VOLUNTARY ASSISTED DYING

SHORT COMPANION PAPER TO THE CONSULTATION PAPER: A PROPOSAL FOR TASMANIA

LARA GIDDINGS MP AND NICK MCKIM MP

FEBRUARY 2013
In June 2010 we announced that we would be working together to prepare a Private Member’s Bill to allow for voluntary assisted dying for terminally ill Tasmanians. We did so at that time because we believed that there was a compelling case for law reform in this area. As we demonstrate through this Consultation Paper, the case for legalising a form of voluntary assisted dying has continued to strengthen since our announcement to develop a new Bill, and we have good reason to believe that the case in support of law reform will only continue to grow. As legislators we believe that the law in this area has not kept up with changes in medical practice, social values or the views of the vast majority of the community. It is time for change.

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

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

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

We know that the limited change we are proposing will not go as far as some people will want but we believe that the model we are putting forward is the most responsible approach.
We also appreciate that there are some people who are strongly opposed to voluntary assisted dying law reform and will not accept any form of assisted dying. We respect their views and the model we propose will protect their right to not access an assisted death or, if they are doctors, to not provide assisted dying.

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

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

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

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

Lara Giddings MP and Nick McKim MP
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ABOUT THE CONSULTATION PAPER AND THE CONSULTATION PROCESS

CONSULTATION PAPERS

Two papers have been released for consultation:

- a long and detailed paper, Voluntary Assisted Dying: A Proposal for Tasmania, that sets out our proposed model, associated issues and accompanying information, arguments and analysis in more detail; and
- a short companion paper which primarily presents our proposed model in a condensed form.

CONSULTATION PROCESS

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

A number of specific consultation questions are included throughout this document and in a consolidated list in Appendix 2 of this paper. These questions do not represent an exhaustive list, but are questions to which we are specifically interested in seeking feedback on. We also welcome your feedback on any other aspect of our proposed model. Your response can be as short or as detailed as you like. A detachable response form is provided for your convenience on page 30.

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

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

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

THE CASE FOR & AGAINST VOLUNTARY ASSISTED DYING LAW REFORM

(For further information regarding the discussion in this Part see Section 2 of the detailed Consultation Paper: A Proposal for Tasmania: pgs 6-18)

WHY ‘VOLUNTARY ASSISTED DYING’?

There are a range of different definitions used to cover the variety of forms of assisted dying, and many definitions are dependent on a specific context.

In this paper we use the term ‘voluntary assisted dying’ to mean medical intervention, at the request of an eligible patient, with the intention of causing the patient’s death in order to end their suffering.

This intervention could be undertaken:

- by the patient themselves (as in cases of ‘self-administered assisted dying’), or
- by the doctor (as in cases of ‘doctor-administered assisted dying’).
INCREASING SUPPORT FOR VOLUNTARY ASSISTED DYING LEGISLATION

In Tasmania, as in Australia generally, community opinion in favour of voluntary assisted dying has increased steadily over the last 20 years and remains at a very high level. The opinion poll results in support of voluntary assisted dying have been consistent no matter how the question has been asked.¹

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

…reliance upon public support for the legalisation of active voluntary euthanasia can never, of itself, be sufficient justification for reform of the law. Public opinion may quite possibly be misguided or misinformed, or may have failed to take into account the full implications of legalisation. Before the case for reform is made out, it must be shown that the consequences of legalisation have been considered, and that no harm is likely to result to society or its members if active voluntary euthanasia is legalised.²

We also share her conclusion that:

Within these confines, however, public opinion should be recognised as having some role in shaping the law, indicating, as it does, prevailing morality and the needs of the community. After all, ultimately, the law must serve the community and it must therefore be responsive to real social needs … Thus while evidence of community support for legalisation of active voluntary euthanasia would not of itself be decisive, it would undoubtedly be a relevant factor in determining the appropriateness of legalisation.³

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

THE CASE FOR VOLUNTARY ASSISTED DYING REFORM: PRINCIPLES AND VALUES

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

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

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

**PERSONAL AUTONOMY**

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

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

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

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

We are also very concerned that some people are taking their own lives ahead of time while they still can without implicating their loved ones and that this sometimes occurs by very unsatisfactory means and without medical support.

There is also clear evidence that doctors and family members are acting out of compassion and helping terminally ill patients to achieve an assisted death. However, without legal and professional guidance and oversight, this practice is clandestine, with all the problems that result from that kind of practice. Those doctors who aid terminally ill patients put themselves at risk of prosecution and professional sanction if their actions are discovered.

Having the option of accessing an assisted death can provide a sense of reassurance to terminally ill patients, even if they ultimately do not make that choice.

**PREVIOUS ATTEMPTS AT REFORM IN TASMANIA**

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

In May 2009, Nick McKim tabled the Dying with Dignity Bill 2009 in the House of Assembly. The Bill allowed for terminally ill patients who were experiencing intolerable pain and suffering to request the assistance of a doctor to end their lives. On 18 June 2009, the House of Assembly voted to send the Bill to the Joint Standing Committee on Community Development for investigation. The Committee issued its final report in October 2009 and, unlike the 1998 Committee which found that voluntary euthanasia should not be decriminalised, the 2009 Committee make no comment about this. The Dying with Dignity Bill 2009 was brought on for debate in the House of Assembly in November 2009 where it was defeated 15 votes to 7 with two Members absent. Some Members of Parliament said that while they supported voluntary euthanasia in principle, they held reservations about the workability of the model presented in the Bill.

In light of strong and increasing support for voluntary assisted dying within the community, as well as concerns that the law is condoning an existing and unregulated practice,¹ we believe the law as it currently stands is out of touch with public opinion and community expectations.

### CURRENT PRACTICES IN END-OF-LIFE CARE

In the contemporary medical treatment of patients suffering at the end of their lives, the principle of the 'double effect' has arisen out of “established medical ethics [which] permit a doctor to administer medication or other treatment with the intention to relieve suffering even if it is 'foreseen' that the patient's life may be shortened as a side-effect of the treatment.”⁸ Both the 1998 and the 2009 parliamentary reports found that this practice was occurring in Tasmania. We also note the Australian Medical Association’s (AMA) position statement on end-of-life care which explains that:

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

- not initiating life-prolonging measures
- not continuing life-prolonging measures
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.⁹

We recognise that many commentators acknowledge that this form of end-of-life management “has become an established part of medical practice and is relatively uncontroversial.”¹⁰ What is controversial is when action is undertaken by a doctor with the explicit intention of hastening a patient’s death, either with the patient’s request (and in the absence of specific assisted dying legislation) or without that patient’s request.

There are clear indications that in Australia (and elsewhere in jurisdictions that do not have specific voluntary assisted dying legislation) the law “has not prevented the practice of euthanasia or the intentional ending of life without the patient’s consent.”¹¹ There are also clear indications that in Australia doctors are making “medical end-of-life decisions explicitly intended to hasten the patient’s death without the patient’s request.”¹² Both the 1998 and 2009 Tasmanian parliamentary reports cited the 1997 study by Kuhse et al titled ‘End-of-life Decisions in Australian Medical Practice’. The data collected through this survey showed that “Australia had a significantly higher rate of intentional ending of life without the patient’s consent, both through the administration of drugs and by withholding or withdrawing treatment, than in the Netherlands.”¹³ The data showed that:

- 30.9 per cent of deaths were the result of a ‘double effect’ decision where medication such as opioids were administered to alleviate pain in such large doses that they had a probable life shortening effect;
1.8 per cent of all Australian deaths were the result of active voluntary euthanasia;

3.5 per cent of deaths were the result of active involuntary euthanasia; and

28.6 per cent were the result of passive voluntary or involuntary euthanasia. 14

Kuhse’s study showed that “in 30% of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient’s life, of which 4% were in response to a direct request from the patient.” 15 A similar study was referenced in the final report from the Commission on Assisted Dying in the United Kingdom. In 2009, a UK survey of 2,869 doctors who had treated a patient that had died in the previous year was undertaken. The results of the survey showed that “17.1 per cent of deaths had involved a ‘double effect’ decision. In 15.1 per cent of these deaths the doctor reported ‘knowledge of probable or certain hastening of end of life’ and in 2 per cent of the deaths the doctor reported ‘partly intending to end life’.” 16

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

… In some cases patients had difficulty ensuring that their wishes would be respected in regard to their medical treatment when they became incompetent … [And] there is evidence to suggest that abuses of the current prohibition on active voluntary euthanasia do occur and Tasmania may not be immune to such abuses. 17

The 1998 Committee also noted that “whilst the extent of active voluntary euthanasia may be contested there is sufficient evidence including anecdotal accounts given by witnesses to the Committee to suggest that it is a current practice.” 18 In her evidence to the 1998 Committee, Tasmanian academic Professor Margaret Otlowski highlighted the inconsistency between the law and contemporary medical practice. Otlowski submitted that:

Despite the strict legal prohibition of the practice, with the threat of the most serious criminal liability (i.e. for murder) the reality of the matter is that not infrequently, requests for active voluntary euthanasia are made by patients, and a significant proportion of doctors are responding to such requests.” 19

Otlowski further argues that “It is unsatisfactory to have a situation where it is commonly known that the law is being breached by the medical profession, yet breaches are usually ignored or pass unpunished.” 20 This kind of anecdotal evidence was repeated during the course of the 2009 Committee.

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

Otlowski argues that “if active euthanasia is in fact being practised, it is imperative that these decisions are based upon the patient’s choice rather than the idiosyncratic views of individual doctors … [and a] more permissive but regulated legal environment” will allow us to protect and respect the end-of-life preferences of terminally ill patients and provide protection to the doctors who assist them. 21
Palliative care is the “specialised care and support provided for someone living with a terminal condition. Palliative care also involves care and support for family members and carers. Palliative care is provided in a sensitive way, taking into account individual and family uniqueness, cultural and spiritual beliefs and lifestyle patterns.” A patient who is receiving palliative care will have an active, progressive and far-advanced terminal illness from which there is little or no prospect of cure. Palliative care aims to achieve the best quality of life for the patient, while also ensuring family members and carers are supported and provided with necessary information.

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

Voluntary assisted dying is different from palliative care, and we believe competent patients who are suffering from a terminal condition should have the option to voluntarily hasten their death when palliative care and other treatment options are not effective in meeting their needs and wishes.

**ADVANCE CARE PLANNING**

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

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

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

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

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

THE CASE AGAINST VOLUNTARY ASSISTED DYING REFORM

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

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

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

However, we have found that there are many claims and arguments against voluntary assisted dying legislation which, when subjected to careful scrutiny, do not meet the requirements of accuracy, relevance and intellectual credibility. These claims and arguments also fail to acknowledge the risks and disadvantages in the current system where voluntary assisted dying is forbidden, but still occurs. We have been unable to find any satisfactory substantiation of the repeated claims that voluntary assisted dying legislation constitutes a threat to society as a whole, to people in vulnerable groups (such as people with a disability or the elderly), to the role of the doctor, or to the doctor-patient relationship.

As mentioned above, opponents of voluntary assisted dying predominantly use these main arguments against law reform:

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

SANCTITY OF HUMAN LIFE

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

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

THE ‘SLIPPERY SLOPE’ ARGUMENT

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

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

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

The idea of a ‘slippery slope’ depends on a number of false assumptions, such as the belief that there will be “no plausible halting points between the initial commitment to a premise, action or policy and the resultant bad outcome.” The Royal Society of Canada Expert Panel’s report on end-of-life decision-making provides a detailed, erudite discussion on the general concepts involved in the ‘slippery slope’ approach. The Royal Society’s report concluded that the ‘slippery slope’ arguments “are, in almost all cases, logically invalid.” The report also states “Some slippery-slope arguments that can be found in the literature about assisted dying are good examples of fear-mongering rather than of a realistic assessment of the risks that might accompany the decriminalization of assisted dying.”

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

In relation to the issue of the impact on people in ‘vulnerable’ groups, a 2007 study by Battin et al asked the question “If physician-assisted suicide (PAS) and/or voluntary active euthanasia were legalised, would this disproportionately affect people in ‘vulnerable’ groups?” Using the data available in the annual reports on the operation of the Oregon and Dutch systems, the researchers analysed whether vulnerable groups of patients (such as the elderly or minors, people from racial or ethnic minorities or people with a physical disability) were over-represented in the statistics of patients who received an assisted death in those jurisdictions.
In response to the concerns that elderly people would be at risk, the research showed that in Oregon “Persons aged 18-64 were over three times more likely than those over age 85 to receive assisted dying … [and] In the Netherlands, rates of assisted dying were lowest in the people over 80.” The research concluded that “there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying – concerns that death in this way would be practiced more frequently on persons in vulnerable groups.”

We recognise the concerns that opponents of voluntary assisted dying have that “the small number of people who would likely to benefit from assisted dying legislation did not justify the risk to the much larger number of potentially vulnerable people.”

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

Indeed, one of the key arguments used to justify the ‘slippery slope’ hypothesis is the incidence of doctors using drugs with the intention of ending a patient’s life without the patient’s explicit request. This practice would only be caused by voluntary assisted dying legislation if it only occurred in those places with such legislation. This is certainly not the case as this practice occurs in Australia and in many other countries that do not have specific voluntary assisted dying legislation. It is also the case that the incidence of the practice of intentionally ending a patient’s life without the patient’s explicit request has dropped significantly in the Netherlands and Belgium following the enactment of their legislation in 2002. Appendix 6 of the longer Consultation Paper details information on the decrease that has occurred in the Netherlands from a high of 0.8 per cent per annum in 1990 (approximately 1000 deaths) to 0.4 per cent in 2005 (approximately 550 deaths) and to a low of 0.2 per cent in 2010.

THE ROLE OF THE DOCTOR

The third main argument against voluntary assisted dying centres on the role of the doctor. This argument holds that “it should never be a doctor’s job to kill. His or her obligation is to cure, to palliate and to care, not to end a patient’s life.” The Hippocratic Oath is often referred to as the basis for this view, although for very good reasons it has been replaced by codes such as the Australian Medical Association’s Code of Ethics. The Hippocratic Oath is an oath that requires allegiance to ancient Greek gods, refers only to male doctors and forbids surgery: it is clearly not a relevant model for 21st century medical care and treatment.

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

A further fear expressed about the role of the doctor in a legislated system of voluntary assisted dying is the damage that could be caused to the relationship of trust between a doctor and his or her patient, should a doctor actively participate by providing assistance. We are not aware of any evidence that this damage has occurred as a result of voluntary assisted dying legislation that has now been in place for many years. In fact, there are indications that it has not occurred. For example, according to a survey in
2008, public trust in doctors in the Netherlands was at 91 per cent, amongst the highest in Europe, with Belgium not far behind at 88 per cent.44

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

We remain concerned about the risks of allowing assisted dying to occur in an unregulated environment. As Otlowski argues, not only is there a “very real risk of abuse if the law condones what is an unregulated practice. Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism, and in the belief that they are acting in the patient’s best interests.”45 One of our aims for proposing this model for voluntary assisted dying legislation is to encourage frank and open conversations that will improve provision of information and communication between the doctor and patient around end-of-life expectations. We believe this will improve, not erode, the doctor-patient relationship.

CONCLUSION

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

We firmly believe that parliamentarians have a responsibility to act unless there are compelling grounds not to, such as evidence of major negative effects for some individuals, groups of patients, or for the community more generally. However, evidence shows that consistently expressed fears about voluntary assisted dying law reform have been found in practice to be unjustified and vulnerable groups have not been put at increased risk where voluntary assisted dying law reform has been achieved.46

Our society has changed significantly in many ways over the past decades. We now all have greater expectations about the kinds of choices we can make about our own lives. Attitudes towards rights and freedoms and the value of ‘quality of life’ have also changed, as has medical treatment options, especially at the end-of-life. We know that the vast majority of the population want a legal option for assisted dying in addition to the current legal right to refuse treatment or withdraw from treatment.

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

We recognise and acknowledge fears expressed by opponents of voluntary assisted dying with regard to the possible risks posed to vulnerable groups. We recognise that close and constant attention must be given to the operation of laws that allow for any form of voluntary assisted dying and have made provision for this in our proposed model. We have sought to improve safeguards as a result of learning from overseas experience and based on a well-founded assessment of the risks. We are convinced that after intense scrutiny, researchers have conclusively shown that there is “no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.”47

So long as the practice of euthanasia occurs in an unregulated environment, patients remain at risk of being abused. We believe that having legislation to regulate voluntary assisted dying would provide safeguards for both patients and doctors, and would reduce the level of non-voluntary euthanasia. The aim of voluntary assisted dying legislation is not to replace the role of palliative care or other treatments in providing care for the terminally ill at the end-of-life. Rather, we consider it a compassionate option for the small number of terminally ill patients for whom
The evidence from overseas shows that over the past fifteen years it has been possible to create a safeguarded legislative framework that allows for medical assistance in death, provided that a number of specific criteria and reporting requirements are met.

Palliative care cannot relieve all their pain and suffering.

(For further information regarding the discussion points presented in this Part, see Sections 2 and 3 of the detailed Consultation Paper: A Proposal for Tasmania.)

VOLUNTARY ASSISTED DYING LEGISLATION IN PRACTICE

(For further information regarding the discussion in this Part, see Section 4 of the detailed Consultation Paper: A Proposal for Tasmania: pgs 25-27)

KEY SIMILARITIES AND DIFFERENCES

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

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

These are:

- The request for assistance must be voluntary, consistent and persistent.
- The person making the request must be mentally competent and capable of making the decision.
- The doctor’s involvement is voluntary.
- More than one doctor must be involved.
- The patient is not offered assisted dying, they must request it.
- There are specific reporting and monitoring requirements that must be adhered to.
- The patient must be a resident of the jurisdiction.

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

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

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

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

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

PROPOSAL FOR A TASMANIAN BILL

(For further information regarding the discussion in this Part, see Section 5 of the detailed Consultation Paper: A Proposal for Tasmania: pgs 28-66.)

WHAT THE PROPOSED MODEL IS DESIGNED TO ACHIEVE

Legislation to allow for voluntary assisted dying in Tasmania would not give anyone an unfettered right to medical assistance to help them die. What it would provide is the opportunity for a terminally ill patient who makes a voluntary request for assisted dying to have their request considered thoroughly, carefully and compassionately. Like other laws on voluntary assisted dying, our proposed model is designed to establish safeguards through clear requirements that must be met and processes that must be followed by doctors in dealing with the request and providing assistance. It is also designed to have clear reporting requirements that protect patient and doctor privacy while enabling scrutiny of data and reporting.

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

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

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

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

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

ABOUT THE PROPOSED MODEL

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

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

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

Through the literature on voluntary assisted dying frameworks and reviewing the safeguards and provisions contained in the legislation in place in Oregon, Washington, the Netherlands and
Belgium we have identified 15 key provisions that we believe should be included in any responsible legislation for Tasmania on voluntary assisted dying. These provisions, which provide safeguards against abuse, set out requirements in relation to: voluntariness; mental competence; informed decision; the person’s condition or experience of suffering; the type of assistance; the age of the patient; requirement for a written request; residency requirements; consultation and referral requirements; the identity of the assisting doctor; specified waiting (or ‘cooling-off’) periods; family notification; due medical care and safe handling of prescription medicines; opportunity to rescind the request; and the reporting and scrutiny of cases.

VOLUNTARINESS

PROPOSED MODEL

- We propose that only voluntary requests for assisted dying be considered.
- There will be multiple checks during the process to confirm the persistence and consistency of the voluntary request, in addition to other provisions, that together contribute to confirmation of the voluntary nature of the request.
- Requirements to establish the voluntary nature of the request will include a signed written request by the patient that confirms that their request is voluntary, informed and is not being made as the result of coercion or under duress.
- We propose that to help confirm the voluntary nature of the request the patient identify the reasons for their request. This data will be collected by the independent oversight body.
- The attending doctor, the consulting doctor and the witnesses to the patient’s written request will contribute to the confirmation of the voluntary nature of the request.

MENTAL COMPETENCE

PROPOSED MODEL

- We propose that only competent patients can access an assisted death. Competent means that the patient is able to communicate health care decisions for themselves and is not suffering from impaired decision-making due to a psychiatric or psychological disorder or depression.
- Both the attending doctor and consulting doctor must confirm that the patient is competent.
- If either doctor is unsure about the patient’s competence then they must take all necessary steps to resolve that uncertainty.
- The witnesses to the patient’s written request must also confirm that the patient is competent to the best of their knowledge and belief.

RATIONALE

We recognise that “Considerable disagreement exists over the prevalence of mental disorder in individuals who request physician assisted suicide, and the influence that mental disorder may have on capacity to request assisted dying.” Other research has concluded that “a level of appropriate sadness or depression is considered normal in terminally ill patients approaching the end of their life. Further, the existence of depression does not necessarily mean that a person lacks mental capacity.” The research of Lewis and Black confirms this finding noting “In
both the Netherlands and Oregon, depression is significantly less prevalent in granted requests than in refused requests, and in the Netherlands, severe depression is not significantly present in requests generally. This evidence would appear to suggest that individuals with depression who receive assisted dying nevertheless retain capacity to make a request.54

In the Netherlands, decisionally competent patients suffering from therapy resistant depression have been able to access an assisted death in the Netherlands and examples of these cases are detailed in the annual reports of the Regional Euthanasia Review Committees. What has been important in these cases is the confirmation by the physician and the independent consultant that “the patient’s suffering was lasting and unbearable,” 55 and that together the patient and the physician have come to the conclusion “that there was no other reasonable solution for the situation he was in”56 as required under the Dutch Act. We recognise that cases such as these are very sensitive and, particularly for observers outside the medical profession, can be more difficult to make sense of than cases that involve a patient suffering from a terminal illness such as cancer.

The question of whether a person with dementia should be able to request an assisted death often comes up in the debates around assisted dying. In the Netherlands a small number of patients with dementia have accessed an assisted death and these cases have been documented in the annual reports of the Regional Euthanasia Review Committees. In 2010 there were 25 notifications involving patients suffering from dementia and in each case the Committees found that the patient’s doctor had acted in accordance with the due care criteria of the Dutch Act.57

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

INFORMED DECISION

PROPOSED MODEL

- We propose that to be eligible for an assisted death a patient must make an informed decision.
- To ensure the patient is making an informed decision, we propose that the attending doctor must inform the patient of:
  - their medical diagnosis and prognosis;
  - the potential risks associated with taking the medication to be prescribed;
  - the probable result of taking the medication to be prescribed; and
  - the feasible alternatives such as palliative care, pain control and hospice care.
- In signing the doctors’ declaration form both the attending doctor and the consulting doctor will certify that the patient is making an informed decision.

RATIONALE

Under our proposed model the patient’s attending doctor would be required to inform the patient of their prognosis and diagnosis, the risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives to an assisted death such as palliative care and pain management strategies. This approach will allow doctors to explore different treatment options to an assisted death with their patients, while respecting their patient’s right to refuse any treatments that they consider burdensome. This conversation could also play an important role in helping to screen for involuntary requests.
THE PERSON’S CONDITION AND EXPERIENCE OF SUFFERING

PROPOSED MODEL

- We propose that the person accessing assistance to die must be terminally ill.
- ‘Terminally ill’ means the advanced stages of an incurable and progressive medical condition, due to disease or injury, that can be reasonably expected to cause the death of that person without significant medical intervention.
- ‘Advanced stages’ means as determined in line with accepted medical practice, guidelines or protocols.
- Both the attending and consulting doctors will be required to confirm that the patient is terminally ill.
- We propose that the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient’s condition and to relieve the patient’s suffering adequately and to the satisfaction of the patient.
- We are proposing that no person shall qualify for an assisted death solely on the basis of disability or age.

RATIONALE

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

Our model aims to give priority to the patient’s wishes to not endure prolonged suffering or futile treatments, while also respecting the doctor-patient relationship. We recognise that the best options for patients are determined through cooperative and respectful relationships with their doctor/s when both parties are well informed.

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

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

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

As the 2010 annual report from the Regional Euthanasia Review Committees in the Netherlands states:

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

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

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

CONSULTATION POINT:

Under our proposal, the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient’s condition and to relieve the patient’s suffering adequately and to the satisfaction of the patient.

- Should ‘unbearable’ or ‘unrelievable’ suffering be included as a separate eligibility criteria?
- Should eligibility be linked to an anticipated life-expectancy?
- Should patients with non-terminal yet progressive illnesses be eligible for an assisted death?

(For further information regarding this Consultation Point, see Section 5.6 “The Person’s Condition and Experience of Suffering” in the detailed Consultation Paper: A Proposal for Tasmania: pgs 39-43)

TYPE OF ASSISTANCE

PROPOSED MODEL

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

RATIONALE

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

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

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

... may be appropriate and adequate in many cases, [but] it does not represent a complete solution to the existing difficulties in this area. There will always be a proportion of patients who are physically unable to commit suicide. For others, the concept of suicide may be objectionable, yet they may willingly seek active voluntary euthanasia [doctor-administered assisted dying]. If the legal
reform response were limited to physician-assisted suicide, these categories of people would not be provided for.\textsuperscript{62}

Similarly, in a review of ten proposed Bills before state legislatures in the United States, Assistant Professor Russell Korobkin observed that “Legalizing PAD [physician-assisted death] but not voluntary euthanasia could be viewed as discriminating against incapacitated individuals, even though they have a moral claim to the right to end their lives that is equally as strong.”\textsuperscript{63}

In proposing a model that includes both self-administered assisted dying and doctor-administered assisted dying we want to ensure that the law does not exclude patients who would be eligible for self-administered assisted dying, but due to some disability or incapacity are physically unable to self-administer the medication. We are also aware that in the Netherlands some doctors “who intend to provide assistance with suicide sometimes end up administering a lethal medication themselves because of the patient’s inability to take the medication, or because of problems with the completion of physician-assisted suicide [self-administered assisted dying].”\textsuperscript{64}

For example, in the 2010 annual report from the Dutch Regional Euthanasia Review Committees it was reported that there were 3,136 notifications consisting of 2,910 cases of euthanasia (where the doctor administered the lethal medication), 182 cases of assisted suicide (where the patient administered the medication themselves) and 44 cases involving a combination of the two.\textsuperscript{65} While the report does not elaborate on the reasons why there were 44 cases involving a combination of both assisted suicide and euthanasia, it is reasonable to assume that in some cases the doctor was required to intervene and perform euthanasia if the patient’s attempt at assisted suicide was not successful. This intervention is required because the doctor’s participation must satisfy the due care criteria (‘exercise due medical care and attention in terminating the patient’s life or assisting in his suicide’).

Similar problems with the self-administration of the lethal medication have been reported in Oregon. For example, in the Annual Report’s on the operation of Oregon’s Death with Dignity Act, it has been reported that between 1999 and 2011 there were 22 cases of complications involving regurgitation of the medication and 5 cases recorded where a patient ingested the medication before regaining consciousness. In these cases the patient later died of their underlying illness days or months later and their deaths were not recorded as a death under the provisions of the Act.\textsuperscript{66} As Otlowski notes, assistance from the attending doctor “to complete the task would not appear to be possible under the Oregon model, and one can imagine nothing more disturbing for a patient than to awaken from a failed attempt.”\textsuperscript{67}

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

\[ \ldots \text{the presence of the prescribing physician or other health care provider may not seem to be of great importance. However, it may be desirable to have a healthcare provider present (or at least in the vicinity) in the event of complications. Moreover, the absence of health care providers, in particular, the prescribing physician, may leave the individual who dies feeling abandoned by the very people who have assumed a fiduciary commitment to them in their terminal phase of life.}\]\textsuperscript{68}

\textbf{CONSULTATION POINT:}

Opinion polling consistently shows strong support for a doctor being able to provide a lethal dose of medication to a terminally ill patient.

- Do you think the patient’s attending doctor should be able legally to administer the fatal dose?
- Should voluntary assisted dying be limited to the patient self-administering the fatal dose?
- If only self-administered assisted dying is legal, what assistance should be provided to those who are physically unable to commit the act?

(For further information regarding this Consultation Point, see Section 5.7 “Type of Assistance” in the detailed Consultation Paper: A Proposal for Tasmania: pgs 43-46)

**AGE OF THE PATIENT**

**PROPOSED MODEL**

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

**WRITTEN REQUEST**

**PROPOSED MODEL**

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

- In the event the patient is physically unable to sign a request the patient may designate someone to sign on their behalf. This person cannot be a witness to the request.
- A copy of the patient's written request, and a notation of both oral requests, is to be kept on the patient's medical record.
- The original copy of the written request is to be forwarded to the independent oversight body by the attending doctor.
- Under our proposed model a person will not be able to request an assisted death through an advance directive.

**RATIONALE**

A written request is an important record of the patient's intent that still remains after the oral requests have been made and discussed.

As a safeguard, the written request would need to be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

The witnesses to the written request play an important role in confirming the voluntariness of the patient's request. In their report on safeguards, Lewis and Black observe that “In Oregon some cases have raised voluntariness concerns due to the failures to meet the witnessing requirements designed to ensure voluntariness. However, it is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness.”

In order to
avoid similar concerns being raised in Tasmania, we are proposing that the original copy of the written request would be forwarded to the independent oversight body by the attending doctor.

This will allow the oversight body to ensure the voluntariness of the request has been confirmed before the request proceeds further. In addition, a copy of the written request is to be attached to the patient’s medical record and notations of the patient’s oral requests are also to be recorded on the patient’s medical record.

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

A key difference between the approach to voluntary assisted dying taken in the Netherlands and Belgium with that of Oregon and Washington is that the Dutch and Belgian Acts allow for a patient to access voluntary assisted dying through an advance directive. This approach allows the patient to make a written statement requesting an assisted death in the future event that they suffer from an incurable illness and are not conscious to make a request at the time.

Of the patients that accessed an assisted death by advance request in Belgium between 2002 and 2007, only 2.1 per cent were by an advance request.

The Commission on Assisted Dying considered the option of whether an advance request should be recommended as part of an assisted dying regime in the United Kingdom. They concluded that:

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

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

We believe that mental competence and the confirmation of the persistent nature of the patient’s wishes at the time that assisted dying is provided are important safeguards in our proposed model of voluntary assisted dying.

Accordingly, we do not think it is appropriate to allow for a patient to be provided with an assisted death through a written advance directive if they have lost competence and the ability to confirm the persistent nature of their request. As discussed, Tasmanian adults can register an ‘Enduring Guardian’ with the Guardianship and Administration Board.

Appointing an Enduring Guardian allows an individual to give “their instructions about decisions that the Enduring Guardian must carry out, so long as those decisions are lawful, clearly expressed and practically possible to carry out.”

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

**CONSULTATION POINT:**

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

(For further information regarding this Consultation Point, see Section 5.9 “Written Request” in the detailed Consultation Paper: A Proposal for Tasmania: pgs 47-49)
RESIDENCY REQUIREMENT

PROPOSED MODEL

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

RATIONALE

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

While the Dying with Dignity Bill 2009 sought a 12 month residency requirement, we are not proposing that the patient must have been living in Tasmania for any specified length of time. In this regard we note that it is a requirement of the Commonwealth Electoral Act 1918 that an individual have resided at their address for at least one month before changing their enrolment details on the State and Commonwealth electoral rolls. This requirement suggests that an adult can live in any state or territory for a period of one month before being considered a resident of that jurisdiction.

CONSULTATION AND REFERRAL REQUIREMENTS

PROPOSED MODEL

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

RATIONALE

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

We are not proposing that the legislation require that the doctors be ‘independent’ of each other in the sense that they are not associated in any way or are not known to each other because in the Tasmanian context, our small population makes that unreasonable and impractical. This is particularly the case in small town and rural areas. However, every effort needs to be made to avoid the perception of influence of one doctor over the other, for example where there is a close family relationship between the attending and consulting doctor or where one doctor is employed by the other.
To help ensure independent physicians are available to provide advice and be consulted on requests in both the Netherlands and Belgium consultation services have been set up. In the Netherlands there is the ‘Support and Consultation on Euthanasia’ (SCEN) program which was established by the government with the aim of professionalising “the consultation process and thus make physicians take responsibility for the quality of the practice.”

Like the SCEN program in the Netherlands, in the Flanders region of Belgium the ‘Life EndInformation Forum’ (LEIF) has been established and provides an independent consultation for physicians treating patients at the end of their lives.

The main difference between the organisations is the wider scope of services provided by LEIF than the SCEN program. This is consistent with the broader legislative approach taken in Belgium where a law on accessing palliative care and patient rights were passed by the Belgian parliament at the same time as the Act on Euthanasia. LEIF physicians accordingly provide a consultation service to attending physicians and patients that covers not only euthanasia but all the other aspects of end-of-life care. Van Wesemael et al concluded in their study of SCEN and LEIF that:

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

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

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

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**CONSULTATION POINT:**

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

(For further information regarding this Consultation Point, see Section 5.11 “Consultation and Referral Requirements” in the detailed Consultation Paper: A Proposal for Tasmania: pgs 51-54)
IDENTITY OF THE ATTENDING DOCTOR

PROPOSED MODEL

- We propose that the attending doctor be the doctor who has the primary responsibility for the care of the patient and the treatment of the patient’s terminal condition.
- A doctor will always retain the right to refuse to assist a patient that requests an assisted death.
- If the patient has their request for assistance refused they may request that their relevant medical records be forwarded to a new doctor.

RATIONALE

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

We recognise that some doctors will be willing to provide assistance to their patients, and others will not.

If a patient’s doctor is unwilling to provide them with assistance, and that patient wishes to seek assistance from another doctor then they may request that their relevant medical records be forwarded to the new attending doctor.

WAITING PERIODS

PROPOSED MODEL

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

RATIONALE

Legislated waiting periods between a patient’s request and the provision of assistance are an important safeguard as it allows the patient “to fully consider the immense importance of their decision.”

We are mindful that, as we propose that eligible patients would need to have an advanced, progressive and incurable condition a lengthy and convoluted approval process would be inappropriate and too great a burden on the patient.

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

PROPOSED MODEL

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

RATIONALE

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

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

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

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

DUE CARE: SAFE HANDLING OF PRESCRIPTION MEDICINE

PROPOSED MODEL

- We are proposing that the lethal medication prescribed to an eligible patient must stay under the supervision of the attending doctor.

- For this reason the attending doctor will be required to collect the medication from the pharmacy and deliver it to the patient when it is to be taken.

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

RATIONALE

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

It is important that the lethal medication prescribed to an eligible patient stay under the supervision of the attending doctor and not be given to the patient until they choose to take it. For this reason we are proposing that the attending doctor will be required to collect the
medication from the pharmacy and deliver it to the patient at the time it is to be taken. Any unused medication is required to be returned to the pharmacy for safe disposal.

OPPORTUNITY TO RESCIND REQUEST

PROPOSED MODEL

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

RATIONALE

A legislated requirement that an eligible patient be offered the opportunity to rescind their request is an extremely important safeguard.

We are proposing an approach based on that in place in Oregon and Washington where a patient is able to rescind their request at any point during the process.

The attending doctor must also offer the patient the opportunity to rescind their request at a number of specific points during the process, including just before the patient takes the medication.

REPORTING AND SCRUTINY OF CASES

PROPOSED MODEL

- We propose that an independent oversight mechanism be established.
- This independent oversight body would be required to prepare an annual report on the operation of the Act to be tabled in Parliament.
- The independent oversight body would be required to check that the eligibility requirements of the legislation have been met before assisted dying is provided.
- We are proposing that at key points of the process, the oversight body must be notified by the patient’s attending doctor. The attending doctor must:
  - forward to the oversight body the original of the patient’s written request.
  - forward to the oversight body the original doctors’ declaration form signed by both the attending and consulting doctors certifying the eligibility of the patient.
  - notify the oversight body that a prescription has been written.
  - notify the oversight body of the death of a patient to whom a prescription for lethal medication has been written, but not ingested.
  - notify the oversight body of the death of a patient following administration of the lethal medication.
- The independent oversight body will be responsible for undertaking community education programs about the Act directed to both patients and their families and doctors.
- We propose that a full review of the Act be undertaken after 5 years of operation.
CONSULTATION POINT:

We are proposing that an independent oversight mechanism be established to monitor and report on the operation of voluntary assisted dying legislation.

- Do you think this body should take the form of an independent ‘committee’ (as occurs in Belgium and the Netherlands) or could this monitoring be undertaken by a government department (as occurs in Oregon and Washington)?

(For further information regarding this Consultation Point, see Section 5.17 “Reporting and Scrutiny of Cases” in the detailed Consultation Paper: A Proposal for Tasmania: pgs 62-66)
APPENDIX 1

FLOW CHART: PROPOSED MODEL OF VOLUNTARY ASSISTED DYING

On Day 1 the patient asks their doctor (the attending doctor) about assisted dying.

The attending doctor discusses what assisted dying involves with the patient and explores with them their palliative care and other treatment options. The doctor also encourages the patient to inform their family of their request. The doctor notes the oral request on the patient’s medical record.

→ The patient decides they no longer want an assisted death – process abandoned.

The patient understands what their treatment options are and wishes to continue.

→ Patients who are not aged over 18 or are not Tasmanian residents are ineligible.

The attending doctor is required to confirm that the patient is over 18 years of age and is a resident of Tasmania.

→ The patient can rescind their request at any time and in any manner.

On Day 3 the patient can complete the formal written request which is signed by two witnesses. The attending doctor is responsible for forwarding the original copy of the written request to the independent oversight body and for attaching a copy to the patient’s medical record.

→ If the answer to any of these questions is “no” the process cannot continue.

From Day 3 until the doctors’ declaration is signed by both doctors: the attending and consulting doctors separately assess whether the patient is terminally ill; is competent to make the decision; is acting voluntarily and has a clear and settled wish to die which they have reached without coercion; is aware of palliative care and other treatment options. If both doctors agree the patient meets these criteria the process can continue.

→ The patient can rescind their request at any time and in any manner.

Both doctors sign the doctors’ declaration form which certifies eligibility and the form is sent to the independent oversight body.

→ The patient can rescind their request at any time and in any manner.

14 day ‘cooling off’ period commences: the ‘cooling off’ period commences and lasts for 14 days from the date that both doctors have signed the doctors’ declaration form.

→ If the patient rescinds their request the doctor must return the unused medication to the pharmacy.

14 day ‘cooling off’ period concludes: the patient meets with the attending doctor at the end of the ‘cooling off’ period to reiterate their oral request for an assisted death.

→ The patient’s death is recorded as an assisted death. All medical records must be sent to the independent oversight body within 14 days.

The attending doctor can now write the prescription for life ending medication. The prescription must be sent to a pharmacy until it is to be dispensed.

→ If the patient rescinds their request the doctor must return the unused medication to the pharmacy.

The patient contacts the attending doctor and asks for the life-ending medication to be dispensed. The attending doctor collects the medication from the pharmacy and delivers it to the patient.

→ The annual report is tabled in Parliament by the Minister by 31 October each year.

The attending doctor gives the patient an opportunity to rescind their request before proceeding.

→ The annual report is tabled in Parliament by the Minister by 31 October each year.

The patient either administers the medication themselves (self-administered assisted dying) or the doctor administers it to the patient (doctor-administered assisted dying).

The patient’s death is recorded as an assisted death. All medical records must be sent to the independent oversight body within 14 days.

The independent oversight body compiles an annual report detailing all requests, prescriptions issued and deaths under the legislation.

The annual report is tabled in Parliament by the Minister by 31 October each year.
APPENDIX 2  📜 CONSULTATION POINTS

While these questions do not represent an exhaustive list, we are specifically interested in receiving feedback to the following questions. We also welcome your feedback on any other aspect of our proposed model.

Under our proposal, the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient’s condition and to relieve the patient’s suffering adequately and to the satisfaction of the patient.

- Should ‘unbearable’ or ‘unrelievable’ suffering be included as a separate eligibility criteria? (See pg 18.)

- Should eligibility be linked to an anticipated life-expectancy? (See pg 18.)

Opinion polling consistently shows strong support for a doctor being able to provide a lethal dose of medication to a terminally ill patient.

- Do you think the patient’s attending doctor should be able legally to administer the fatal dose? (See pg 20.)

- Should voluntary assisted dying be limited to the patient self-administering the fatal dose? (See pg 20.)

- If only self-administered assisted dying is legal, what assistance should be provided to those who are physically unable to commit the act? (See pg 20.)

- What provisions should be made for those patients who are physically unable to sign a request? (See pg 21.)

- Do you think a video recording of the request would be appropriate? Or should the patient be able to designate someone to sign the request on their behalf as occurs in Belgium? (See pg 21.)
• What are your views on the role of an independent consultation service in a legislated model of voluntary assisted dying? (See pg 23.)

• Should the consulting doctor have to meet face-to-face with the patient? (See pg 23.)
• Is it enough for them to just review the patient’s medical record? Could the utilisation of ‘telehealth’ or ‘e-health’ technology replace a face-to-face consultation? (See pg 23.)

We are proposing that an independent oversight mechanism be established to monitor and report on the operation of voluntary assisted dying legislation.
• Do you think this body should take the form of an independent ‘committee’ (as occurs in Belgium and the Netherlands) or could this monitoring be undertaken by a government department (as occurs in Oregon and Washington)? (See pg 27.)

• Any other feedback?

How to send your submission:
Post it to GPO Box 123, Hobart, Tasmania 7001.
Email it to premier@dpac.tas.gov.au
ENDNOTES

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

2 Margaret Otlowski, ‘Active Voluntary Euthanasia: A Timely Reappraisal’, University of Tasmania Law School Occasional 

3 Ibid.

4 House of Assembly Community Development Committee, ‘Report on the need for legislation on voluntary euthanasia’, 

Thomson, M. Phillips and M. Johnson (eds), British Social Attitudes: the 23rd report – Perspectives on a changing society, (London: 

6.

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

8 The Commission on Assisted Dying, “The current legal status of assisted dying is inadequate and incoherent …”, (London: 

9 Australian Medical Association, Position Statement on the Role of the Medical Practitioner in End of Life Care, (2007), available 
online at: 

10 Lorena Bartels and Margaret Otlowski, ‘A right to die? Euthanasia and the law in Australia’, Journal of Law and Medicine, 

11 Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, ‘End-of-life decisions in Australian medical 

12 Ibid.

13 Ibid.

14 Ibid.

15 Ibid.

16 The Commission on Assisted Dying, “The current legal status of assisted dying is inadequate and incoherent…”, p. 51.


18 Ibid, p. 33.

19 Ibid, p. 32.


22 Tasmanian Association for Hospice and Palliative Care, ‘About Palliative Care’, (2010), available online at: 

23 Ibid.

24 The Royal Australian College of General Practitioners, ‘Guidelines: Advance Care Plans’, (10 May 2007), available online 
at: 

25 Office of the Public Guardian, ‘Enduring Guardianship Infosheet’, (April 2011), available online at: 

26 Ibid.


28 House of Assembly Community Development Committee, ‘Report on the need for legislation on voluntary euthanasia’, 
p. 18.


Academies of Arts, Humanities and Sciences of Canada, November 2011), pp. 63-68.

31 Ibid, p. 64.

The current legal status of assisted dying is inadequate and incoherent … “, p. 81.
45 Otlowski, ‘Getting the law right on physician-assisted death’, p. 128.
46 See for example, Battin et al, ‘Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups’.
49 Ibid.
51 Lewis and Black were commissioned to produce an expert briefing paper for the Commission on Assisted Dying on legal safeguards. Their report is titled ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’ and is available at http://www.commissiononassisteddying.co.uk/wp-content/uploads/2012/01/ penney-lewis-briefing-paper.pdf. In this report Lewis and Black considered eight safeguards (the type of assistance; the person’s condition and/or experience of suffering; making the request for assistance; the age of the person requesting assistance; consultation and referral requirements; the identity of the assistor; due medical care; and the reporting and scrutiny of cases). To these eight safeguards we have also considered residency requirements, waiting periods, family notifications and the opportunity to rescind/revoke the request. We have separately considered mental capacity, voluntariness, informed decision making, and the written request which were considered by Lewis and Black under the heading ‘making the request for assistance’.
52 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted suicide’, p. 10.
54 Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 64.
55 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (§2(1)(b)).
56 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (§2(1)(d)).
61 Oregon Death with Dignity Act 1994 (§2.01(2)); Washington Death with Dignity Act 2008 (§2(2)).
64 Otlowski, ‘Getting the law right on physician-assisted death’, p. 137.
The annual reports on the operation Oregon’s Death with Dignity Act 1994 are published by the Oregon Public Health Division. The reports can be found online at: [http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx).

Otlowski, ‘Getting the law right on physician-assisted death’, p. 137.

Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 52.

Ibid, p. 11.


Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 39.

The Commission on Assisted Dying, ‘The current legal status of assisted dying is inadequate and incoherent …’, p. 310.


Commonwealth Electoral Act 1918 (§99).


Lewis and Black, ‘The effectiveness of safeguards in jurisdictions that allow assisted dying’, p. 66.

Van Wesemael et al, ‘Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium’. p. 3.

Ibid, p. 4.

Ibid.


Bazalgette and Bradley, “The legal and ethical status of assisted dying is inadequate and incoherent … .”, p. 83.

Ibid.


Ibid.


**BIBLIOGRAPHY**


