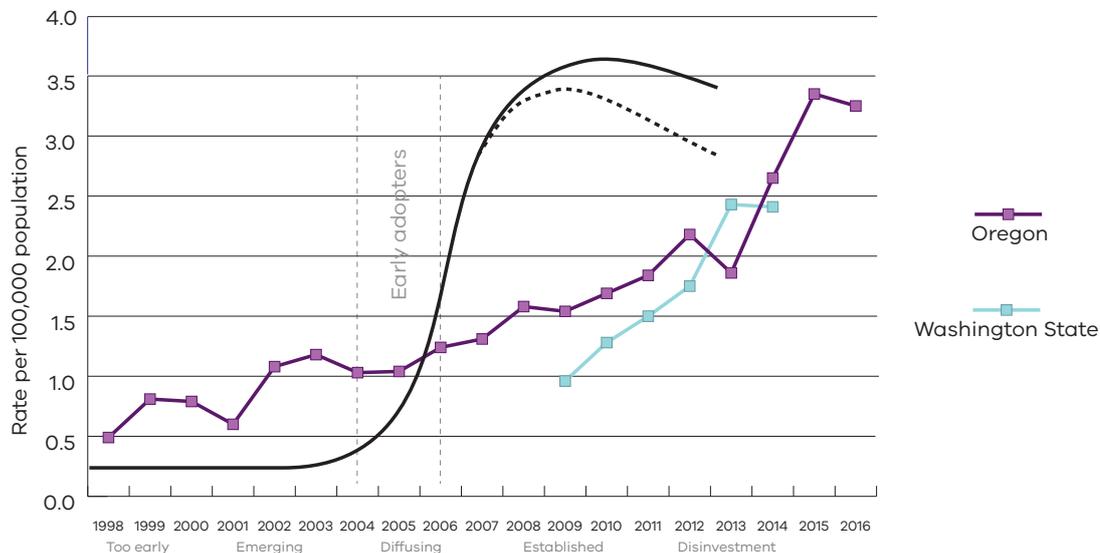
Supporting the safe introduction of voluntary assisted dying

The Panel is of the view that voluntary assisted dying implementation must, as far as possible, be evidence-based so as to promote consistent good practice. As voluntary assisted dying would be a new medical intervention for the Victorian health care system, evidence from other fields of medical practice, and from the implementation of voluntary assisted dying in other jurisdictions, will need to be reviewed. While evidence of good implementation should consider both the European and North American jurisdictions, the Panel notes that the framework proposed by the Parliamentary Committee is most aligned with approaches in North American jurisdictions that have introduced voluntary assisted dying legislation.

Evidence from research findings on the uptake of new medical interventions shows that without a deliberate strategy for introducing the intervention, based on research into clinical practice, its uptake can be slow and haphazard. The transfer of research evidence into clinical practice is difficult and can take a generation of clinicians before being accepted into practice. Introducing new interventions or research into clinical practice requires skill, determination, time, money and planning.²⁴⁶

When the patterns of uptake for voluntary assisted dying are compared with the expected trend for any new medical intervention or research, it shows that the uptake of voluntary assisted dying is consistent with the expected utilisation pattern of any other new intervention or research. Figure 1 illustrates this by setting out the utilisation trends for Oregon and Washington per 100,000 population against the general expected trend for the uptake of new medical interventions (the general uptake graph shows the pattern over a generation of 25 years).²⁴⁷ Understanding the general utilisation trend for new medical interventions should inform the implementation approach for voluntary assisted dying and will help guide implementation preparation.

Figure 1: Utilisation trends for voluntary assisted dying in Oregon and Washington per 100,000 population against the general expected trend for the uptake of new medical interventions



246 National Health and Medical Research Council (2000), *How to put evidence into practice: implementation and dissemination strategies*, Commonwealth of Australia, viewed 29 May 2017, Canberra, <<https://www.nhmrc.gov.au/guidelines-publications/cp71>>; Rogers, E (1983), *Diffusion of Innovations*, The Free Press, New York; Orr, G (2003), *Diffusion of Innovations*, by Everett Rogers (1995) (Review), viewed 27 June 2017, <web.stanford.edu/class/symbiosys205/Diffusion%20of%20Innovations.htm>.

247 This graph has been developed by the Department of Health and Human Services, using Rogers, E (1983), *Diffusion of Innovations*, The Free Press, New York and data derived from Oregon Public Health Division, Center for Health Statistics, Oregon Health Authority (2017), *Oregon Death with Dignity Act: data summary 2016*, State of Oregon, Portland, viewed 4 May 2017, <<http://www.oregon.gov/oha/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>> and Washington State Department of Health (2016), *Washington State Department of Health 2015 Death with Dignity Act report*, Washington State, viewed 7 May 2017, <<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>>.

Examples from North America show how services can engage health practitioners to consider how best to approach voluntary assisted dying within their organisations. The Seattle Cancer Care Alliance undertook its policy development in 2008 (see box below) and the UHN in Toronto, Canada, has recently implemented a hospital Medical Assistance in Dying program in response to Canadian legislation passed in June 2016.

Systematic reviews have shown that multi-pronged approaches that use a number of interventions for implementation are more likely to yield effective uptake of good practice.²⁴⁸ For research transfer to occur, implementation planning should take into account four key enablers: good information, good access to information, supportive environments and evidence-based promotion of knowledge uptake.²⁴⁹

The Panel notes that a multi-pronged approach to implementation is likely to be more successful. Feedback from stakeholders involved in the consultation process identified a range of resources that they considered should be developed as part of implementation planning, including appropriate community information. A selection of these resources are summarised in the Panel's interim report. The evidence-based approaches identified in the literature should be reviewed to identify the role these approaches may play in effectively implementing voluntary assisted dying. These approaches include:

- educational outreach;
- decision support systems;
- clinical guidelines;
- guidelines on effective communication;
- information for consumers, including issues consumers might want to consider in decision making;
- guideline companion materials to support consumers through the process;
- checklists;
- interactive training forums and packages;
- clinical audit and feedback; and
- supporting local consensus processes to develop service delivery responses.

The Panel notes that the Parliamentary Committee did not support the use of check lists in voluntary assisted dying. While the Panel strongly supports the delivery of voluntary assisted dying as part of a therapeutic and person-centred process, it also notes that the use of checklists has shown to significantly improve health practitioner performance in a number of clinical interventions and should not be dismissed as a possible quality assurance tool in voluntary assisted dying.²⁵⁰

248 National Health and Medical Research Council (2000), *How to put evidence into practice: implementation and dissemination strategies*, Commonwealth of Australia, viewed 29 May 2017, Canberra, <<https://www.nhmrc.gov.au/guidelines-publications/cp71>>; Davis, D et al (1995), 'Changing physician performance: a systematic review of the effect of continuing medical education strategies', *Journal of the American Medical Association*, vol. 274, no. 9, pp. 700–705; Grol, R et al (1998), 'Attributes of clinical guidelines that influence use of guidelines in general practice: observational study', *British medical journal*, vol. 317, no. 7162, pp. 858–861.

249 Ibid.

250 Winters, B et al (2009), 'Clinical review: checklists: translating evidence into practice', *Critical care*, vol. 13, no. 6, pp. 210–218, p. 210.

As part of its recommendations, the Panel has also set out obligations for pharmacists about the information they must provide as well as their reporting requirements to the Voluntary Assisted Dying Review Board. The Panel acknowledges that many community pharmacists play an important role in supporting people and their families during periods of serious illness, particularly in providing people with information and advice about medications.

As part of resource development, the Panel advocates that the Implementation Taskforce work closely with pharmacy bodies to develop evidence-based resource material and establish structures that support pharmacists who may choose to participate in voluntary assisted dying. The guidance and structures developed for pharmacists participating in the methadone program in Victoria provides a working example of how these resources and supports can be developed and established.²⁵¹

The Panel urges that evidence-based approaches be reviewed and adopted so that voluntary assisted dying can be effectively implemented in Victoria. The introduction of voluntary assisted dying should utilise the 'plan, do, study, act cycle' approach developed by the US Institute for Health Improvement with a focus on improvement and learning.²⁵²

The development and implementation of voluntary assisted dying should take into account quality dimensions such as accessibility, appropriateness, capacity, continuity, effectiveness, responsiveness and safety.²⁵³ These quality dimensions provide clear measures that can be assessed and reviewed as part of a 'plan, do, study, act' cycle.

Introducing voluntary assisted dying into a comprehensive care centre

In November 2008, the US state of Washington passed the *Death with Dignity Act*. In response, the Seattle Cancer Care Alliance (the Alliance) developed a Death with Dignity program designed to adhere to legal regulations, maintain safety and ensure quality of patient care.

Policy development

The Alliance instigated its death with dignity policy after considerable internal engagement with physicians. To prepare for the policy, the Alliance:

- undertook an institution-wide educational program outlining the provisions of the law and the planned program; and
- conducted a confidential survey in March 2009 asking physicians whether they would be willing to act as either a prescribing or consulting physician.

Only those willing to participate were asked to be involved in the program.

The medical director wrote the policy, which was approved by the Medical Executive Committee.

²⁵¹ Department of Health and Human Services (2017), *Pharmacotherapy (opioid replacement therapy)*, State of Victoria, viewed 7 June 2017, <<https://www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy>>.

²⁵² Institute for Healthcare Improvement (2017), viewed 21 June 2017, <<http://www.ihl.org/Pages/default.aspx>>.

²⁵³ National Health Performance Committee (2001), *National health performance framework report: a report to the Australian Health Ministers' Conference*, Queensland Health, Brisbane, viewed 6 June 2017, <<http://www.pc.gov.au/research/supporting/health-performance-framework-2001/nphfr2001.pdf>>.

What the policy set out

Information packages for patients, physicians and patient advocates (staff from the social work department of the hospital) supplemented the policy, which set out basic aspects of the requirements as well as addressing more controversial issues identified in its development. For example, the policy sets out that:

- New patients are not accepted solely for the purpose of accessing the Death with Dignity program.
- Participants of the program are required to sign an agreement not to take the lethal prescription in a public area or manner.
- No staff or faculty are compelled to participate in the program.

Quality assurance and improvement

The auditing and monitoring of the program is embedded as part of the Alliance's safety and quality program, and checklists and medical charts are randomly audited. Any unexpected complications are monitored, as are any complaints from patients and families.

The Alliance continues to identify and address process and quality issues, seeking out opportunities for improvements. For example, reports of uncontrolled pain or fear of future symptoms at the time of the initial request have prompted the Alliance to review how these patients are linked into the Alliance's specialist pain and palliative care services. Palliative care consultations are now offered at the initial request as part of the Alliance's policy.

Death with Dignity program review

In 2012 the Alliance reviewed its Death with Dignity program. The review found that 114 patients had enquired about the Death with Dignity program between 5 March 2009 and 31 December 2011 and showed the program had been well accepted by patients and physicians. The review concluded:

Our Death with Dignity program both allows patients with cancer who wish to consider this option to do so within the context of their ongoing care and accommodates variation in clinicians' willingness to participate. The program ensures that patients (and families) are aware of all the options for high quality end-of-life care, including palliative and hospice care, with the opportunity to have any concerns or fears addressed, while also meeting state requirements.

For more information about the Death with Dignity program please see:

Loggers, E et al (2013), 'Implementing a death with dignity program at a comprehensive cancer center', *New England Journal of Medicine*, vol. 368, no. 15, pp. 1417–1424.

Ministerial Advisory Panel Recommendation 62

That appropriate workforce support, information, clinical and consumer guidelines, protocols, training, research and service delivery frameworks to support the operation of the legislative framework are developed in a partnership between Safer Care Victoria, the Voluntary Assisted Dying Review Board and the Department of Health and Human Services in consultation with key clinical, consumer and professional bodies and service delivery organisations.

Ministerial Advisory Panel Recommendation 62

That the Implementation Taskforce establishes a collaborative coordination process across responsible agencies to periodically review the resources and frameworks that support the operation of voluntary assisted dying.

Policy intent

To provide a mechanism for ensuring collaboration and coordination between key agencies.

To establish clear responsibility for the ongoing maintenance and updating of key resources.

Research

The Parliamentary Committee Inquiry

The Parliamentary Committee's recommended framework includes establishing the research position of 'Chair of end of life' at a Victorian university to conduct ongoing research into end-of-life care and choices in Victoria. The Parliamentary Committee proposed that the Chair be established through a Government expression of interest process.

Discussion

The majority of consultation feedback supported undertaking research to inform improvements in end-of-life care and voluntary assisted dying, noting that there is already a number of Victorian universities supporting end-of-life care research. Feedback supported investment in end-of-life care research; however, there was also feedback that questioned why Government would support the establishment of one specific research position (as suggested by the Parliamentary Committee) over support for a number of academics who already have research expertise in this area. In addition, it was pointed out that different areas of expertise have been established across several universities, and collaboration with them is more likely to address the wide range of issues requiring research.



The Panel is of the view that it is likely to be more effective for government to support, as part of the annual review of implementation, a program of research that is based on agreed policy and clinical priorities. This is proposed in Recommendation 65 below. In this way, research is aligned to policy and clinical priorities, and existing research expertise can be utilised.

Research into areas such as the reasons why people request voluntary assisted dying, guideline development, education and training, and support for health practitioners, have all been identified as areas requiring further research.²⁵⁴

The Panel also notes the proposed role of the Voluntary Assisted Dying Review Board in facilitating research. The development and commissioning of research should be in partnership with the Board, Safer Care Victoria and the Department of Health and Human Services. The Panel considers that a channelling of funds towards a research agenda would call on the strengths of each of these bodies, and may be more beneficial than establishing a specific research position.

Research considerations about medications

Best practice assessments of medications used in voluntary assisted dying focus on identifying medications that are easily tolerated by the gastrointestinal tract, have no adverse side effects (such as tremors or sweating), are fast acting, and remain stable over time. Cost of medication must also be considered as this may impact on access for some people.²⁵⁵

These considerations are important for a voluntary assisted dying legislative framework that predominately relies on a person self-administering a lethal dose of medication to ensure it operates safely. The available medications should be those that reduce risks of adverse events and provide confidence and comfort to the person and their family. The implementation process should focus on identifying appropriate medications for voluntary assisted dying that will promote best practice and support quality improvement. The Panel recommends that the accepted evidence-based approaches discussed above be applied to the development of voluntary assisted dying medications and medication guidance.

As part of implementation planning, the Panel recommends working with a university (preferably one with a pharmacology department) to undertake research on the available medication options, the development of high-quality formulations, dosage guidelines and clinical and consumer information for best practice in prescribing and using medications for voluntary assisted dying.

²⁵⁴ National Health Performance Committee (2001), *National health performance framework report: a report to the Australian Health Ministers' Conference*, Queensland Health, Brisbane, viewed 6 June 2017, <<http://www.pc.gov.au/research/supporting/health-performance-framework-2001/nphfr2001.pdf>>.

²⁵⁵ Bryant, T (2016), 'Aid in dying: the availability of ideal medications for use in "right to die" jurisdictions in the United States', *Quinnipiac Law Review*, vol. 34, pp. 705–746.

Ministerial Advisory Panel Recommendation 64

That the Implementation Taskforce provide advice to the Department of Health and Human Services on engaging with a university to undertake research on the best practice identification and development of medications for use in voluntary assisted dying.

Ministerial Advisory Panel Recommendation 65

That a collaborative research program is developed with existing research entities to identify key clinical, policy and practice issues and align research with these priorities.

Policy intent

Supporting quality improvement and evidence development about end-of-life care and choices.

Resourcing

The Parliamentary Committee Inquiry

Of the 49 recommendations made by the Parliamentary Committee, 27 relate to making improvements to palliative care. A number of these recommendations relate to ensuring appropriate levels of resources are allocated to supporting end-of-life care services, including developing funding approaches that allocate resources to home-based palliative care, supporting hospitals to better respond to end-of-life care needs and advocating for a greater role for general practitioners in end-of-life care.

Discussion

The Panel notes that the Victorian Government has supported the Parliamentary Committee's recommendations to improve palliative care and has developed *Victoria's end of life and palliative care framework*, which highlights that current end of life and palliative care models are unsustainable and will not meet future demand without significant redesign.²⁵⁶ Continued investment in the framework was supported in the consultation process, noting that one of the key reforms of the framework – to make end of life and palliative care 'everybody's business' – was an important step to ensuring coordinated and responsive care.

²⁵⁶ Department of Health and Human Services (2016), *Victoria's end of life and palliative care framework: a guide for high-quality end of life care for all Victorians*, State of Victoria, Melbourne, viewed 1 May 2017, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/end-of-life-and-palliative-care-framework>>.

The Panel is of the view that the Implementation Taskforce should review the practical resourcing considerations in enacting voluntary assisted dying legislation. This will include the establishment of the Voluntary Assisted Dying Review Board, the development and maintenance of implementation guidance and support materials and the resourcing required to support a safe and compassionate voluntary assisted dying framework.

The Panel notes that many people who access voluntary assisted dying will already be receiving end of life and palliative care services to address their clinical needs, and will benefit from the overall investment in and focus on these services.

Commencement

The Parliamentary Committee Inquiry

As part of its recommendation for a voluntary assisted dying framework for Victoria, the Parliamentary Committee recommended that any voluntary assisted dying legislation should include an 18-month period between Royal Assent and operation, to allow appropriate time to prepare for implementation on a practical and clinical level.²⁵⁷

Discussion

There was universal support expressed in the Panel's forums for the Parliamentary Committee's proposed 18-month implementation period leading up to the commencement of any new legislation. This period was thought to allow sufficient time to prepare and plan for the best possible implementation of voluntary assisted dying in Victoria. Stakeholders commented that learning from the experiences of other jurisdictions and considering how best to adapt approaches in Victoria should inform any implementation plan. The Panel is also of the view that an 18-month implementation period will allow sufficient time to appropriately consult and consider evidence from other jurisdictions.

Ministerial Advisory Panel Recommendation 66

That, in order to prepare for implementation, there is an 18-month period between the passage and commencement of the voluntary assisted dying legislation

Policy intent

To provide adequate time for planning and establishment of the voluntary assisted dying framework.

²⁵⁷ Legislative Council Legal and Social Issues Committee (2016), *Inquiry into end of life choices: final report*, Parliament of Victoria, Melbourne, p. 237, viewed 8 February 2017, <<https://www.parliament.vic.gov.au/lpic/inquiry/402>>.



Appendices

Appendix 1: Voluntary Assisted Dying Framework Summary

Eligibility

The person must meet all of the eligibility criteria

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.

Decision-making capacity

- The test in the Medical Treatment Planning and Decisions Act is used to assess decision-making capacity.
- Referral required for specialist assessment when there is doubt about the person's decision-making capacity.

Eligibility considerations

- Mental illness does not satisfy the eligibility criteria, nor does mental illness exclude a person from eligibility.
- Disability does not satisfy the eligibility criteria, nor does disability exclude a person from eligibility.

Voluntary

- A request for voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others.
- Health practitioners cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.
- A person may withdraw from the process at any time. When a person withdraws from the voluntary assisted dying process, they must commence the process from the beginning if they decide to make a subsequent request for voluntary assisted dying.
- Appropriately accredited, independent interpreters may assist in making verbal and written requests for voluntary assisted dying.

Making a request for voluntary assisted dying

(from the perspective of the person making the request)

First request to a medical practitioner

- A request for voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person.
- A request for information about voluntary assisted dying does not constitute a first request.
- A person must make three separate requests to access voluntary assisted dying: a first request, followed by a written request, and then a final request.



First assessment by the coordinating medical practitioner

- The person must be properly informed of:
 - their diagnosis and prognosis;
 - the treatment options available to them and the likely outcomes of these treatments;
 - palliative care and its likely outcomes;
 - that the expected outcome of taking the lethal dose of medication will be death;
 - the possible risks of taking the lethal dose of medication;
 - that they are under no obligation to continue with a request for voluntary assisted dying, and that they may withdraw their request at any time; and
 - any other information relevant to their needs.
- The person is assessed by the coordinating medical practitioner as to whether they meet the eligibility criteria, understand the information, are acting voluntarily and without coercion, and their request is enduring.



Second assessment by the consulting medical practitioner

- The consulting medical practitioner must also ensure the person is properly informed.
- The consulting medical practitioner must also assess whether the person meets the eligibility criteria and whether their request is voluntary and enduring.



Written declaration of enduring request

- Declaration is signed by the person and witnessed in the presence of the coordinating medical practitioner.
- The two witnesses must be independent, and one must not be a family member.
- Provides an opportunity for the person to make a personal statement about their decision.



Final request to the coordinating medical practitioner

- The final request may only be made at least 10 days after the first request and cannot be made on the same day the second assessment is completed.
- A contact person will take responsibility for returning any unused lethal medication after the person has died and act as a point of contact.

Receiving a request for voluntary assisted dying (from the perspective of the health practitioner)

Participation

- A health practitioner may conscientiously object to participating in the provision of information, assessment of a person's eligibility and the prescription, supply or administration of the lethal dose of medication for voluntary assisted dying.



Roles

- The two assessing medical practitioners are:
 - the coordinating medical practitioner
 - the consulting medical practitioner.
- The coordinating medical practitioner or the person may request that coordination of the process be transferred to the consulting medical practitioner.



Qualifications

- Both the coordinating medical practitioner and the consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered) and:
 - at least one of the medical practitioners must have at least five years post fellowship experience;
 - at least one of the medical practitioners must have relevant expertise in the person's disease, illness or medical condition.



Training

- Both assessing medical practitioners are required to have completed specified training before undertaking an assessment.
- The specified training comprises obligations and requirements under the legislation including:
 - assessing the eligibility criteria under the legislation
 - assessing decision-making capacity and when referral may be required
 - assessing the voluntariness of a person's decision and identifying risk factors for abuse.



Assessment obligations

- Two medical practitioners must undertake independent assessments of a person's eligibility for voluntary assisted dying.
- Both assessing medical practitioners must ensure the person is properly informed.
- Both assessing medical practitioners assess whether the person meets the eligibility criteria and whether their request is voluntary and enduring.
- Referral for specialist assessment must be made if there is doubt about the person's decision-making capacity.
- To conclude the assessment process the coordinating medical practitioner completes a certification for authorisation.

Completing the process

Appointment of a contact person

- The person appoints a contact person who will take responsibility for returning any unused lethal medication after the person has died and act as a point of contact for the Board.



Certification for authorisation

- The coordinating medical practitioner completes a certification for authorisation to confirm in writing that they are satisfied that all of the requirements have been met.
- The prescription of the lethal medication requires an authorisation process.



Accessing the medication

- At the point of dispensing the lethal dose of medication, the pharmacist must:
 - attach labels clearly stating the use, safe handling, storage and return of the medication
 - provide the person with information about administering the medication and the likely outcome.
- The person is required to store the lethal dose of medication in a locked box.



Self-administration of the medication

- The legislation does not preclude health practitioners from being present when a person self-administers the medication if this is the preference of the person.
- There is protection in the legislation for health practitioners who are present at the time the person self-administers the medication, including that the health practitioner is under no obligation to provide life-sustaining treatment.

or

Medical practitioner administration of the medication

- Not being able to self-administer is defined as being physically unable to self-administer or digest the medication.
- If the person is not able to self-administer, the coordinating medical practitioner may administer the lethal dose of medication.
- If the coordinating medical practitioner administers the lethal dose of medication, a witness who is independent of the coordinating medical practitioner must be present. The coordinating medical practitioner and the witness must certify that the person's request is voluntary and enduring.

Governance and safeguards

Guiding Principles

- Guiding principles are included in the legislation to help guide interpretation.

Voluntary Assisted Dying Review Board

- The Board is established under statute to review every case of voluntary assisted dying and report on the operation of voluntary assisted dying in Victoria, including:
 - reviewing each case of voluntary assisted dying and each assessment for voluntary assisted dying to ensure compliance with the statutory requirements
 - referring breaches of the statutory requirements to the appropriate authority to investigate the matter
 - collecting information and data, setting out additional data to be reported and requesting additional information from medical practitioners or health services
 - monitoring, analysing, considering and reporting on matters relating to voluntary assisted dying
 - supporting improvement by facilitating and conducting research relating to voluntary assisted dying and maintaining and disseminating guidelines to support the operation of the legislation
 - any other functions necessary to promote good practice.
- Board membership, appointed by the Minister for Health, reflects the appropriate knowledge and experience required for the Board to perform its functions.

Protections

- There are clear protections for health practitioners who act in good faith and without negligence to facilitate access to voluntary assisted dying under the legislation.
- A health practitioner must notify the Australian Health Practitioner Regulation Agency if they believe that another health practitioner is acting outside the legislative framework.
- Any other person may notify the Australian Health Practitioner Regulation Agency if they believe that a health practitioner is acting outside the legislative framework.

Offences

- It would be an offence to:
 - induce a person, through dishonesty or undue influence, to request voluntary assisted dying
 - induce a person, through dishonesty or undue influence, to self-administer the lethal dose of medication
 - falsify records related to voluntary assisted dying
 - administer a lethal dose of medication to a person without decision-making capacity.

Reporting and review

Reporting to the Voluntary Assisted Dying Review Board

- The legislation stipulates mandatory reporting by medical practitioners, pharmacists and the Department of Health and Human Services to the Voluntary Assisted Dying Review Board at numerous points of the voluntary assisted dying process.
- Reporting forms are set out in the legislation to provide certainty and transparency about the information that is collected.

Medical practitioner reporting

- Medical practitioner reporting must take place within seven days of:
 - completing the first assessment (regardless of the outcome)
 - completing the second independent assessment (regardless of the outcome)
 - completing the certification for authorisation (which will incorporate the written declaration and contact person forms)
 - when the lethal dose of medication is administered by a medical practitioner.

Medication reporting

- Medication reporting must take place within seven days:
 - by the Department of Health and Human Services when the prescription is authorised
 - by the pharmacist when the prescription is dispensed
 - by the pharmacist when the contact person returns unused lethal medication.

Monitoring after death

- The death certificate identifies the underlying disease, illness or medical condition as the cause of death.
- Accessing voluntary assisted dying should not affect insurance payments or other annuities.
- The medical practitioner who certifies death must notify the Registrar of Births, Deaths and Marriages if they are aware that the person has been prescribed a lethal dose of medication or if they are aware that the person self-administered a lethal dose of medication under the legislation.
- The Registrar of Births, Deaths and Marriages and the Voluntary Assisted Dying Review Board share information relating to voluntary assisted dying.
- A death by means of voluntary assisted dying in accordance with the legislative requirements is not considered a reportable death for the purpose of the Coroners Act.

Annual report

- The Voluntary Assisted Dying Review Board will report to Parliament every six months in the first two years, and thereafter annually.

Legislative review

- The legislation will be subject to review five years after commencement.

Implementation

Implementation within existing care

- Implementation to occur within the context of existing care available to people at the end of life, and ensure voluntary assisted dying activity is embedded into existing safety and quality processes.

Implementation planning and governance

- Work to establish the Voluntary Assisted Dying Review Board begins at least 12 months before the legislation commences.
- The Board is supported to develop a clear work plan to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engaging and sharing information with other partners for quality improvement purposes.
- The Department of Health and Human Services establishes and supports an implementation taskforce to investigate and advise on the development of voluntary assisted dying. The implementation taskforce should have the coordinating role in overseeing and facilitating the work set out in the implementation recommendations.
- A gap analysis is undertaken of existing entities and functions against the functions proposed for End of Life Care Victoria to determine a clear role for the proposed agency.

Implementation support

- Appropriate workforce support, information, clinical and consumer guidelines, protocols, training, research and service delivery frameworks to support the operation of the legislative framework are developed in a partnership between Safer Care Victoria, the Board and the Department of Health and Human Services in consultation with key clinical, consumer and professional bodies and service delivery organisations.
- The implementation taskforce establishes a collaborative coordination process across responsible agencies to periodically review the resources and frameworks that support the operation of voluntary assisted dying.

Research

- Implementation taskforce provides advice to the Department of Health and Human Services on engaging with a university to undertake research on the best practice identification and development of medications for use in voluntary assisted dying.
- A collaborative research program is developed with existing research entities to identify key clinical, policy and practice issues and to align research with these priorities.

Commencement

- An 18-month period between passage of the legislation and commencement in order to prepare for implementation.

Appendix 2: Voluntary assisted dying and human rights

This appendix explores the interaction of the Panel's recommendations with the Victorian *Charter of Human Rights and Responsibilities Act 2006* ('the Charter').

The Panel has used the Charter as a framework for considering the rights of all Victorians when making decisions and resolving complex issues in relation to voluntary assisted dying. Every human life has equal value, and human rights provide guidance for upholding and safeguarding this value. The human rights in the Charter allow people to live their lives with freedom and dignity but also protect against exploitation, violence and abuse.

Voluntary assisted dying legislation must strike a balance between promoting autonomy and providing appropriate safeguards to protect vulnerable people from abuse. Providing for unfettered autonomy in end-of-life decision-making would leave many people at risk of abuse and would fail to redress social disadvantages that render some people less able to exercise their autonomy. In contrast, focusing solely on providing appropriate safeguards to protect people who are at risk of abuse would result in a failure to acknowledge and respect that people can make their own decisions about their life in accordance with their values.

Promoting individual autonomy and providing appropriate safeguards are critical, and neither aim is paramount. Instead, they must be balanced. An appropriate balance should not only recognise the importance of these aims separately but also the role they play in promoting each other. Safeguards are sometimes necessary to ensure that people are able to exercise their autonomy through voluntary and properly informed decisions. Similarly, the ultimate aim of providing safeguards is to protect people so they may flourish. This aim should not be lost in the immediate desire to prevent potential harm, as safety is of limited value if a person is not also free to live a life in accordance with their values.

The Charter has provided important guidance for developing the proposed voluntary assisted dying legislation and protecting human rights. The Charter identifies 20 fundamental human rights that promote and protect the values of freedom, respect, equality and dignity. The Charter places an obligation on government to properly consider human rights in making a decision and to act compatibility with human rights. The Charter must also be considered when developing policy and legislation. A *Statement of Compatibility* is tabled in Parliament when a Bill is introduced stating whether the Bill is compatible with human rights, and the nature and extent of any incompatibility.

The Charter recognises these competing ideals and provides a framework for balancing important human rights considerations. It recognises that some human rights may be limited when this is an appropriate and proportionate response to legitimate concerns. That is, the limitation must not be a disproportionate response to a concern and any limitation must target the actual issue of concern. To ensure this occurs, when limiting a human right factors such as the nature of the right, the purpose and degree of the limitation, and whether there are less restrictive ways to address the concern, must be considered.²⁵⁸

There will inevitably be circumstances in which one human right must be limited to promote another human right. To create a safe and compassionate voluntary assisted dying legislative framework, it is necessary to limit some human rights to ensure people are protected from abuse. In making its recommendations, the Panel sought to strike a balance between:

- a person's desire to make autonomous decisions about the timing and manner of their death; and
- a framework that provides the appropriate safeguards for Victorians who may be at risk of abuse.

The Panel has also sought to balance the use of appropriate safeguards by ensuring voluntary assisted dying is practically accessible to Victorians who meet the eligibility criteria.

Giving effect to human rights that protect the sanctity of every human life, and applying appropriate safeguards to protect individuals who may be at risk of abuse, are part of a just, fair and inclusive society. Within such a free and democratic society, all Victorians should have the ability to make relevant decisions about their own lives. This is reflected in Victorian law, which recognises that all adults are presumed to have decision-making capacity unless there is evidence to the contrary.

The Panel considered each human right in the Charter and found seven rights to be particularly relevant to voluntary assisted dying. These are:

- the right to recognition and equality before the law (s 8);
- the right to life (s 9);
- the right to protection from torture and cruel, inhuman or degrading treatment (s 10);
- the right to privacy and reputation (s 13(a));
- the right to freedom of thought, conscience, religion and belief (s 14(1));
- the right to protection of the best interests of the child (s 17(2)); and
- the right to liberty and security of the person (s 21(1)).

The compatibility of the Panel's recommendations with these human rights is discussed below.

The right to recognition and equality before the law

The right to recognition and equality before the law under section 8 of the Charter requires that all people are recognised as persons before the law and have the right to enjoy their human rights without discrimination.

The Panel considered the right to recognition and equality before the law was particularly relevant to questions about who should be eligible to access voluntary assisted dying. While the right suggests that people should not be prevented from accessing voluntary assisted dying because of particular personal attributes such as age or disability, the Panel considered that some reasonable limits could be placed on this right.

The Panel recommends access for people who are aged 18 years and over and have decision-making capacity in relation to voluntary assisted dying. Excluding people on

the basis of age and circumstances where lack of decision-making capacity is a result of a disability limits this right and could amount to discrimination. The right is not unreasonably limited though, as equality of access to the framework must be balanced against protection from abuse. The Panel is of the view that these criteria represent reasonable limits to ensure decisions to access voluntary assisted dying are voluntary, well-considered and enduring. The Panel concluded it is appropriate to prevent access by people under the age of 18 years and people who do not have decision-making capacity in relation to voluntary assisted dying because of the difficulty of ensuring they are making a voluntary and informed decision.

The Panel recognised that equality before the law also requires that people who have a disability or mental illness should not be excluded from accessing voluntary assisted dying on this basis if they meet all the eligibility criteria.

The Panel concluded that the narrow eligibility criteria, and the limits placed on the right to recognition and equality before the law, are necessary to protect people from abuse and to ensure voluntary assisted dying is only accessible to those who the legislation is intended for - those who are experiencing intolerable suffering at the end of their lives. The narrow eligibility criteria are an important safeguard to ensure free, informed and voluntary decisions and to prevent involuntary assisted dying. Therefore, the Panel is of the view that the limits on the right to recognition and equality before the law are reasonable in the circumstances.

The right to life

Section 9 of the Charter provides that every person has the right to life and the right not to be arbitrarily deprived of life. The right to life is a 'supreme' but not absolute right in international law, meaning it can be limited where justifiable. The right to life includes a positive duty to introduce appropriate safeguards to minimise the risk of loss of life. A key consideration for the Panel was how the framework's safeguards could be designed to protect the right to life and prevent death outside the framework.

In some international jurisdictions, the argument that the right to life includes the right to choose the manner of one's death has been rejected.²⁵⁹ It has, however, been accepted in other jurisdictions that the right to life does not prohibit the legalisation of voluntary assisted dying.²⁶⁰ In Canada it was held that the right to life is not a 'duty to live' and that this could not be used as a basis for justifying an absolute prohibition on voluntary assisted dying.²⁶¹

The Panel recognises the fundamental importance of the right to life, especially in relation to safeguards to ensure people will not be arbitrarily deprived of life. The Panel considered that a voluntary assisted dying regime can be relevant to and compatible with the right to life, provided that there were sufficient safeguards to prevent abuse. Hence, while many of the Panel's recommended steps in the voluntary assisted dying process might appear onerous, they also represent important safeguards for the community to prevent exploitation.

²⁵⁹ *R (Pretty) v DPP* [2002] 1 AC 800.

²⁶⁰ *Pretty v United Kingdom* (2002) 35 EHRR 1.

²⁶¹ *Carter v Canada (Attorney General)* [2012] BCSC 886, [1077].

In making its recommendations, the Panel also balanced the rights and interests of those wanting to access voluntary assisted dying with the interests of other members of the community. This meant the Panel had to ensure only those who are eligible for voluntary assisted dying would be able to access the lethal dose of medication, and that the return of the lethal doses of medication, if not self-administered, would be regulated, thereby preventing access by the broader public and safeguarding lives. The Panel's recommended medication monitoring process strikes an appropriate balance between the need to make the medication practically accessible and the need to protect the community from misuse.

Overall, the Panel considered how the framework's eligibility criteria and other safeguards in the framework (such as strict controls of dispensing and return of the lethal dose of medication) could support people wanting to access assisted dying as an end of life choice, whilst ensuring voluntary consent to protect those vulnerable to abuse or coercion. The Panel considered that any limit on the right to life was reasonable and justified given that a request for voluntary assisted dying must be initiated by the person, its purpose in giving effect to people's decisions at the end of their life, and its stringent eligibility requirements and safeguards that confine the risk of arbitrary deprivation of life.

The right to protection from torture and cruel, inhuman or degrading treatment

Under section 10 of the Charter, the right to protection from torture and cruel, inhuman or degrading treatment includes the right to not be subjected to medical treatment without a person's full, free and informed consent. This right emphasises the importance of ensuring requests are voluntary and decisions to access voluntary assisted dying are properly informed.

The Panel's recommendations ensure there are multiple points in the process to assess the voluntariness of a person's request and to properly inform the person of alternative options. The second independent assessment, the independent witnessing requirements, and the presence of an independent witness when a medical practitioner administers the medication are all critical safeguards to ensure a person is not subject to medical treatment without their consent. The requirement that the request must always come from the person themselves and be repeated three times over at least 10 days also ensures the decision is the person's own, is voluntary and not the product of undue influence or coercion. The Panel is of the view that the framework it has recommended will ensure only those who are making voluntary and properly informed decisions will access medical treatment for voluntary assisted dying, thereby ensuring that this right will not be limited.

The right to privacy and reputation

The right to privacy under section 13 of the Charter recognises the need to respect people's privacy and prevent unlawful or arbitrary interference, including in regard to a person's physical integrity. Other jurisdictions have recognised the close link between the principles of human dignity, freedom and privacy. The Panel's recommendations promote personal autonomy by allowing Victorians to make choices that are consistent with their preferences and values. The framework will allow people who are suffering at the end of their life to choose voluntary assisted dying in highly limited circumstances.



In relation to information privacy, while the Panel recognises the concerns of some stakeholders that every aspect of voluntary assisted dying should be publicly reported on to ensure transparency, the Panel considered that this must be balanced against people's right to privacy. Accessing voluntary assisted dying should not mean a person no longer has a right to privacy. Privacy should be upheld where viable. The Panel's recommendation about the reporting of cause of death on the death certificate of a person who has accessed voluntary assisted dying seeks to preserve privacy for the person and their family.

The Panel's support of the Parliamentary Committee's recommendation that the Voluntary Assisted Dying Review Board provide a de-identified annual report recognises the need to balance the right to privacy with public transparency and accountability. While it is not necessary to know who has accessed voluntary assisted dying, information about the characteristics of those who have accessed, or attempted to access, voluntary assisted dying is important for assessing the operation of the legislative framework.

While the Voluntary Assisted Dying Review Board will hold identifying information, the Panel recommends that this information only be used to identify potential wrongdoing and for referral to appropriate agencies, such as Victoria Police and the Australian Health Practitioner Regulation Agency. The Panel is of the view that any interference with the right to privacy would be lawful, because it would be clearly set out in the legislation. It would not be arbitrary, as any personal information would only be provided to specified authorities on the basis of identification and investigation of potential wrongdoing to protect individuals and the community from harm. Therefore the framework would not limit the right to privacy.

The right to freedom of thought, conscience, religion and belief

The right to freedom of thought, conscience, religion and belief under section 14 of the Charter recognises people's right to hold their own views and to express them. The right is grounded in the principles of personal autonomy and self-determination. It also acknowledges that people may live their lives in accordance with their beliefs and that the State should not arbitrarily interfere with the expression of people's beliefs.

The Panel's recommendation that health practitioners be able to conscientiously object to participating in voluntary assisted dying recognises their right to freedom of thought, conscience, religion and belief. The Panel also considered that while it is important to recognise health practitioners' rights, health practitioners should also recognise their patients' right to freedom of thought, conscience, religion and belief and should not allow their own beliefs to interfere with their patient's access to lawful medical treatment.

To respect the rights of health practitioners under section 14 of Charter, the Panel has not recommended mandatory referral if a health practitioner has a conscientious objection. The Panel notes that this does not mean that practitioners may use their conscientious objection to impede people's access to voluntary assisted dying.

The right to the protection of the best interests of children

Section 17(2) of the Charter provides that children are entitled to protection of their best interests. The application of the right to the protection of the best interests of children is not clear in voluntary assisted dying because it depends on how the 'best interests' of the child are conceived. International case law suggest that it can be in a terminally ill child's best interests to withdraw medical treatment and allow them to die, but it is not clear when this point is reached and whether this could extend to causing the child's death.²⁶²

After careful consideration, the Panel recommends that only people aged 18 years and over should be able to access voluntary assisted dying. This recognises the complexity of the decision to access voluntary assisted dying and the requisite capacity for mature thought and decision-making. As discussed above, it also recognises that children have the right to protection, and access to the framework might not be in their best interests due to their particular vulnerabilities. Equality of access to the framework must be balanced against protection of children including from potential abuse that may lead to involuntarily dying.

The right to liberty and security of the person

Section 21 of the Charter provides that every person has the right to liberty and security. The right to liberty and security of the person again recognises the principle of autonomy. The Canadian Supreme Court found that the prohibition on voluntary assisted dying contravened the right to life, liberty and security of the person, which were all taken to relate to autonomy and quality of life.²⁶³ It found that denying a person the opportunity to determine the manner and timing of their death in response to serious pain and suffering impinged on their liberty and security.

The Panel notes that, in Victoria, the right to liberty and security of the person does not include the word 'life'. This means the Victorian right has a different scope, and is focused on issues of arbitrary arrest or detention. In Victoria the right to life is a separate right (as discussed above). This makes the Victorian right to liberty and security of the person less applicable to voluntary assisted dying in Victoria, as the Panel's recommended framework does not relate to detention or any deprivation of liberty. If the right is relevant, the Panel's recommendations promote this right by enhancing the ability of Victorians at the end of their life to make choices about the manner and timing of their death, consistent with their preferences and values.

²⁶² See, for example, *Great Ormond Street Hospital v Constance Yates, Chris Gard, Charles Gard (A Child, By his Guardian Ad Litem)* [2017] EWHC 972 (Fam), [128].

²⁶³ *Carter v Canada (Attorney General)* [2012] BCSC 886.

Appendix 3: Safeguards and jurisdictional comparison

The Panel has considered in detail the existing legislative frameworks that support voluntary assisted dying in other jurisdictions to more fully inform its deliberations and recommendations.

A list of the extensive safeguards proposed by the Panel for the legislative framework for Victoria was provided in Part C of this Final Report. Sections A and B in this Appendix consider how these safeguards compare with those that operate in other jurisdictions that have legislated for voluntary assisted dying in North America and Europe. Section A identifies whether or not these safeguards have been included in the legislation of other jurisdictions. Section B adopts a more descriptive approach and outlines the key features of other legislation.

This summary provides a comparison with legislation in other jurisdictions. Jurisdictions that legalise voluntary assisted dying through more minimal legislation (such as Switzerland) or through court decisions have not been included. A selection of those jurisdictions that have created a voluntary assisted dying framework through an act of parliament are the ones that have been used for these comparisons. It is worth noting that some jurisdictions may have comparable safeguards in broader health system legislation that are not included nor specified within their voluntary assisted dying legislation. Some jurisdictions also rely heavily on regulations, rather than including the detail in legislation. The Panel is of the view that the detail should be included in legislation to ensure transparency about the framework that is being considered. Providing the detail in legislation also means that the framework can only be changed through an act of parliament.

Disclaimer: Every reasonable effort has been made to ensure that the information in this Appendix is complete and accurate. However the information relied upon from international jurisdictions is subject to change and interpretation, and the content of this appendix is for comparative purposes only.

Section A: Safeguards and jurisdictional comparison

Safeguards and jurisdictional comparison	Proposed for Victoria	North America						Europe	
		Oregon, US, 1997	Washington, US, 2009	Vermont, US, 2013	California, US, 2016	Colorado, US, 2016	Canada, 2016	Belgium, 2002	Netherlands, 2002
Access									
1. Voluntary	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Limited to 18 years and over	✓	✓	✓	✓	✓	✓	✓	x	x
3. Residency requirement	✓	✓	✓	✓	✓	✓	–	x	x
4. Limited to those with decision-making capacity	✓	✓	✓	✓	✓	✓	✓	x	x
5. Must be diagnosed with condition that meets restrictive set of criteria	✓	✓	✓	✓	✓	✓	✓	✓	x
6. End of life is clearly defined	✓	✓	✓	✓	✓	✓	x	x	x
7. End of life condition combined with requirement for suffering	✓	x	x	x	x	x	✓	x	x
8. All of the eligibility criteria must be met	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Mental illness alone does not satisfy the eligibility criteria	✓	–	–	–	–	–	–	x	x
10. Disability alone does not satisfy the eligibility criteria	✓	✓	✓	–	✓	✓	–	x	x
Request									
11. Must be initiated by the person themselves	✓	✓	✓	✓	✓	✓	✓	✓	✓
12. No substitute decision makers allowed	✓	✓	✓	✓	✓	✓	✓	✓	✓
13. Cannot be included as part of an advance directive	✓	✓	✓	✓	✓	✓	✓	x	x
14. Health practitioner prohibited from raising voluntary assisted dying	✓	x	x	x	x	x	x	x	x
15. Person must make three separate requests	✓	✓	✓	✓	✓	✓	x	x	x
16. Must have written request	✓	✓	✓	✓	✓	✓	✓	✓	x
17. Two independent witnesses to the request	✓	✓	✓	✓	✓	✓	✓	x	x
18. Specified time must elapse between requests	✓	✓	✓	✓	✓	✓	✓	x	x
19. Additional time must elapse between steps of completing process	✓	✓	✓	–	x	x	x	✓	x
20. Must use independent accredited interpreter (if an interpreter is required)	✓	x	x	x	✓	x	–	x	x
21. No obligation to proceed, may withdraw at any time	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ included in voluntary assisted dying legislative framework

– safeguard with comparable intent included

x not included in voluntary assisted dying legislative framework. This may mean the law is silent on the matter, or that the law establishes a contrary parameter.

Safeguards and jurisdictional comparison		Proposed for Victoria	North America						Europe	
			Oregon, US, 1997	Washington, US, 2009	Vermont, US, 2013	California, US, 2016	Colorado, US, 2016	Canada, 2016	Belgium, 2002	Netherlands, 2002
Assessment										
22. Eligibility and voluntariness assessed by medical practitioners	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
23. Must be two separate and independent assessments by medical practitioners	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
24. Assessing medical practitioners must have high level of training/experience	✓	–	–	✗	–	–	–	✗	~	✗
25. Assessing medical practitioners must have undertaken prescribed training	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
26. Requirement to properly inform person	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
27. Referral for further independent assessment if there is doubt about decision-making capacity	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗
28. Coordinating medical practitioner must confirm in writing that they are satisfied that all of the requirements have been met	✓	✓	✓	✓	✓	✓	✓	–	–	✓
Medication management										
29. Person required to appoint contact person who will return medication if unused	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
30. Medical practitioner must obtain a permit to prescribe the medication to the person	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
31. Medication must be labelled for use, safe handling, storage and disposal	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
32. Pharmacist also required to inform the person	✓	✗	✗	✗	✗	✗	✗	✓	✗	✗
33. Medication must be stored in a locked box	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Administration										
34. Medication must be self-administered (except in exceptional circumstances)	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗
35. If physical incapacity medical practitioner may administer	✓	✗	✗	✗	✗	✗	✗	✓	✓	✓
36. Additional certification required if administered by medical practitioner	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
37. Witness present if medical practitioner administers	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗

✓ included in voluntary assisted dying legislative framework

– safeguard with comparable intent included

✗ not included in voluntary assisted dying legislative framework. This may mean the law is silent on the matter, or that the law establishes a contrary parameter.

Safeguards and jurisdictional comparison	Proposed for Victoria	North America						Europe	
		Oregon, US, 1997	Washington, US, 2009	Vermont, US, 2013	California, US, 2016	Colorado, US, 2016	Canada, 2016	Belgium, 2002	Netherlands, 2002
Practitioner protections									
38. Health practitioner may conscientiously object to participating	✓	✓	✓	✓	✓	✓	✓	✓	✓
39. Explicit protection for health practitioners who are present at time of person self-administering	✓	✓	✓	✓	✓	✓	✓	x	x
40. Explicit protection for health practitioners acting in good faith without negligence within the legislation	✓	✓	✓	✓	✓	✓	✓	x	✓
41. Mandatory notification by any health practitioner if another health practitioner acting outside legislation	✓	x	x	x	x	x	x	x	x
42. Voluntary notification by a member of the public of a health practitioner acting outside legislation	✓	x	x	x	x	x	x	x	x
Mandatory reporting									
43. Reporting forms set out in legislation	✓	✓	✓	x	✓	✓	x	-	-
44. Reporting mandated at a range of points and from a range of participants to support accuracy	✓	x	x	x	-	x	-	x	x
45. First assessment reported	✓	x	-	-	✓	-	x	x	x
46. Second assessment reported	✓	x	-	-	✓	-	x	x	x
47. Final certification for authorisation reported	✓	x	✓	✓	✓	✓	-	✓	✓
48. Additional form reported if medication administered by medical practitioner	✓	x	x	x	x	x	x	x	x
49. Prescription authorisation reported by DHHS	✓	x	x	x	-	x	x	x	x
50. Dispensing of medication reported	✓	x	✓	-	x	✓	✓	x	x
51. Return of unused medication to pharmacist reported	✓	x	x	x	x	x	x	x	x
52. Death notification data reported by registry	✓	x	x	x	x	x	x	x	-

✓ included in voluntary assisted dying legislative framework

- safeguard with comparable intent included

x not included in voluntary assisted dying legislative framework. This may mean the law is silent on the matter, or that the law establishes a contrary parameter.

Safeguards and jurisdictional comparison	Proposed for Victoria	North America						Europe	
		Oregon, US, 1997	Washington, US, 2009	Vermont, US, 2013	California, US, 2016	Colorado, US, 2016	Canada, 2016	Belgium, 2002	Netherlands, 2002
Offences									
53. New offence to induce a person, through dishonesty or undue influence, to request voluntary assisted dying	✓	✓	✓	x	✓	✓	x	x	x
54. New offence to induce a person, through dishonesty or undue influence, to self-administer the lethal dose of medication	✓	x	x	x	✓	x	x	x	✓
55. New offence to falsify records related to voluntary assisted dying	✓	✓	✓	x	✓	✓	✓	x	x
56. New offence of failing to report on voluntary assisted dying	✓	x	x	x	x	x	✓	x	x
57. Existing criminal offences for the crimes of murder and aiding and abetting suicide continue to apply to those who act outside the legislation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oversight									
58. Guiding principles included in legislation	✓	x	x	x	x	x	✓	x	x
59. Oversight body is an independent statutory body	✓	x	x	x	x	x	x	✓	✓
60. Functions of oversight body described in legislation	✓	x	–	x	x	–	x	✓	✓
61. Oversight body reviews compliance	✓	x	–	✓	–	✓	–	✓	✓
62. Oversight body reviews all cases of voluntary assisted dying	✓	x	–	x	✓	x	–	✓	✓
63. Oversight body has referral powers for breaches	✓	–	–	–	–	–	–	✓	✓
64. Oversight body also has quality assurance and improvement functions	✓	x	x	x	x	x	x	✓	✓
65. Oversight body has expanded multidisciplinary membership	✓	x	x	x	x	x	x	✓	✓
66. Oversight body reports publicly	✓	✓	✓	✓	✓	✓	✓	✓	✓
67. Five year review of the legislation	✓	x	x	x	x	x	✓	x	x
68. Guidelines to be developed for supporting implementation	✓	x	x	x	✓	x	✓	x	x

✓ included in voluntary assisted dying legislative framework

– safeguard with comparable intent included

x not included in voluntary assisted dying legislative framework. This may mean the law is silent on the matter, or that the law establishes a contrary parameter.

Section B: Safeguards and jurisdictional comparison: key features

Jurisdictional comparison: key features	North America										Europe	
	Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>		Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>			
Access	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria	Proposed for Victoria
1. Voluntary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. 18 years and over	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Residency requirement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Limited to those with decision-making capacity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Must be diagnosed with condition that meets restrictive set of criteria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. End of life is clearly defined	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7. End of life condition combined with requirement for suffering	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
8. All of the eligibility criteria must be met	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Mental illness alone does not satisfy the eligibility criteria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10. Disability alone does not satisfy the eligibility criteria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Jurisdictional comparison: key features	Proposed for Victoria		North America										Europe		Netherlands 2002
	Request		Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>					
11. Must be initiated by the person themselves	✓		Request is written and witnessed by two independent individuals. Requests repeated with 15 days waiting period between two oral requests.	Request written and witnessed by two independent individuals. Second oral request reiterated at least 15 days after initial oral request. Prescription at least 48 hours after written request.	Written request in presence of two independent witnesses. Requests repeated with 15 days waiting period between two oral requests. Prescription at least 48 hours after request.	Two oral requests 15 days apart and a written request, witnessed by two individuals.	Two oral requests separated by at least 15 days and a written request which is witnessed by two independent individuals.	Request is written and witnessed by two independent individuals. 10 days between written request and the day on which medical assistance in dying is provided. Supports those with communication difficulties	Request must be voluntary, well-considered and repeated. Request in writing. May be included in an advance directive.	Request must be voluntary and well-considered. No written request required (unless person has lost capacity).					
12. No substitute decision makers allowed	✓														
13. Cannot be included as part of an advanced directive	✓														
14. Health practitioner prohibited from raising voluntary assisted dying	✓														
15. Person must make three separate requests	✓														
16. Written request witnessed in the presence of a medical practitioner	✓														
17. Two independent witnesses to request	✓														
18. Specified time must elapse between requests	✓														
19. Additional time required to elapse between steps of completing process	✓														
20. Must use independent accredited interpreter (if an interpreter is required)	✓														
21. No obligation to proceed, may withdraw at any time	✓														

Jurisdictional comparison: key features	Proposed for Victoria		North America						Europe		
	✓		Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>	
Assessment											
22. Eligibility and voluntariness assessed by medical practitioners	✓		Attending physician assesses eligibility and informs patient. Consulting physician confirms and verifies. Counselling referral if suffering from psychiatric or psychological disorder or depression causing impaired judgement.	Attending physician assesses eligibility and informs patient. Refers to consulting physician for confirmation of diagnosis and verification that patient is competent and acting voluntarily. Counselling referral if suffering from psychiatric or psychological disorder or depression causing impaired judgement.	Physician assesses eligibility and informs patient. Refers to second physician for medical confirmation. Verifies judgement not impaired or referred for evaluation.	Attending physician assesses eligibility and informs patient. Refers if indication of mental disorder. Consulting physician conducts second assessment, and referral if required.	Attending physician assesses eligibility and informs patient. Refers to consulting physician for confirmation. Refers if suffering from mental disorder that impacts on decision making capacity.	Assessment undertaken by medical practitioner, who must also ensure another practitioner has given written confirmation of person meeting criteria	Assessment is undertaken by one physician, who consults an independent physician about the disorder. If the person is not expected to die in the near future, a psychiatrist or specialist in the disorder must conduct a second assessment and confirm the suffering cannot be alleviated.	Assessment undertaken by one physician who has consulted with one other independent physician who has seen the person and given written opinion.	
23. Must be two separate and independent assessments by medical practitioners	✓										
24. Assessing medical practitioners must have high level of training/experience	✓										
25. Assessing medical practitioners must have undertaken prescribed training	✓										
26. Both assessing medical practitioners required to properly inform person	✓										
27. Referral for further independent assessment if there is doubt about decision-making capacity	✓										
28. Coordinating medical practitioner must confirm in writing that they are satisfied that all of the requirements have been met	✓										

Jurisdictional comparison: key features	Proposed for Victoria	North America				Europe			
		Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>
Medication management									
29. Person required to appoint contact person who will return medication if unused	✓	Dispensing record filed with authority. Silent about unused medication.	Any medication not used must be disposed of by lawful means.	Department of Health shall adopt rules for safe disposal of unused medications.	Unused medication personally delivered to facility or disposed of by lawful means.	Unused medication returned to physician or disposed of by lawful means.	Medical practitioner informs pharmacist of purpose of medication. Silent about unused medication.	Legislation is silent on medication management	Legislation is silent on medication management
30. Medical practitioner must obtain a permit to prescribe the medication to the person	✓								
31. Medication must be labelled for use, safe handling, storage and disposal	✓								
32. Pharmacist also required to inform the person	✓								
33. Medication must be stored in a locked box	✓								
Administration									
34. Medication must be self-administered (except in exceptional circumstances)	✓	Medication must be self-administered. No option for physician administration of medication	Medication must be self-administered. No option for physician administration of medication	Medication must be self-administered. No option for physician administration of medication	Medication must be self-administered. Requires form 48 hours before self-administration. No option for physician administration.	Medication must be self-administered. No option for physician administration of medication.	Medication may be self-administered or administered by medical practitioner or nurse	Provides for physician administered only.	Physician may administer or assist in self-administration.
35. If physical incapacity medical practitioner may administer	✓								
36. Additional certification required if administered by medical practitioner	✓								
37. Witness present if medical practitioner administers	✓								

Jurisdictional comparison: key features	Proposed for Victoria	North America										Europe	
		Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>				
Mandatory reporting													
43. Reporting forms set out in legislation	✓	Request form is included in legislation.	Administratively required documentation and a copy of dispensing record filed with Department of Health, Department conducts annual review of all records.	Physician to file a report with department of health documenting completion of all the requirements.	Request form, interpreter form, final attestation included in legislation. Also included are attending physician and consulting physician checklist and compliance forms and follow up forms. Department of Health shall collect and review the information.	Request form is included in legislation. Physician documents information in individual's medical record. Dispensing record filed with Department. Department conducts annual review of a sample of records.	Minister for Health makes regulations for provision and collection of information.	Oversight body sets out a registration form that must be filled in by physician whenever lethal dose of medication is administered. Must be submitted within four days.	Physician notifies municipal autopsy via form and provides report on observance of due care requirements.				
44. Reporting mandated at a range of points and from a range of participants to support accuracy	✓	Details of request and assessment only filed in patient's medical record.											
45. First assessment reported to Board	✓												
46. Second assessment reported to Board	✓	Health care provider files copy of dispensing record with authority.											
47. Final certification for authorisation submitted to Board	✓	Authority conducts annual review of a sample of records.											
48. Additional form reported to Board if medication administered by medical practitioner	✓												
49. Prescription authorisation reported by DHHS to Board	✓												
50. Dispensing of medication reported to Board	✓												
51. Return of unused medication to pharmacist reported to Board	✓												
52. Death notification data reported to BDM and collected by Board	✓												

Jurisdictional comparison: key features	Proposed for Victoria		North America						Europe	
		✓	Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>
Offences										
53. New offence to induce a person, through dishonesty or undue influence, to request voluntary assisted dying		✓	Includes offences for forging or altering requests and coercion.	Includes offences for forging or altering requests and coercion.	No offences included.	Includes offences for forging or altering requests and coercion.	Includes offences for failing to comply with safeguards and requirements and for forgery and destruction of documents	Does not set out offences. If Commission determines that physician has not acted in accordance with legislation may refer to public prosecutor.	Offences for inciting another to commit suicide or intentionally assists another or provides with means to do so.	
54. New offence to induce a person, through dishonesty or undue influence, to self-administer the lethal dose of medication		✓								
55. New offence to falsify records related to voluntary assisted dying		✓								
56. New offence of failing to report on voluntary assisted dying		✓								
57. Existing criminal offences for the crimes of murder and aiding and abetting suicide apply to those who act outside the legislation		✓								

Jurisdictional comparison: key features	Proposed for Victoria	North America										Europe	
		Oregon, US 1997 <i>Death with Dignity Act</i>	Washington, US 2009 <i>Death with Dignity Act</i>	Vermont, US 2013 <i>Patient Choice at End of Life Act</i>	California, US 2016 <i>End of Life Option Act</i>	Colorado, US 2016 <i>End of Life Options Act</i>	Canada 2016 <i>Medical Assistance in Dying Act</i>	Belgium 2002 <i>Act on Euthanasia</i>	Netherlands 2002 <i>Termination of Life on Request and Assisted Suicide (Review Procedures) Act</i>				
Oversight													
58. Guiding principles included in legislation	✓	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	No distinct statutory oversight body.	Establishes a Commission that reviews reporting forms to determine if there has been compliance.	Establishes Regional Review Committees who determine if physician has acted in accordance with the requirements of due care.	Committees issue annual report
59. Board is an independent statutory body	✓	Oregon Health Authority reviews only a sample of records maintained.	Department of health annually reviews all records maintained.	Department of Health shall adopt rules to facilitate collection of information regarding compliance.	Department of Public Health collects and reviews the submitted information.	Department of health and environment annually reviews a sample of records maintained.	Minister of Health to make regulations for the collection of information for monitoring.	Commission comprised of 16 members: 8 doctors, 4 lawyers, 4 others.	Minister of Health to make regulations for the collection of information for monitoring.	Minister of Health to make regulations for the collection of information for monitoring.	Commission comprised of 16 members: 8 doctors, 4 lawyers, 4 others.	Committees issue annual report	Committees issue annual report
60. Board functions described in legislation	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
61. Board reviews compliance	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
62. Board reviews all cases of, and each attempt to access, voluntary assisted dying	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
63. Board has referral powers for breaches	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
64. Board also has quality assurance and improvement functions	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
65. Board has expanded multidisciplinary membership	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
66. Oversight body reports publicly	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
67. Five year review of the legislation	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report
68. Guidelines to be developed for supporting implementation	✓	Authority must publish annual report.	Department adopts rules to facilitate the collection of information regarding compliance.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department maintains records.	Department publishes a statistical report every year.	Department generates a biennial statistical report.	Department publishes a statistical report every year.	Department publishes a statistical report every year.	Commission publishes two-year reports	Committees issue annual report	Committees issue annual report



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