TABLES OF COMPARISON: SAFEGUARDS AND PROVISIONS OF EXISTING VOLUNTARY ASSISTED DYING LEGISLATION AND PROPOSALS[i]

THE PERSON'S CONDITION AND/OR EXPERIENCE OF SUFFERING

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
The patient must be suffering from a terminal disease which is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months" (§1.01(12)).	The patient must be suffering from a terminal disease which is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months" (§1(13)).	The patient's suffering must be "lasting and unbearable" (§2(1)(b)), and that there be "no other reasonable solution for the situation he was in" (§2(1)(d)). There is no requirement that the patient be diagnosed with a terminal illness.	Section 3 states that "the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident." There is no requirement that the cause of the patient's suffering be a terminal illness.	There is no requirement that the patient be terminally ill or suffering from a specified medical condition. However, lethal medication must be supplied and dispensed in accordance with federal laws and doctors must operate "within the limits of accepted professional practice."[ii]	To obtain medical aid in dying the patient must "be at the end of life"(undefined) and "suffer from an incurable serious illness"; " suffer from an advanced state of irreversible decline in capability"; and "suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable." (§26)

Tasmanian *Voluntary Assisted Dying Bill 2013*:

The Tasmanian approach was to provide a 'last resort' option to people at the end of their lives and as close to death as possible, and who had intolerable and unrelievable suffering.

S12 - "For the purposes of this Act, an eligible medical condition is an incurable and irreversible medical condition, whether caused by illness, disease or injury –
(a) that would result in the death of a person diagnosed with the medical condition and that is causing persistent and not relievable suffering for the person that is intolerable for the person; or
(b) that is a progressive medical condition that is causing persistent and not relievable suffering, for a person diagnosed with the medical condition, that is intolerable for the person –
and that is in the advanced stages with no reasonable prospect of a permanent improvement in the person's medical condition."

Specific last resort provision

S22 (2) and (3) provide the "last resort option". **S22(2)** states that the person's doctor "must discuss with the eligible person whether there are any relevant treatment options available that may adequately and to the satisfaction of the eligible person –
(a) improve the eligible person's medical condition; or
(b) relieve the eligible person's suffering".

S22(3) requires the doctor to provide assisted dying only "If the eligible person and the eligible person's primary medical practitioner are satisfied there are no relevant treatment options available as discussed [under S22(2)]".

MENTAL COMPETENCE

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
The patient must be capable of making and communicating health care decisions to their doctors (§1.01(3)). If either the attending or consulting physician are of the opinion that "the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement" they must refer the patient for counselling (§3.03).	The patient must be competent of making and communicating health care decisions to their doctors (§1(3)). If either the attending or consulting physician are of the opinion that "the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement" they must refer the patient for counselling (§6).	The patient's request must be "voluntary and carefully considered" (§2(1)(a)). Lewis and Black explain that "The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent."[iii]	The patient must be "legally competent and conscious at the moment of making the request" (§3.1).	Lewis and Black explain that "the person assisted with suicide must have capacity if their act is to be considered suicide. The physician must personally examine the person seeking assistance and assess their capacity according to the test set out in the Civil [Criminal] Code. Individual right to die associations have also developed their own tests."[iv] DIGNITAS' guidelines state that if there are concerns about the member's mental competence "or if there is a feeling that the member is obviously not making his/her decision free from external pressure but rather is being influenced by [someone else], the conversation will be continued by giving both DIGNITAS escorts the chance to speak with the member alone. If the doubts of both DIGNITAS escorts cannot be completely removed … then the AS will be cancelled."[v]	To obtain medical aid in dying, a patient must "be capable of giving consent to care" (§26(1))

Tasmanian *Voluntary Assisted Dying Bill 2013*:

Person must be capable/competent and has to be up to the primary doctor to determine if there are any indications of need for psychiatric assessment because judgement affected

S10(1) "For the purposes of this Act, an assisted dying request is an eligible request if the person making the assisted dying request – …
(c) is competent"

S3 (Interpretation*)* - *competent*, in relation to a person, means the person –
(a) has the ability to make and communicate, to health care providers, considered decisions in relation to the person's medical treatment, including communicating through persons familiar with the person's manner of communicating; and
(b) is not suffering from a psychiatric or psychological disorder, or depression, to a degree that may cause the judgement of the person to be impaired.

Options for referral as a means for primary practitioner to satisfy himself/herself about competence and voluntariness
Referral for psychiatric assessment/counselling, if any, is related to the check of competence and voluntariness.

S14(d) - "if the primary medical practitioner is not satisfied that the person is competent to make the initial oral request, or is not voluntarily making the initial oral request, refer the person for counselling and discuss with the person the reasons for the referral"

Psychiatric assessment/counselling may not always be the most appropriate referral and the Bill provides a range of options depending on the nature of the primary medical practitioner's concern
S3 -"counselling means a consultation between a psychiatrist, or psychologist, and a person to determine, in the opinion of that psychiatrist or psychologist, whether or not the person –
(a) is competent to make an assisted dying request; and
(b) is making that request voluntarily"

S15, 16 and 17 - set out requirements to be met in relation to counselling.

S15(3) provides for referral to non-medical personnel, eg social worker - "Nothing in this section prevents a person's primary medical practitioner from referring the person to a psychiatrist, or psychologist or any other person, at any time, or for any reason, the primary medical practitioner thinks appropriate".

The Vermont legislation, *An act relating to patient choice and control at end of life*, May 2013, includes another alternative:
"(8) The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker licensed in Vermont for confirmation that the patient was capable and did not have impaired judgment."

INFORMED DECISION

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
The patient must be making an informed decision and the attending physician is required to inform the patient of "his or her medical diagnosis, … prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and palliative care" (§3.01(c)).	The patient must be making an informed decision and the attending physician is required to inform the patient of "his or her medical diagnosis, … prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and palliative care" (§4(c)).	The request must be informed and the physician is required to "inform the patient about the situation he was in and about his prospects" (§2(1)(c)).	Section 3.1 states that the patient's decision must be "well considered." The physician must "inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences" (§3.2.1).	Individual right to die organisations have their own guidelines. DIGNITAS' guidelines state that after a request is made, DIGNITAS staff consider "whether the applicant can be given any immediate recommendations for possible alternatives with the hope of being able to continue life under better conditions."[vi]	The patient's physician must make "sure that the request is an informed one, in particular by informing the patient of the prognostic and of other therapeutic possibilities and their consequences" (§28(1)(b))

Tasmanian *Voluntary Assisted Dying Bill 2013*:

No need to have separate palliative care specialist referral, can make it up to the primary doctor to get that information for the patient instead of forcing dying person with intolerable suffering to jump over another hurdle

S12 contains very detailed requirements on the information to be provided to the patient -

S12(2) - The following information is specified for the purposes of subsection (1):
(a) the medical diagnosis of, and medical prognosis for, the person;
(b) the processes and procedures for making assisted dying requests including, but not limited to, the information specified in subsection (3);
(c) the various methods of administration of medication that is likely to be prescribed to the person under an assisted dying prescription;
(d) the potential risks that are associated with the administration of medication that is likely to be prescribed to the person under an assisted dying prescription;
(e) the probable result of the administration of medication that is likely to be prescribed to the person under an assisted dying prescription;
(f) all other reasonable treatment options available to the person including, but not limited to, palliative care;
(g) any other medical or treatment information that is considered, by the person's primary medical practitioner, to be relevant.

S12(3) - (3) Information to be provided under subsection (2)(b) is to include –

(a) that a person must make an initial oral request, a written request and a subsequent oral request to be an eligible person for the purposes of this Act; and
(b) the waiting periods that apply, or may apply, as part of the processes and procedures under this Act; and
(c) that the primary medical practitioner is required to be on the same premises (but not necessarily within sight of the person) if the person intends to self-administer the medication that is likely to be prescribed to the person under an assisted dying prescription; and
(d) the possible complications that may occur after the medication, that is likely to be prescribed to the person under an assisted dying prescription, is administered to the person; and
(e) any steps the primary medical practitioner may take, if such a complication occurs.

TYPE OF ASSISTANCE

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
Physician assisted suicide (patient must self-administer the lethal dose). Voluntary euthanasia is not permitted.	Physician assisted suicide (patient must self-administer the lethal dose). Voluntary euthanasia is not permitted. Unlike the Oregon Act, the Washington law explicitly states that the patient must self-administer the medication (§2(1)).	Voluntary euthanasia and assisted suicide.	Voluntary euthanasia which is defined as "intentionally terminating life by someone other than the person concerned, at the latter's request" (§2).	It is not a crime to assist another person's suicide if the assistor does not have a selfish motive. Voluntary euthanasia is not permitted.	If all conditions met, "medical aid in dying may be administered to a patient requesting it, the physician must administer such aid personally and take care of the patient until their death." (§29)

Tasmanian *Voluntary Assisted Dying Bill 2013*:

Important to note the problems in Oregon from oral ingestion (eg regurgitation) and self-administration only rules out people like Loredana Mulhall (MS sufferer - NSW)

The Bill provides for both self-administration (as in Oregon) and doctor-administration of the medication for assisted dying -

S24 - (1) … "prescribed medication may be administered to an eligible person by –
(a) the eligible person; or
(b) the eligible person's primary medical practitioner.

(2) If an eligible person intends to self-administer prescribed medication, the eligible person's primary medical practitioner must –
(a) offer the eligible person a chance to rescind any assisted dying request made by the eligible person before dispensing the prescribed medication to the eligible person for self-administration; and
(b) remain on the same premises as the eligible person (but not necessarily within sight of the eligible person) until, and while, the eligible person self-administers the prescribed medication; and
(c) take any steps, as determined under section 18(2)(c), the primary medical practitioner considers necessary.

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
The attending physician must "refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily" (§3.01(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient's disease. Section 3.03 states that "if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling." The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression. The patient must be informed about palliative care options in accordance with Section §3.01(c)(E).	The attending physician must "refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily" (§4(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient's disease. Section 6 states that "if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling." The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression. The patient must be informed about palliative care options in accordance with Section 4(c)(v).	The patient's physician must consult another "independent physician who has seen the patient and has given his written opinion on the requirements of due care" (§2(1)(e)). Lewis and Black explain that "[t]he consultation requirements are more stringent if the patient's suffering is the result of a psychiatric disorder."[vii]	The patient's physician must consult another physician who is required to review the medical record, examine the patient, confirm the patient's constant and unbearable physical and mental suffering that cannot be alleviated (§3.2.3). The consulting physician must be independent of both the patient and the attending physician and be competent to give an opinion about the disorder in question (§3.2). If there is a nursing team that forms part of the patient's regular care, the attending physician must discuss the patient's request with the nursing team (§3.2.4). An additional requirement exists for patients who are "not expected to die in the near future" (§3.3).	While individual right to die organisations have their own guidelines, Lewis and Black explain that "[s]ince 2008, physicians in Zurich are required to meet the individual seeking suicide assistance in person on two occasions before a prescription is issued."[viii]	The patient's physician must "obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met. The physician consulted must be independent of both the patient requesting medical aid in dying and the physician seeking the second medical opinion. The physician consulted must consult the patient's record, examine the patient and provide the opinion in writing". (§28(3))

Tasmanian *Voluntary Assisted Dying Bill 2013*:

S18(2) "If a person's primary medical practitioner is satisfied that the person has an eligible medical condition and that the person's initial oral request was an eligible request, the primary medical practitioner must –

(a) refer the person to a secondary medical practitioner for confirmation of the medical diagnosis of, and medical prognosis for, the person".

S3 (Interpretation) - ***secondary medical practitioner***, in relation to a person, means a medical practitioner who –

(a) is qualified to make a medical diagnosis of, and medical prognosis for, the person; and

(b) has specialised qualifications, or experience, in diagnosing and treating the eligible medical condition of the person; and

(c) has accepted a referral in respect of the person from the person's primary medical practitioner.

S19 sets out the responsibilities of a secondary medical practitioner who accepts the referral. **S19(3)(b)** states that the report of the secondary medical practitioner "may contain any other information that the secondary medical practitioner considers relevant".

REPORTING AND SCRUTINY OF CASES

Oregon	Washington	The Netherlands	Belgium	Switzerland	Quebec, Canada
Section 3.11 sets out the reporting requirements to be undertaken by the Department of Human Services. Section 3.11 also requires "any health care provider upon dispensing medication … to file a copy of the dispensing record with the department [of Human Services]." The Department of Human Services is required to prepare an annual report on the operation of the Act (§3.11(3)).	Section 15 sets out the reporting requirements to be undertaken by the Department of Health. Section 15 also requires "any health care provider … to file a copy of the dispensing record and other such administrative required documentation with the department." The documentation is to be provided to the department within thirty calendar days after the writing of a prescription and dispensing of medication (§15(1)(b)). The prescribing physician must file all documents required after the death of the patient with the department no later than 30 days after the patient has died (§15(1)(b)). The Department of Health is required to prepare an annual report on the Act (§15(3)).	Regional review committees are established under Section 3 of the Act. For the physician to be protected by the legal defence provided by the 2001 Act, he or she must report the case to the municipal pathologist (§20(2)). The municipal pathologist is responsible for forwarding the file to the relevant review committee: "If this committee finds that the physician did not act in accordance with the due care criteria, the case is referred to the Public Prosecution Service."[ix] The review committees are required to provide an annual report on their activities (§17).	The Belgian Act establishes a Federal Control and Evaluation Commission (§6). Section 5 states that "any physician who has performed euthanasia is required to fill in a registration form … and to deliver the document to the Commission within four working days. Section 7 details the information the physician is required to provide about the patient. The Commission is responsible for reviewing all cases of euthanasia to ensure they were undertaken in accordance with the Act (§8). If the Commission believes that the statutory criteria have not been met they will refer the case to the public prosecutor (§8).	Individual right-to-die organisations produce their own reports on their activities. The only reporting requirement is that "assisted suicides must be reported to the local authorities as unnatural deaths."[x] Concerns have been raised about a lack of reporting of assisted suicide in Switzerland, particularly as there is no national body to which assisted suicide must be reported. This means that there is no national reporting data available for review.[xi]	"All information and documents in connection with a request for medical aid in dying, regardless of whether the physician administers it or not, including the form used to request such aid, the reasons for the physician's decision and, where applicable, the opinion of the physician consulted, must be recorded orfiled in the patient's record." (§31) The Act also provides for "a commission on end-of-life care" with the mandate to examine any matter relating to end-of-life care" (§35 - 42) "A physician who administers medical aid in dying must give notice to the Commission within the next 10 days and send the Commission, in the manner determined by government regulation, the information prescribed by regulation." (§41)

Tasmanian *Voluntary Assisted Dying Bill 2013*:

Part 4 provides for the appointment of a Registrar with the following functions under **S33 (1)** -

(a) review a death that occurs as a result of assistance provided under this Act, for the purpose of monitoring compliance with this Act;

(b) investigate, report and make recommendations to the Minister on any matter relating to the operation or administration of this Act;

(c) communicate to appropriate authorities any concerns the Registrar has about compliance or non-compliance with this Act;

(d) distribute information, and provide education, relating to –

(i) the functions of the Registrar; and

(ii) the operation of this Act;
(e) perform such other functions, or exercise such other powers, as may be prescribed.

General record requirements of the Registrar are covered in **S34** and Annual Report to Parliament is covered in **S35**.

Detailed record requirements for the medical practitioner are set out in **S28** -
(1) A person's primary medical practitioner is to record, or file, the following information or documents on the person's medical records:
(a) the primary medical practitioner's medical diagnosis of, and medical prognosis for, the person;
(b) each assisted dying request made by the person;
(c) each determination by the primary medical practitioner as to whether or not the person –
(i) is competent; or
(ii) is making an informed decision to end his or her life; or
(iii) is voluntarily making an assisted dying request;
(d) each written report provided to the primary medical practitioner under section 15;
(e) each written report provided to the primary medical practitioner under section 19(2);
(f) each time the primary medical practitioner –
(i) informed the person that he or she may rescind an assisted dying request made by the person; and
(ii) offered the person an opportunity to rescind an assisted dying request made by the person;
(g) the steps intended to be taken to fulfil the assisted dying request of the person, including a notation of the prescribed medication;
(h) after the prescribed medication has been administered to the person, the steps taken to fulfil the assisted dying request of the person, including any steps taken by the primary medical practitioner, or that the primary medical practitioner is aware were taken, in respect of any complications that occurred after the administration of the prescribed medication;
(i) a note by the primary medical practitioner that he or she has complied with all relevant requirements of this Act;
(j) any other document or information as prescribed.

(2) A person's primary medical practitioner must send, to the Registrar, a copy of the records required to be kept in respect of the person under subsection (1) as soon as practicable after the record is made, or filed, under that subsection.
Penalty: Fine not exceeding 50 penalty units.

(3) No later than 14 days after the death of an eligible person in accordance with this Act, the eligible person's primary medical practitioner must –
(a) ensure that a copy of each record required to be kept in respect of that eligible person under subsection (1) has been sent to the Registrar in accordance with subsection (2); and
(b) send to the Registrar a copy of the notification given under section 35 of the Births, Deaths and Marriages Registration Act 1999 in respect of the eligible person; and
(c) send to the Registrar a copy of any other information that the primary medical practitioner considers relevant.

Penalty: Fine not exceeding 50 penalty units.

(4) A pharmacist who dispenses prescribed medication under the authority of this Act must file a copy of any record made under the Poisons Act 1971 in respect of that medication with the Registrar no later than 14 days after making the record.
Penalty: Fine not exceeding 50 penalty units.

References

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[i] The information in these tables, other than the Quebec details, is taken from Giddings, L and McKim, N, Voluntary Assisted Dying: A Proposal for Tasmania, Feb 2013 (obtainable at http://dwdtas.org.au/wp-content/uploads/2013/05/Voluntary-Assisted-Dying-A-Proposal-for-Tasmania.pdf). The original document includes additional tables comparing other provisions including Voluntariness, Written Request, Residency Requirement , Age of patient, Identity of the Attending Doctor, Waiting Periods, Family Notifications, Due Medical Care and Opportunity to Rescind Request. It also includes considerable additional detail on the similarities and differences between the legislation in different jurisdictions.

[ii] Lewis and Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', p. 6. (Lewis and Black were commissioned to produce an expert briefing paper for the Commission on Assisted Dying on legal safeguards. Their report is titled 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying' and is available at 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'.)

[iii] Lewis and Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', p. 6.

[iv] Ibid, p. 7.

[v] DIGNITAS, 'How DIGNITAS Works', p. 19.

[vi] DIGNITAS, 'How DIGNITAS Works', p. 8.

[vii] Lewis and Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', p. 7.

[viii] Ibid, p. 23.

[ix] Lewis and Black, 'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', p. 10.

[x] Ibid.
[xi] Ibid.