Dying with Dignity Tasmania (Inc)

COMPARISON OF VOLUNTARY ASSISTED DYING SAFEGUARDS[1]

All regulatory frameworks for doctor-provided voluntary assisted dying are working safely, regardless of the differences

As the Victorian inquiry and all other recent thorough reviews have shown, all the regulatory frameworks for doctor-provided voluntary assisted dying are working safely, regardless of the differences between them. This is because they all have multiple safeguards but, in particular, are all doctor-safeguarded and have the additional safeguard of regulated oversight with careful monitoring, scrutiny and reporting.

Importance of establishing a framework that suits the culture and values where the law is being introduced

The differences between assisted dying legal approaches reflect the significantly different cultures and history of law reform, and priorities given to particular principles and values, in different societies. The Victorian report makes the critically important point that "*these jurisdictions* [with legal assisted dying] *highlight the importance of establishing **a framework that suits a particular jurisdiction's medical and legal culture** and of providing the appropriate safeguards within that framework*" (p205) and "***an assisted dying framework must reflect the values and culture unique to a particular jurisdiction**. Certain elements of each framework are effective precisely because they reflect this uniqueness*" (p217). [Our emphases] The Committee concluded that "*any Victorian response must also be tailored to best fit with Victorian culture and values*" (p210).

NEW TASMANIAN *VOLUNTARY ASSISTED DYING BILL 2016*

The new Tasmanian *Voluntary Assisted Dying Bill 2016*[2] was moved in the Parliament on 17 November 2016. Debate in the House of Assembly will occur on 24 May 2017.

The Bill provides a 'last resort' assisted dying option through a regulated doctor-safeguarded framework that includes strong safeguards, is workable and meets a number of aims. The Bill is based on thorough research and analysis of existing legislation and relevant proposals. There has also been thorough reconsideration of the *Voluntary Assisted Dying Bill 2013* in the light of the comments and concerns at the time of the 2013 debate and, since then, the significant reports, Parliamentary debates and policy by medical organisations[3].

A DwDTas summary of the Bill[4] provides a brief overview of the Bill, its aims and background information.[5] This comparison is of key safeguards in the 2016 Tasmanian Bill with those in overseas legislation and the assisted dying framework recommended in the 2016 report of the Victorian inquiry into end of life choices[6]. The detailed provisions of the Victorian Voluntary Assisted Dying Bill will not be known until later in the year. The Victorian Government established an Expert Panel to finalise the Bill and, on 30 January 2017, issued a discussion paper[7]. The interim report of the panel was released on 17 May 2017[8]. Additional comparisons are available, including in the Tasmanian 2013 Proposal[9] and in the report of the Victorian inquiry into end of life choices. Key safeguards that are compared in this analysis are: voluntariness, competence of the person making the request, informed decision, eligible medical condition, doctor safeguards, regulatory monitoring, scrutiny and reporting, type of assistance, age and waiting periods.

LEGISLATION

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victoria
Death with Dignity Act 1994 Commenced operation 1997	*Termination of Life on Request and Assisted Suicide Act 2002* Commenced operation 2002	*Act on Euthanasia 2002* Commenced operation 2002	Articles 114 and 115 of the Swiss Criminal Code Commenced 1942	*An Act respecting end of life care* (2014) Commenced operation December 2015	*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (2016) Commenced operation June 2016	The Victorian Voluntary Assisted Dying Bill will be prepared this year

VOLUNTARINESS

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
The patient's request must be voluntary. Both the patient's doctors and the witnesses to the patient's written request are required to confirm that the request is being made voluntarily by the patient (§2.02, §3.01(a) and §3.02).	The patient's request must be voluntary (§2(1)(a)).	The patient's request must be "voluntary, well considered and repeated and is not the result of any external pressure" (§3(1)).	Individual right to die organisations in Switzerland have their own internal protocols for determining whether assistance will be provided. For example, the guidelines released by DIGNITAS state that "throughout the entire process of preparing an AS, DIGNITAS follows the rule that it is never DIGNITAS which initiates the next phase and further proceedings but that it is always and only the member's own prompting which leads the entire process of the AS from one phase to the next, and the process will not move on until the member declares they are ready for the next step.	"Before administering medical aid in dying the physician must (1) be of the opinion … after…(a) making sure the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure.	241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria: [including] (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure	The request "must be completely voluntary, free of coercion".

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

The greatest guarantee of voluntariness is that the person must initiate every one of the three requests - initial oral, written and subsequent oral – and advise the primary medical practitioner when the prescription is to be issued (**S23(1)(a)**). The person must also be offered numerous opportunities to rescind their request.

The primary medical practitioner must be convinced that each request is voluntary. If in doubt, he/she must refer the person to a psychiatrist or a psychologist for counselling (**S14(2)**). The voluntariness must also be confirmed by a second medical practitioner. A person cannot receive an assisted death until a secondary medical practitioner confirms the opinion of the primary medical practitioner on voluntariness. (See section below on Doctor Safeguards).

The written request (**S17**) must be witnessed under **S17(3)(b)** by "at least two adults" one of whom needs to be independent (see **S17(4), (5) and (6)**.

COMPETENCE

Oregon[10]	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
The patient must be capable of making and communicating health care decisions to their doctors (§1.01(3)). If either the attending or consulting physician are of the opinion that "the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement" they must refer the patient for counselling (§3.03).	The patient's request must be "voluntary and carefully considered" (§2(1)(a)). Lewis and Black explain that "The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent."[11]	The patient must be "legally competent and conscious at the moment of making the request" (§3.1).	Must have capacity if their act is to be considered suicide. DIGNITAS' guidelines state that if there are concerns about the member's mental competence "or if there is a feeling that the member is obviously not making his/her decision free from external pressure but rather is being influenced by [someone else], the conversation will be continued by giving both DIGNITAS escorts the chance to speak with the member alone. If the doubts of both DIGNITAS escorts cannot be completely removed … then the AS will be cancelled."[12]	To obtain medical aid in dying, a patient must "be capable of giving consent to care" (§26(2)). (There is no specific requirement in this Act for the doctor to refer the patient for psychiatric or psychological assessment.)	Capable of making decisions with respect to their health; (§241.2 (1)(b)) They give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (§241.2 (1)(e)) (There is no requirement for the doctor to refer the patient for psychiatric or psychological assessment.)	Adult with decision making capacity about their own medical treatment. Patients whose decision-making capacity is in question due to mental illness must be referred to a psychiatrist for assessment.

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Under the Tasmanian Bill, the person has to be competent at the time of each request, in order for that request to be an eligible one. The only exceptions to this in other jurisdictions are limited ones in The Netherlands and Belgium but the provisions are very rarely used.

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

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

S14(2) - "If the primary medical practitioner reasonably suspects that the person is not competent to make the initial oral request, or is not voluntarily making the initial oral request, he or she must refer the person for counselling and discuss with the person the reasons for the referral". **S3 - "counselling** means a consultation between a psychiatrist, or psychologist, and a person to determine, in the opinion of that psychiatrist or psychologist, whether or not the person – (a) is competent to make an assisted dying request; and (b) is making that request voluntarily".

S15 and 16 - set out requirements to be met in relation to counselling and reporting. **S15(3)** "Nothing in this section prevents a person's primary medical practitioner from referring the person to a psychiatrist, or psychologist or any other person, at any time, or for any reason, the primary medical practitioner thinks appropriate".

INFORMED DECISION

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
The patient must be making an informed decision and the attending physician is required to inform the patient of "his or her medical diagnosis, … prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and palliative care" (§3.01(c)).	The request must be informed and the physician is required to "inform the patient about the situation he was in and about his prospects" (§2(1)(c)).	Section 3.1 states that the patient's decision must be "well considered." The physician must "inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences" (§3.2.1).	Individual right to die organisations have their own guidelines. DIGNITAS' guidelines state that after a request is made, DIGNITAS staff consider "whether the applicant can be given any immediate recommendations for possible alternatives with the hope of being able to continue life under better conditions."[13]	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)) The physician must make sure that such a decision is made freely and provide the person with all information needed to make an informed decision, in particular information about other therapeutic possibilities, including palliative care. ((§5)	They give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (§241.2 (1)(e))	The request … Must be properly informed. The primary and secondary doctor must each properly inform the patient: • of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results • of palliative care and its likely results • that they are under no obligation to continue with a request for assisted dying, and may rescind their request at any time • of the probable result and potential risks of taking the lethal drug.

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S12 contains very detailed requirements on the information to be provided to the patient including those above for other legislation and the Victorian recommendation. For example, **S12(2)** - (f) all other reasonable treatment options available to the person including, but not limited to, palliative care.

ELIGIBLE MEDICAL CONDITION

	Terminal illness[1]	Specified Timeframe	Specified suffering	
Oregon[14]	Yes	Yes	No	The Oregon (and other US) law allows a prescription for lethal drugs to be provided to people who have a terminal illness and who qualify for free federally funded palliative care. This occurs when someone has a prognosis, "within reasonable medical judgement" their death is expected within 6 months.[15] (§1.01(12)).
Netherlands	No	No	Yes	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.
Belgium	No (except children)	No	Yes	Section 3 states that "the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident." There is no requirement that the cause of the patient's suffering be due to a terminal illness.
Switzerland	No	No	No	There is no requirement that the patient be terminally ill or suffering from a specified medical condition, or demonstrating a specified level of suffering. However, lethal medication must be supplied and dispensed in accordance with federal laws and doctors must operate "within the limits of accepted professional practice."[16]
Quebec	No	No	Yes	To obtain medical aid in dying the patient must: 3. be at the end of life [undefined] 4. suffer from an incurable serious illness; 5. suffer from an advanced state of irreversible decline in capability; and 6. suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable." (§26)
Canada	No	No	Yes	A person may receive medical assistance in dying if … they have a grievous and irremediable medical condition. (§241.2 (1)(c)) A person has ***a grievous and irremediable medical condition*** only if they meet all of the following criteria: (a) they have a serious and incurable illness, disease or disability; (b) they are in an advanced state of irreversible decline in capability; (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. (§241.2 (2)) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition, and report to Parliament within two years of the start of a review. (§9.1) Canadian Health Dept advice - ("People with a mental illness are eligible for medical assistance in dying as long as they meet all of the listed conditions. However, you are not eligible for this service if: you are suffering only from a mental illness; death is not reasonably foreseeable when considering all the circumstances of your medical condition; or a mental illness reduces your ability to make medical decisions"
Victorian inquiry[17]	No	No	Yes	At the end of life (final weeks or months of life) and suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable. Suffering as a result of mental illness only does not satisfy the eligibility criteria.

[1] That is, an illness or condition that is likely to result in death. See for example, the definition in the South Australian *Consent to Medical Treatment Act 1995*.

				The Committee's view is that assisted dying in Victoria should be provided only to those who are at the end of life, as determined by a primary doctor and an independent secondary doctor. … Assisted dying should provide an option that can limit suffering at the very end of life, not a way to end life for those who are otherwise not dying. (p223) Doctors are best placed to assess whether a patient is at the end of life. The Committee trusts the judgement of doctors, specialists and health practitioners in determining whether a patient is at the end of life, according to the nature of their condition and its likely trajectory. The Committee believes that empowering doctors to make this assessment is preferable to allocating an arbitrary time limit based on factors that are not applicable to the Victorian context. (p224)

Special notes:

1. 'Eligible medical condition' is the requirement that differs most between legislation because it is the section of the law most strongly related to the culture and fundamental principles, values and priorities of the place where the law is being introduced. As the Victorian inquiry report put it, an assisted dying framework must reflect "the values and culture unique to a particular jurisdiction", including the medical and legal culture. The reasons for the differences and the values underpinning the Tasmanian 'last resort' approach are to be covered in detail in Issues Paper 2.
2. Contrary to the most common misunderstanding about assisted dying legislation:
   - "terminal illness" is not, and has never been, a requirement in European legislation – the key cultural value is compassionate ending of unbearable suffering; and
   - demonstrating suffering is not, and has never been, a requirement in Oregon and other US States – the key cultural value is individual autonomy.

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The approach taken in the Tasmanian Bill is supported by many public surveys and the 2016 AMA member poll[18].

S11 - "For the purposes of this Act, an eligible medical condition –
(a) is the advanced stages of a serious incurable and irreversible medical condition, whether caused by illness, disease or injury, **as diagnosed by a medical practitioner who has specialised qualifications, or experience, in diagnosing and treating the medical condition**; and

(b) the person's medical condition, or associated medical treatment, or complications resulting from the medical condition or treatment –

(i) is causing persistent suffering for the person that is intolerable for the person; and

(ii) there is no reasonably available medical treatment or palliative care options that would, having regard to both the treatment and any consequences of the treatment, relieve the person's suffering in a manner that is acceptable to the person; and

(c) there is no reasonable prospect of a permanent improvement in the person's medical condition."

'Last resort' provision

S22 (2) and (3) provide the 'last resort' requirement. **S22(2)** states that the person's doctor "must discuss with the eligible person whether there are any relevant treatment options available that may adequately and to the satisfaction of the eligible person – (a) improve the eligible person's medical condition; or
(b) relieve the eligible person's suffering". **S22(3)** requires the doctor to provide assisted dying only "If the eligible person and the eligible person's primary medical practitioner are satisfied there are no relevant treatment options available as discussed [under S22(2)]".

DOCTOR SAFEGUARDS

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
The attending physician is defined as "the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease" (§1.01(2)). The attending physician must "refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily" (§3.01(d)). The consulting physician must be qualified to make a professional diagnosis and prognosis regarding the patient's disease. Section 3.03 states that "if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counselling." The request for assistance can only proceed once the counsellor determines that the patient is not suffering from depression. The patient must be informed about palliative care options in accordance with Section §3.01(c)(E).	Under Dutch law only physicians can provide assistance with assisted suicide or voluntary euthanasia. The physician does not need to be the patient's primary physician but it is required "that the physician must know the patient sufficiently well to assess whether the due care criteria are met." The patient's physician must consult another "independent physician who has seen the patient and has given his written opinion on the requirements of due care" (§2(1)(e)). Lewis and Black explain that "[t]he consultation requirements are more stringent if the patient's suffering is the result of a psychiatric disorder."[19]	The role of the attending physician is not defined. However, the Act does state that the physician must have "several conversations with the patient spread out over a reasonable period of time" in order "to be certain of the patient's constant physical or mental suffering and of the durable nature of his/her request" (§3(2)(2)). The patient's physician must consult another physician who is required to review the medical record, examine the patient, confirm the patient's constant and unbearable physical and mental suffering that cannot be alleviated (§3.2.3). The consulting physician must be independent of both the patient and the attending physician and be competent to give an opinion about the disorder in question (§3.2). If there is a nursing team that forms part of the patient's regular care, the attending physician must discuss the patient's request with the nursing team (§3.2.4). An additional requirement exists for patients who are "not expected to die in the near future" (§3.3). The physician must refer the person for examination and a report from a second independent physician who is a psychiatrist or a specialist in the person's disorder	Lewis and Black explain that "[i]n Switzerland, there is no legal criterion that relates to the identity of the assistor: in the absence of selfish motives, any individual may in principle assist in the suicide of another." While individual right to die organisations have their own guidelines, Lewis and Black explain that "[s]ince 2008, physicians in Zurich are required to meet the individual seeking suicide assistance in person on two occasions before a prescription is issued."[20]	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))	***medical practitioner*** means a person who is entitled to practise medicine under the laws of a province. ***nurse practitioner*** means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner - or under an equivalent designation - and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients. (§241.2 (3)Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must … (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1); (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent. The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they (a) are not a mentor to the other practitioner or responsible for supervising their work; (b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or (c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity. (§241.2 (6)) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards. (§241.2 (7))	A request for assisted dying must be approved by a primary doctor and an independent secondary doctor. Each doctor must be properly qualified to make a professional diagnosis and prognosis regarding the patient's specific condition. Each doctor must independently judge whether the person's request satisfies all of the criteria outlined below. (p237)

Special note: The doctor safeguards in the Tasmanian Bill and in other regulated assisted dying systems are the most important guarantees of safe, effective legislation, particularly when backed up by the regulatory monitoring, scrutiny and reporting system.

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

Safeguard of specialised diagnosis: Before a person commences the process for assisted dying, under **S11, Eligible medical condition**, he/she must have a diagnosis of their medical condition from "a medical practitioner who has specialised qualifications, or experience, in diagnosing and treating the medical condition".

In **S3**:

- **medical practitioner** is defined as "a person who holds general registration under the *Health Practitioner Regulation National Law (Tasmania) 2010* in the medical profession".
- Doctors' participation is entirely voluntary:
  - **primary medical practitioner** "in relation to a person, means a medical practitioner who accepts primary responsibility for an assisted dying request made under this Act"
  - **secondary medical practitioner** "in relation to a person, means a medical practitioner who has accepted a referral in respect of the from the person's primary medical practitioner".

Significant responsibilities of primary medical practitioner:

- There are many sections of the Bill that set out the responsibilities of the primary medical practitioner and the action that must be taken at each stage of the process to ensure that rigorous examination is undertaken of requests and only those persons who meet all the eligibility requirements receive an assisted death, including referrals to other medical professionals. (See in particular **S14** for responsibilities after initial oral request, **S18** after written request, and **S22** after subsequent oral request.)
- The primary medical practitioner cares for and supports persons to the end of the process, including the delivery of the prescribed medication and being available to administer the medication or to support the person who is self-administering and, if there are complications, to assist as agreed (**S18(3)(c)**).
- The primary medical practitioner has the responsibility for the strict requirements for safe handling of medication.

Confirmation by independent second medical practitioner: A person cannot receive an assisted death until a secondary medical practitioner confirms the opinion of the primary medical practitioner on the key criteria of competence, voluntariness and eligible medical condition.

S18(3) [At the time of the written request], "if a person's primary medical practitioner is satisfied that the person has made an eligible request, the primary medical practitioner must –

(a) refer the person to a secondary medical practitioner for confirmation of the primary medical practitioner's opinion that the person's written request meets the requirements of section 10 (c) [competence], (d) [voluntariness] and (e) [eligible medical condition]".

S19 sets out the responsibilities of a secondary medical practitioner who must be **independent** of the primary medical practitioner. ***S19(1)*** *states that "A medical practitioner may only accept a referral [from a primary medical practitioner] if he or she is independent of the primary medical practitioner".* **S19(2)** sets out the requirements for independence. **S20** sets out the responsibilities of the primary medical practitioner on receipt of the written report from the secondary medical practitioner in the event that it supports or does not support the primary medical practitioner's opinion.

Compared to other legislation and proposals, the Tasmanian Bill has much more specific and detailed provisions on the significant record keeping and reporting responsibilities of doctors under the legislation, and associated offences and penalties. These are significant additional safeguards related to the Registrar's official monitoring, scrutiny and Parliamentary reporting. Detailed record requirements for the medical practitioner are set out in **S28** -

(1) A person's primary medical practitioner is to record, or file, the following information or documents on the person's medical records:

(a) the primary medical practitioner's medical diagnosis of, and medical prognosis for, the person;

(b) each assisted dying request made by the person;

(c) each determination by the primary medical practitioner as to whether or not the person –

(i) is competent; or

(ii) is making an informed decision to end his or her life; or

(iii) is voluntarily making an assisted dying request;

(d) each written report provided to the primary medical practitioner under section 15;

(e) each written report provided to the primary medical practitioner under section 19(2);

(f) each time the primary medical practitioner –

(i) informed the person that he or she may rescind an assisted dying request made by the person; and

(ii) offered the person an opportunity to rescind an assisted dying request made by the person;

(g) the steps intended to be taken to fulfil the assisted dying request of the person, including a notation of the prescribed medication;

(h) after the prescribed medication has been administered to the person, the steps taken to fulfil the assisted dying request of the person, including any steps taken by the primary medical practitioner, or that the primary medical practitioner is aware were taken, in respect of any complications that occurred after the administration of the prescribed medication;

(i) a note by the primary medical practitioner that he or she has complied with all relevant requirements of this Act;

(j) any other document or information as prescribed.

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

(3) No later than 14 days after the death of an eligible person in accordance with this Act, the eligible person's primary medical practitioner must –
(a) ensure that a copy of each record required to be kept in respect of that eligible person under subsection (1) has been sent to the Registrar in accordance with subsection (2); and
(b) send to the Registrar a copy of the notification given under section 35 of the Births, Deaths and Marriages Registration Act 1999 in respect of the eligible person; and
(c) send to the Registrar a copy of any other information that the primary medical practitioner considers relevant. Penalty: Fine not exceeding 50 penalty units.

REGULATORY MONITORING, SCRUTINY AND REPORTING

Oregon	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)).
The Netherlands	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."[21] The review committees are required to provide an annual report on their activities (§17).
Belgium	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).
Switzerland	The reporting requirement is that "assisted suicides must be reported to the local authorities as unnatural deaths."[22] Switzerland does not have Coroners which the Victorian inquiry report claims. The right to die organisations notify the police only – which prompts them, a state attorney (who leads the investigation into the case) and a local district doctor or one from the Institute of Forensic Medicine to come to the place of the assisted suicide. (Advice received from Silvan Luley, one of the managers of Dignitas.) Individual right-to-die organisations produce their own reports on their activities. Dignitas statistics can be accessed at http://www.dignitas.ch.
Quebec	"All information and documents in connection with a request for medical aid in dying, regardless of whether the physician administers it or not, including the form used to request such aid, the reasons for the physician's decision and, where applicable, the opinion of the physician consulted, must be recorded or filed in the patient's record." (§31) The Act also provides for "a commission on end-of-life care" with the mandate to examine any matter relating to end-of-life care" (§35 - 42). "A physician who administers medical aid in dying must give notice to the Commission within the next 10 days and send the Commission, in the manner determined by government regulation, the information prescribed by regulation." (§41)
Canada	Filing information - medical practitioner or nurse practitioner: 241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations. Filing information -pharmacist: (2) Unless they are exempted under regulations made under subsection (3), a pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations. (3) The Minister of Health must make regulations that he or she considers necessary (a) respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying, including (i) the information to be provided, at various stages, by medical practitioners or nurse practitioners and by pharmacists, or by a class of any of them, (ii) the form, manner and time in which the information must be provided, (iii) the designation of a person as the recipient of the information, and (iv) the collection of information from coroners and medical examiners; (b) respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure; (c) respecting the disposal of that information; and (d) exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).

Victorian inquiry	1.5.1 **Assisted Dying Review Board** The Assisted Dying Review Board is to review each approved request for assisted dying. Membership of the Assisted Dying Review Board: • a representative of **End of Life Care Victoria** • a doctor • a nurse • a legal professional • a community member. The function of the Board will not be to approve or reject requests from patients to access assisted dying. That is the role of the primary doctor and independent secondary doctor in each case. Neither will the Board hear appeals from patients whose requests to access assisted dying have been rejected. The purpose of the Board is to ensure that doctors are complying with requirements of the assisted dying framework. If the Board finds a breach of the assisted dying framework, it should forward its report to the appropriate authority. Depending on the nature of the breach, this may be Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency. Those bodies will then determine whether to investigate the case further. The Board should report to Parliament on the operation of the assisted dying framework, including any trends it identifies and recommendations for improvement. For the purposes of increased transparency and accountability, during the first two years of operation these reports should be every six months. Following that the Board should report annually. 1.5.2 **End of Life Care Victoria** The Government should establish a new entity to champion end of life care, and provide information and guidance on end of life care to health services, practitioners and the Victorian community. End of Life Care Victoria will work closely with palliative care and other end of life care health practitioners and services to enhance and support the excellent work already being done in the Victorian health system. End of Life Care Victoria will aim to increase engagement with end of life care in the community and the health sector as a whole.

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

Tasmanian *Voluntary Assisted Dying Bill 2016*

As well as being a doctor-safeguarded system, like other legal assisted dying, the Tasmanian Bill provides for the additional safeguard of a rigorous monitoring, scrutiny and reporting arrangement. The Tasmanian approach is for this to be done most effectively and safely through a Registrar with statutory powers.

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

(a) review a death that occurs as a result of assistance provided under this Act, for the purpose of monitoring compliance with this Act;
(b) investigate, report and make recommendations to the Minister on any matter relating to the operation or administration of this Act;
(c) communicate to appropriate authorities any concerns the Registrar has about compliance or non-compliance with this Act;
(d) distribute information, and provide education, relating to – (i) the functions of the Registrar; and (ii) the operation of this Act;
(e) perform such other functions, or exercise such other powers, as may be prescribed.

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

TYPE OF ASSISTANCE

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
Person must self-administer the lethal dose through oral ingestion. Doctor administration of the drugs is not permitted, even when there are complications.	Both self and doctor-administration are legal.	Doctor administration is provided for in the law, defined as "intentionally terminating life by someone other than the person concerned, at the latter's request" (§2). Self-administration has been determined to be legal as well.	It is not a crime to assist another person's suicide if the assistor does not have a selfish motive. The person must self-administer by taking the final act to administer the drugs. Doctor-administration, or administration by another person is not permitted.	If all conditions are met, "medical aid in dying may be administered to a patient requesting it, the physician must administer such aid personally and take care of the patient until their death." (§29) Self-administration is not provided for in the law.	***medical assistance in dying*** means (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.	Assisted dying should in the vast majority of cases involve a doctor prescribing a lethal drug which the patient may then take without further assistance. The singular exception is where people are physically unable to take a lethal drug themselves. In this case, a doctor should be able to assist the person to die by administering the drug. (p237)

Special note: The type of assistance which is legal varies between jurisdictions. Recent surveys have confirmed a preference for doctor-administration by doctors themselves and the public.[23]

Tasmanian *Voluntary Assisted Dying Bill 2016*

The Bill provides for both self-administration and doctor-administration (as under legal assisted dying everywhere but the US) of the drugs for assisted dying. **S24 -** (1) … "prescribed medication may be administered to an eligible person by –

(a) the eligible person; or

(b) the eligible person's primary medical practitioner.

(2) For the purposes of this Act, administration by the eligible person may include oral ingestion or the activation of a medical device that delivers the medication. (Protection is provided in **S31(2)(a)(i)** for someone "assisting with the preparation of medication or medical devices for the self-administration" which would all happen with the supervision of the primary medical practitioner.)

(3) If an eligible person intends to self-administer prescribed medication, the eligible person's primary medical practitioner must –

(a) offer the eligible person a chance to rescind any assisted dying request made by the eligible person before dispensing the prescribed medication to the eligible person for self-administration; and

(b) remain on the same premises as the eligible person (but not necessarily within sight of the eligible person) until, and while, the eligible person self-administers the prescribed medication; and

(c) take any steps, as determined under section 18(3)(c), the primary medical practitioner considers necessary.

AGE

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
The patient must be an adult aged 18 years or older (§2.01(1)).	Under the 2002 Dutch law, a patient aged between sixteen and eighteen years that "may be deemed to have a reasonable understanding of his interests" may request euthanasia or assisted suicide. In these cases the parent and/or guardians must be consulted but do not have a veto on the final decision (§2(3)). Patients aged between twelve and sixteen and "may be deemed to have a reasonable understanding of his interests" may also request euthanasia or assisted suicide, provided the parents and/or guardian give their consent (§2(3)).	Under the 2002 Belgian law, the patient had to have "attained the age of majority or is an emancipated minor" (§3(1)). An amendment to the law was made in February 2014, after very extensive community and Parliamentary debate, to allow that "a child of any age can be helped to die, but only under strict conditions. He or she must be terminally ill, close to death, and deemed to be suffering beyond any medical help. The child must be able to request euthanasia themselves and demonstrate they fully understand their choice. The request will then be assessed by teams of doctors, psychologists and other care-givers before a final decision is made with approval of the parents."[24] It was expected that this provision would be very rarely used and this has turned out to be the case: the first and only death under the provisions occurred in September 2016, of a 17 year old.[25]	Lewis and Black explain that "in Switzerland, children cannot have the required legal capacity to commit suicide, though the position for adolescents is unclear."312 Membership the right-to-die organisation DIGNITAS is only available for people "of legal age and full capacity of discernment."	26. Only a patient who meets the following criteria may obtain medical aid in dying: (1) be of full age, …	241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria: … (b) they are at least 18 years of age … Note that, as provided for in the Canadian Act, a review is under way related to requests by mature minors for medical assistance in dying. (See in 'eligible medical condition')	An adult, 18 years and over

Tasmanian *Voluntary Assisted Dying Bill 2016*

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

WAITING PERIODS

Oregon	The Netherlands	Belgium	Switzerland	Quebec, Canada	Canada	Victorian inquiry
15 days between two oral requests and 48 hour period between written request and dispensing of the prescription	No	No, except for those whose deaths are not otherwise imminent there is a one month waiting period	Individual right to die organisations have their own guidelines.	No	10 days between written request and assisted dying (reduced from 15 in first reading Bill) "or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances" (§241.2 (3)(g))	No waiting periods. *The Committee recognises the need to guard against impulsive decisions by people experiencing extreme physical and emotional pain in the darkest hours of their lives. The Committee also believes that it is unreasonable to mandate an arbitrary cooling-off period that denies some people who would otherwise qualify to access this option at the end of life. … Doctors routinely assess whether medical treatment decisions are properly considered. As such, the Committee believes the best approach is to allow doctors to determine whether this criterion is established.* (p228)

Tasmanian *Voluntary Assisted Dying Bill 2016*

There must be a minimum of 9 days between the initial request and the administration of drugs for an assisted death, including under **S17(2)** at least 48 hours between initial oral request and written request, and under **S21(2)(b)** at least 7 days between written request and subsequent oral request.

References

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[1] The original of this paper was dated January 2017. This version includes very minor updates and corrections.

[2] Available at http://www.parliament.tas.gov.au/bills/Bills2016/pdf/73_of_2016.pdf .

[3] Particular attention has been given to the extensive consultative process, reports and parliamentary debates in Canada, including the reports, submissions, policies and advice of the Canadian Medical Association, eg Principles-based Recommendations. The 2016 Tasmanian Bill is consistent with the new AMA policy even though the Bill was moved in the Parliament before the new policy and its report on the review and member survey was issued.

[4] Available at http://dwdtas.org.au/wp-content/uploads/2016/11/Tasmanian-VAD-Bill-Summary-29-November-2016.pdf .

[5] DwDTas will be preparing more material to support and informed, rational debate on this issue, to be added to the website and sent directly to MPs. We are happy to respond to specific queries at any time.

[6] Report is available at http://www.parliament.vic.gov.au/lsic/inquiry/402.

[7] Available at https://www2.health.vic.gov.au/about/health-strategies/government-response-to-inquiry-into-end-of-life-choices-final-report .

[8] Interim Report of the Ministerial Advisory Panel: Consultation Overview – Voluntary Assisted Dying Bill, available at https://www2.health.vic.gov.au/~/media/health/files/collections/policies%20and%20guidelines/v/voluntary-assisted-dying-bill-interim-report.pdf

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

[10] 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."

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

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

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

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

[15] The 6 month timeframe is included in the Oregon and other US States for a reason specific to the US situation that does not apply in Australia (or other countries). (See for example, the Report of the Victorian inquiry into end of life choices, p223.) It is a requirement not because it is believed that only those close to death should have access to assisted dying but because the architects of the legislation wanted to be sure that people would not choose assisted dying merely because they could not afford palliative care. When people in the US have their doctor's prognosis of 6 months or less to live they are eligible for free access to palliative care (hospice) services through federal funding. This is obviously very important in the very expensive US health system. Consequently, 90.5% of those who have accessed assisted dying in Oregon have been enrolled for hospice care. (See latest Annual Report for 2015) However, it is also clear from the Oregon Annual reports that the prognoses are unreliable and some people live for a considerable period beyond 6

months. For example, the duration from first request to death ranges from 15 to 1009 days. In other words, at least one person (and maybe more) lived for nearly 3 years, despite their 6 month prognosis.

[16] 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'.)

[17] Victorian Inquiry into end of life choices conducted by the Legislative Council, Legal and Social Issues Committee. Report is available at http://www.parliament.vic.gov.au/lsic/inquiry/402.

[18] In the AMA poll (see note 21), 91% of the AMA members who believed 'euthanasia' should be lawfully allowed for a competent adult supported it in the circumstances of "an incurable illness associated with unrelievable and unbearable suffering" and only 64% for the much narrower circumstances of a "terminal illness". See also the 2016 Essential poll.

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

[20] Ibid, p. 23.

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

[22] Ibid.

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

[24] http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/

[25] http://www.rte.ie/news/2016/0917/817198-euthanasia/