Dear Ms Topic

Please find attached the submission from Dying with Dignity Tasmania (Inc) to the Victorian inquiry into end of life choices.

It consists of the body of the submission and three attachments.

DwDTas would be happy to provide additional written information on request or to provide a representative to provide follow up oral evidence and to answer questions at a hearing.

We can be contacted on the DwDTas number – 0450 545 167 – or you can contact me directly on [redacted] or [redacted]

Yours sincerely
Margaret Sing, President
SUBMISSION TO
THE VICTORIAN INQUIRY INTO END OF LIFE
CHOICES

AUGUST 2015
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ATTACHMENT 2: Table - “Safeguards and provisions in existing legislation”, from the Tasmanian Proposal (2013)

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1. OVERVIEW

- The aim of the Dying with Dignity Tasmania (DwDTas) submission is to provide material to you, the Committee conducting the inquiry, which is significant for the very important work you have to do as a Parliamentary Committee inquiring into the complex and significant issue of end of life choices. We have focused on material that is not otherwise being provided or to supplement other submissions and evidence we endorse.

- DwDTas is a separate but similar organisation to Dying with Dignity Victoria (DwDV) with similar purpose and objectives. Like DwDV, DwDTas is strongly committed to better end of life services to enable people to achieve their wishes about the time and way they die, including promotion, encouragement and practical support for end of life and advance care planning, improved palliative care services and voluntary assisted dying law reform. More information about the organisation, objectives, Committee, priorities and activities is available on our website.

- This submission focusses largely on information and arguments about voluntary assisted dying which are relevant to the requirement for the Committee to examine how end of life choices are managed in other Australian and international jurisdictions, and potential changes to your legislative framework. We have special expertise and material to contribute about voluntary assisted dying law reform to assist the Committee in relation to some major challenges.

- In Section 2, we identify what we believe are challenges for the Committee’s work and identify key criteria for the critical assessment of submissions and evidence related to people, principles, standards of evidence and rationale, and risk assessment. We argue that probably the major challenge for the Committee’s work to address the terms of reference in relation to the issue of voluntary assisted dying legislation, is due to the stark contrast between the approach taken to voluntary assisted dying compared to other end of life choices such as advance care planning and palliative care. There are major differences in consensus, experience, knowledge and understanding and also significant differences between the comprehensiveness and standards of the submissions and evidence to the inquiry on the different issues.

- There are submissions and arguments that cannot be regarded by the Committee as reliable or valid for its considerations. We respect the right of everyone to their opinion on this issue and the right to express those opinions, but the soundness of the basis for those opinions varies even between those with high level qualifications and experience and between those with particular perspectives, eg people with disabilities.

- From a very well-informed perspective, we argue that the knowledge and understanding of existing international legislation and legal practices and possible Australian law reform is extremely poor. When combined with apparently very little effort to gain better knowledge and to check facts and claims, and poorly based fears, this results in most claims and arguments against voluntary assisted dying legislation being inaccurate, distorted, illogical and unreasonable and having no basis in reputable, quality evidence or soundly based considerations.
We have a very thoroughly considered and reasoned position on the detailed issues related to voluntary assisted dying law reform based on values and principles, facts, evidence, thorough research and views of members and experts in medicine, law and ethics. In Section 3 we outline this position with some additional supporting information and reference to other key sources of valuable information. In this section there are brief details about our activities and views on end of life and advance care planning and our detailed guide developed to assist people to do their planning.

Our significant knowledge and understanding and very extensive research database has developed from our involvement over many years with the issue and its relationship to advance care planning and palliative care. This has included recent experience in 2009 (the Dying with Dignity Bill 2009 and the Parliamentary Committee inquiry on the Bill), but more particularly intensive involvement in the development of the 2013 detailed proposal for a voluntary assisted dying Bill in Tasmania, Voluntary Assisted Dying: A Proposal for Tasmania, and the resulting Bill, the Voluntary Assisted Dying Bill 2013. DwDTas was very involved in these processes through representation of DwDTas on the expert panel consulted on the Proposal and the Bill.

Our President, Margaret Sing, was also involved in a personal capacity in the small team that worked with the proponents, Lara Giddings, then Premier of Tasmania, and Nick McKim, then Leader of the Greens, to develop the model in the Proposal and the Bill itself. The perspective on the process and model presented in this submission is that of DwDTas and our President. We recommend the Committee seek evidence from Lara Giddings, who is still a Tasmanian MP and will be one of the sponsors of another voluntary assisted dying Bill expected later this year.

In Section 4, we provide information on the Tasmanian history and experience, including the current situation. We believe it provides valuable information and insights on the issue of voluntary assisted dying law reform that is of benefit to the Committee’s considerations. more information on that experience and current situation and the insights they provide. We are not suggesting that the Tasmanian model or Bill is some sort of ideal. In fact, we are working on proposed amendments to the last Bill for discussion with politicians who are the sponsors and possible sponsors of a new Bill later this year. However, the value is in the principles and concepts, the process followed, the issues considered and the rationale for the decisions made.

In Section 5, we cover the details of existing voluntary assisted dying legislation, compared to the Tasmanian approach. We argue and provide examples of how major fallacies occur in claims and arguments due mainly to ignorance of or ignoring legislative requirements, particularly the significant differences between requirements. In Section 6, we identify key issues for consideration in a legislative framework for voluntary assisted dying in Victoria.

We have continued our commitment and action to develop and maintain our knowledge and understanding and refer to only a fraction of our research material in this submission. We would be happy to respond in more depth to particular queries about any matter in writing or at a hearing, including analysis of some key submissions to the inquiry which are not yet available, eg AMA, Palliative Care Victoria.
2. CHALLENGES FOR THE COMMITTEE’S WORK

Having reviewed many submissions to this inquiry and to other relevant inquiries, we recognise the many challenges that face the Committee in this inquiry, not least dealing with the huge volume of submissions and conflicting views on significant matters.

Contrast between the approach to different end of life choices

Probably the major challenge for the Committee’s work to address the terms of reference in relation to the issue of voluntary assisted dying legislation, is due to the stark contrast between the approach taken to voluntary assisted dying compared to other end of life choices such as advance care planning and palliative care. There are major differences in consensus, experience, knowledge and understanding and also significant differences between the comprehensiveness and standards of the submissions and evidence to the inquiry on the different issues.

Good policy, as reflected in legislation, services and practices, requires a high standard of information and analysis, including risk assessment and management. This is not apparent in many submissions on the issue of voluntary assisted dying. We are very disappointed in the standard of evidence and arguments about this issue in submissions from both Christian and medical individuals and groups, and we believe the Committee should also be concerned. We respect the right of everyone to their opinion on this issue and the right to express those opinions, but the soundness of the basis for those opinions varies even between those with high level qualifications and experience and between those with particular perspectives, eg people with disabilities. Paraphrasing a quote from Robert Kennedy⁵, the issue is also not the extreme nature of the views expressed, but the intolerance of any other views.

There are submissions and arguments that cannot be regarded by the Committee as reliable or valid for its considerations because they fail to demonstrate sufficient knowledge and understanding of existing international legislation and legal practices and possible Australian law reform and instead promote inaccurate and distorted perceptions. There is also a lack of evidence that sufficient efforts have been made to gain better knowledge and to check facts and claims. This results in most claims and arguments against voluntary assisted dying promoting irrational fears based on inaccurate, out of date, distorted, illogical and unreasonable material that has little or no basis in reputable, quality evidence or soundly based considerations. Inaccuracies and distortions also occur because of major omissions of critically relevant data.

We understand that very few people have any need to or interest in developing in-depth knowledge and understanding about voluntary assisted dying law reform. What we find disturbing, however, and important for the Committee to consider, is that many submissions have been made to the inquiry, even by highly qualified and experienced individuals and organisations, that fail to demonstrate there has been attention to developing at least basic knowledge and understanding before commenting on these matters in a submission to a Parliamentary inquiry. There is also no acknowledgement of how limited their research has been, or the limited, if any, checking that has been done of the accuracy, reliability and validity of claims that have been taken from sources which they know or ought reasonably to know are not reliable (eg newspaper articles) or biased (eg only citing well-known opponents with known
affiliations to particular religions or religious positions, such as Professor Margaret Somerville, or Catholic websites such as the Anscombe Bioethics Centre and the European Institute of Bioethics).

We believe that it is, at best, disrespectful of the Committee and the Parliamentary process and at worst, a deliberate attempt to mislead. Regardless of the intention of those making submissions, the worst outcome would be that the Committee is misled, and in turn, inadvertently, misleads your Parliamentary colleagues and the public by relying on poor material.

**Value of high quality reviews and experienced academics**

Information and opinions from all lobby groups needs to be checked and confirmed and that includes DwDtas and other groups arguing for assisted dying, as much as for individuals and groups arguing against.

We recommend that the Committee check all claims by reference to high quality reviews by respected bodies including the submission from the Royal Society of Canada (Sub 660). In particular we recommend the Committee take up the offer made by Professor Udo Schuklenk, in the letter with the submission, to assist the Committee further by inviting him to give oral evidence and be available to answer questions. He can provide important evidence to explain the findings of the Royal Society panel that refute the ‘slippery slope’ arguments including about frequently cited but usually misrepresented issues such as the Groningen Protocol and the issue of deaths without explicit request (often wrongly referred to as ‘without consent’). These are complex but very significant issues for the Committee’s consideration and assessment of the claims and arguments put to the inquiry.

He can also explain the selection process for the panel about which inaccurate claims have been made by opponents in an attempt to discredit the findings of the Royal Society Panel.

Professor Schuklenk will be able to provide up to date evidence on the major developments in Canada towards assisted dying legislation, including the very significant Supreme Court of Canada decision in February 2015 and the significant changes in the approach of the Canadian Medical Association. In his research, publications and blogs, Professor Schuklenk also has addressed other relevant issues, including the very important and challenging issue relevant to the coverage of any voluntary assisted dying law, “Treatment-resistant depressive disorder and assisted dying”. This is the title of the article, co-authored with Professor Suzanne van de Vathorst, published in the Journal of Medical Ethics in June 2015.

We hope he can also provide information on the Quebec review process, report and resulting legislation, which we refer to in Section 5. If not, we hope that you will seek someone who can appear before the Committee to provide information and answer questions.

**Key criteria**

We would like to see the Committee adopt criteria based on some core elements to assess the credibility, reliability and validity of the submissions and also the arguments and proposals it receives in relation to voluntary assisted dying, and in its consideration of a legislative framework for voluntary assisted dying. As we show in Section 3, our position on end of life
choices, including assisted dying, is based on a number of essential elements - people, principles, standards and risk, and we recommend the following criteria be applied:

- **Criterion 1: The response to the people concerned and the reality of the limits to palliative care and other medical treatment.** For example, does the submission or proposal acknowledge that there are people with intolerable and unrelievable suffering who cannot be helped by even state of the art palliative care? Does it suggest long delays in responding to their needs? Is there acknowledgement of the individuality and unique circumstances of each person involved?

- **Criterion 2: Principles and values.** For example, is the submission/argument/proposal consistent with compassion and empathy for people with terrible suffering? Does it reflect respect for individual self-determination and patient autonomy as applied to other issues like advance care directives and other decisions that hasten deaths? Does it reflect respect for doctors, their individual autonomy and responsibility for high standards of professional and ethical practice, and the high standards of our medical system and its oversight? Is it consistent with respect for shared community values such as the right to freedom of religion and belief, and is it consistent with the principles and values otherwise espoused or expected?

- **Criterion 3: Standards of supporting information, evidence, assumptions and arguments.** For example, as commented on in Section 5, does the submission/argument/proposal reflect critically relevant knowledge and understanding of the requirements and differences between VAD legislation? Are arguments and views supported by facts, evidence and reasoned assumptions and analysis? Does the submission/argument/proposal reflect the usual and expected standards of the individual or organisation?

- **Criterion 4: Reasonable risk assessment.** For example, do claims and arguments about risks take into account the demanding requirements and processes and other safeguards including the involvement of at least two doctors before assisted dying requests can be met? Are the relative risks of the status quo and VAD legislation considered?

We believe that, if those criteria are applied, the Committee will note the key differences and contrasts which are also noted in other submissions which we endorse, including those from our colleagues whose principles and objectives largely the same as ours, including Dying with Dignity Victoria (Sub 625) and Dying with Dignity NSW (Sub 676). We also applaud the high quality evidence provided by Professor Hal Swerrissen (Hearings 23 July 2015).

These are key differences, contrasts and inconsistencies which we note and expect the Committee will confirm:

- In submissions and arguments opposed to voluntary assisted dying legislation, and in proposals for alternative approaches, there is an almost total absence of acknowledgement of the people that are at the end of their lives with intolerable and unrelievable suffering and an almost total absence of expressions of empathy and compassion. This is one of the major contradictions in the attitudes to voluntary assisted dying and those who need it and request it compared to those that need palliative care and other end of life treatment that may hasten death. We find it unacceptable, and believe the Committee should also find it unacceptable, especially in submissions from Christian and medical individuals and organisations.
• There is also a total absence of respect for self-determination and patient autonomy for people needing and wanting assisted dying and absence of respect for the principle of freedom of religion and belief. Particular religious beliefs are asserted as if they alone should prevail and be privileged in legislation, patient autonomy is treated as an optional extra and beneficence and non-maleficence are as determined by someone other than the patient, and an attitude implied that ‘I know what’s best for you, even if I’ve never met you’. This is particularly the case for overseas examples frequently used as justification for beliefs about abuses of legislation, even when the only information available is in newspaper articles and only a fraction of those articles is cited.

• There are unacceptable attitudes to people in particular groups who are labelled ‘vulnerable’ based on inaccurate, crude, demeaning, outdated and discriminatory stereotypes and treated as if they are incapable of independent, competent decision-making and unlikely to choose assisted dying unless coerced, manipulated or abused by families and doctors. This includes people who are elderly, have disabilities and are mentally ill. (See recommendation above about Professor Schuklenk’s article.)

• There is general consensus about the value of and support for increases and improvements in awareness, attention and services related to advance care planning and palliative care, and some commonality about the action necessary even if there are some differences in some details and about proposed action. This consensus is across the community and independent of views on voluntary assisted dying. For example, organisations such as DwDTas and Dying with Dignity Victoria (DwDV) are very active in encouraging and promoting end of life and advance care planning, and supporting palliative care because they assist so many people to achieve their wishes for the end of their lives. Voluntary assisted dying is only ever going to be needed or wanted as an additional option for people to achieve their wishes by a very small percentage of the population.

• It is disappointing that there is little if any attention to the limits of palliative care to relieve all suffering and to the limits on the extent to which people’s wishes can be met, eg if they want futile, expensive treatments, or if they want to avoid prolonged unrelievable suffering that they find intolerable and we do not have the option of legal voluntary assisted dying.

• There is strong support and respect for people to protect their wishes and take responsibility for themselves through advance care directives that only come into operation when someone is no longer competent to express their wishes. But in many submissions there is no corresponding support and respect for competent people to take the same steps and responsibility if they are faced with the terrible situation that doctors and palliative care have run out of options to relieve their suffering.

• Assertions are often made without any basis in evidence or reasoned arguments and in numerous cases are contrary to the evidence that is available and reasonable assumptions. For example, the opinion is often expressed that doctors will no longer be trusted and the doctor/patient relationships will be adversely affected, even poisoned, if voluntary assisted dying is legalized. Not only is there no evidence of that happening after decades of carefully and thoroughly scrutinised assisted dying practice, there is also evidence to the contrary.9
3. DWDTAS ACTIVITIES AND VIEWS

(a) End of life and advance care planning

In recent years, hundreds of people have been assisted by information and advice, numerous workshops and speaking engagements that have been provided by DwDTas, especially through our Vice-President, Bill Godfrey.

Our approach to advance care planning is that it is best done as part of the appointment of an Enduring Guardian which in Tasmania provides legal support. We also approach it as part of broader end of life planning. More information is available on our approach on our website at http://dwdtas.org.au/guide-to-end-of-life-planning/. Also available is a copy of a detailed practical guide developed by Bill Godfrey and that offers a guide to all the issues that need to be considered and put in place to ensure that people’s wishes are understood and will be followed, whatever the circumstances of the last part of their life. A very helpful aspect of the guide is that it contains up to date forms.

Our views are very similar to many of the submissions received by the inquiry about the importance and value of advance care planning and the need for action to promote this, and to encourage and assist people to express their wishes. However, there are also some differences in our approach and some concerns, e.g. about the commitment to meet people’s wishes not just encourage them to express them.

(b) Voluntary Assisted Dying Law Reform

This is a summary of our position on voluntary assisted dying law reform which is based on values and principles, facts, evidence, thorough research and views of members and experts in medicine, law and ethics.

1. It is an indisputable fact that some people experience persistent, intolerable and unrelievable suffering as a result of advanced incurable and irreversible medical conditions, and their doctors run out of reasonable options to improve their condition or relieve their suffering. Current options, including palliative care and terminal sedation, help most people, even hasten death, but do not provide everyone with effective and timely relief from suffering combined with way of dying that is acceptable to them.

2. The current law forces a cruel choice: prolonged intolerable suffering or find a way to end it - possibly early and lonely suicide, starving yourself to death, or putting doctors and loved ones at risk if they help you. The law hasn’t kept up with the major changes in medicine and society, is not based on reality, is not effective in preventing assisted dying and is pushing people into worse alternatives. Just because there is only a small percentage of people in this situation is not an acceptable reason to disregard their situation and wishes. This cruelty has to stop.

3. We support VAD legislation where the primary objective is to provide a last resort option for doctors to help people to end their suffering through a way and time of dying they find better than the alternatives. Overseas experience has clearly demonstrated that this can be
done safely and responsibly and we can strengthen the safeguards through a well-designed, carefully regulated and monitored system that respects the repeated, well-informed requests of competent adults and respects our doctors and collaborative doctor-patient relationships.

4. It is very easy to understand the high level of support for doctor-provided assisted dying and that this support is across the community, including among Christians and voters supporting all Parties. People don’t want to die a long, lingering death with prolonged suffering. Compassion is not enough - people want respect and the chance to make decisions about their own lives according to their own beliefs and what is important to them and to decide when their suffering has become intolerable. Unlike opponents of VAD reform, most people respect and trust our doctors to act professionally, ethically and legally, as well as with compassion and respect for patient choices.

5. An increasing number of Parliaments and courts are accepting the overwhelming high quality evidence that VAD legislation overseas is providing a well-tested, compassionate, safe, additional option, valued by patients, doctors and the broader community. There are good reasons to believe that this will be the case here. But MPs voting against VAD Bills here, particularly Liberal Party MPs, have largely ignored this evidence and instead relied on very poor quality data and arguments from a tiny minority, that fail to meet the principles and standards that politicians usually rely on for the development of good policy and laws for the community as a whole.

Supporting information

There is a wealth of information and arguments supporting these views, including in the DwDV submission. We provide here some limited additional information.

- As already commented, one of the major flaws of the case put against VAD legislation in public and parliamentary debates is the almost total absence of acknowledgement of the reality of persistent, intolerable and unrelievable suffering, despite evidence from medical experts and expert bodies and many, many documented and anecdotal examples. Even when there is acknowledgement, there is silence about effective action to address the issue. For example:
  - In 2014, the AMA submission to the Senate inquiry into the Exposure Draft Medical Treatment (Dying with Dignity) Bill made no mention of people in this situation, an omission we find unacceptable.
  - In 2013, AMA (Tasmania) stated in its submission to the consultation on the Tasmanian Proposal (2013): “For most patients in the terminal stage of illness, pain and suffering can be alleviated by therapeutic and comfort care; however, we fully acknowledge that there are still currently instances where the satisfactory relief of suffering cannot be achieved.” However, the only action it advanced involved more palliative care but without any details of exactly what, where, cost or timeframe, that is, palliative care on the ‘never-never’.
the best that Palliative Care can offer to support patients in their suffering, appropriate specialist Palliative Care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.” No specific action to address this is advanced. However, the ANZSPM submission to this inquiry makes no mention of this important point.

- Legal VAD now exists in 10 places as a result of specific laws and Court decisions. This includes:
  - **Europe:** Switzerland (1942 Criminal Code), Belgium and the Netherlands (2002), Luxembourg (2009)
  - **US States:** Oregon (1997), Washington (2008), Montana (Court decisions 2008, 2009), and Vermont (2013). (In New Mexico, a court decision of 2014 found it was legal but was recently overturned on appeal)
  - **Canada:** Quebec (2014)
  - **Other:** Columbia as a result of a court decision in 1997 and one in March 2015 requiring clarification of legality and regulatory guidelines.

- More Bills are being proposed and debated in Western Parliaments, including Canada and the US. The dominant model has a focus on suffering, not on ‘terminal illness’. This issue is addressed more in Section 5.

- As covered in other submissions, there have been major developments in Canada including the Quebec *End of Life Act* 2014 on which more information is provided in Section 5 and the Canadian Supreme Court unanimous 9 - 0 landmark judgement in February 2015 that the prohibition of physician-assisted death is unconstitutional and the Parliament should legislate within 12 months to allow assisted dying for competent adults who clearly consent and have “a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition”.

- Support for a legal option for doctor-provided assisted dying in Australia and elsewhere has been very well documented including in the DwDV submission to this inquiry. We have included with this submission (Attachment 1) a paper on the issue that includes some of the same data, additional analysis, further results from a Tasmanian survey in 2013 and a section on doctors attitudes.

No-one seems to know what the support of VAD legislation is among Australian doctors. However, based on Australian research and anecdotal evidence, and recent surveys of doctors in Canada and the US, we can reasonably assume that at least a significant minority support legalising VAD and many would be prepared to assist.

It also includes information on developments in the Canadian Medical Association to April 2015. Since then, in June 2015, the CMA proposed its own protocols in a draft paper, “Principles-based Approach to Assisted Dying in Canada” and is available at [https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/care-at-the-end-of-life-cma-framework-june2015-e.pdf](https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/care-at-the-end-of-life-cma-framework-june2015-e.pdf). We recommend the Committee consider the paper. We also recommend that the Committee canvas these issues with AMA (Victoria) if they are not covered in its submission.
4. TASMANIAN EXPERIENCE AND CURRENT SITUATION

We have been very concerned to note in a number of submissions opposed to voluntary assisted dying legislation the reference to the findings of “a Tasmanian inquiry” which are cited as support for their own views. In a couple of cases the date - 1998 - is revealed but not in others. It is absurd to suggest that the findings of the inquiry are still relevant, when they are based on information that is close to 20 years old and before the legislation in most jurisdictions even existed. The Committee conducting the inquiry in 1996 - 8 therefore had no access to the vast amount of evidence that is now available that shows its fears have not been realized. The inquiry report is so out of date it did not even include any reference to the Oregon legislation which was passed in 1997. This is a very good example of an outdated claim, distorted by the omission of critically relevant detail.

The much more recent Parliamentary Committee inquiry into the Dying with Dignity Bill 2009, did not make the same findings as in 1998. The 2009 inquiry concluded that the Dying with Dignity Bill 2009:

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

The most recent and intensive development in Tasmania was the 2013 detailed proposal for a voluntary assisted dying Bill in Tasmania, Voluntary Assisted Dying: A Proposal for Tasmania¹⁰, and the resulting Bill, the Voluntary Assisted Dying Bill 2013¹¹.

Both were initiatives of the then Premier, Lara Giddings, and the then Leader of the Greens, Nick McKim. The Voluntary Assisted Dying Bill 2013 was a Private Member’s Bill, co-sponsored by them and based on the Proposal and the resulting public consultation. Unlike most Private Member’s Bills, this one was drafted by the Office of the Parliamentary Counsel.

There are important points about the vote:

- The Bill failed by one vote to pass the Second Reading stage in the House of Assembly in October 2013, that is, the 13 MPs who voted against it voted not to have full debate on the provisions of the Bill in the Committee stage;
- In common with other recent votes on assisted dying Bills in NSW and WA, not a single Liberal Party MP voted for the Bill, despite the fact that the vast majority of Liberal Party voters support a legal option for doctors to provide assisted dying in the circumstances reflected in the Bill.

DwDTas was intensively involved in the process for the Proposal (2013) and the Bill through representation on the expert panel consulted on the proposal and the Bill. Our President, Margaret Sing, was also involved in a personal capacity¹² in the small team that worked with the proponents, Lara Giddings, then Premier of Tasmania, and Nick McKim, then Leader of the Greens, to develop the model and the Bill itself. The perspective on the process and model presented in this submission is that of DwDTas and our President.
The Tasmanian experience and situation provides valuable information and insights on the issue of voluntary assisted dying law reform that is of benefit to the Committee’s considerations. We are not suggesting that the model or Bill is some sort of ideal. In fact, we are working on proposed amendments to the last Bill for discussion with politicians who are the sponsors and possible sponsors of a new Bill later this year.

However, the value is in the principles and concepts, the process followed, the issues considered and the rationale for the decisions made. Considerable time and efforts were put into ensuring the development processes were rigorous and thorough. They involved very extensive research on and thorough critical analysis of existing laws and legal practices, on the need for the legislation and ways to improve on existing models to address perceived risks, and to ensure the model was practical and suited Tasmanian circumstances. The section of the Proposal (2013) which is of particular value is Chapter 5 which sets out in great detail the rationale for the components of the model proposed.

There was one major change from the Proposal (2013) in the final Bill involving the extension of eligibility beyond ‘terminal illness’ to those with in the advanced stages of other incurable and irreversible medical conditions and with intolerable and unrelievable suffering. This occurred as a result of DwDTas lobbying and was based largely on a well-known Tasmanian case involving Elizabeth Godfrey whose son was convicted of assisting her suicide.

We argued that the Proposal (2013) indicated that people in a similar situation to Mrs Godfrey’s would have access to the process to have her request for assisted dying fully dealt with. She had substantial suffering and would have met the proposed requirement. However, she may not have been able to meet the ‘terminal illness’ test because the cause of the suffering was not a condition that would have caused her death. We are happy to provide more details about this issue.

The current situation in Tasmania is that another Private Member’s voluntary assisted dying Bill is expected later this year. Lara Giddings will be a sponsor, along with the now Leader of the Greens, Cassy O’Connor. Both are seeking a Liberal MP to co-sponsor the new Bill. We recommend the Committee seek evidence from Lara Giddings, who has outstanding knowledge, understanding and commitment to the legislation.

5. VOLUNTARY ASSISTED DYING LEGISLATION AND LEGAL PRACTICES

We provide two attachments on this issue that add to the information provided in other submissions we endorse including that of DwDV and the Royal Society of Canada Expert Panel:

- A table “Safeguards and provisions in existing legislation”, from the Tasmanian Proposal (2013) and refer the Committee to the much more detailed Appendix 1 of the Proposal. (Attachment 2)
- Tables of Comparison, prepared by DwDTas using the material from the Proposal and adding information about the legislation in Quebec, Canada, and the comparison provision in the Tasmanian 2013 Bill. (Attachment 3)
The Quebec legislation represents a new model because it provides for voluntary assisted dying within the broader end of life context. The *End of Life Care Act 2014* was passed by an overwhelming vote of 94-22, with no abstentions. There was support from MPs in all Parties, including the strong support of senior MPs including the Liberal Party Premier, a former doctor. The provisions for assisted dying are similar to those in the Tasmanian 2013 Bill but as shown in the Table of Comparisons (and Professor Schuklenk can explain further), a late amendment to the Quebec Bill added ‘at the end of life’ in the requirements.

The level of support is in no small way due to the lengthy community consultation and thoroughly researched review and recommendations that preceded the Bill. This included a consultation paper and final report.15

The important points about the comparisons we have provided in Attachments 2 and 3 are that:

- The requirements, processes and oversight/scrutiny are very demanding, as they need to be.
- Although there are similarities between current legislative frameworks and legal practices related to voluntary assisted dying, there are also very significant differences in the requirements, processes, reporting, statistical collection and reporting, and oversight and monitoring.

The differences reflect the very different social, medical, legal and political cultures in which the changes have occurred and the very different political processes that have led to these frameworks and practices. It is not possible to take a model ‘off the shelf’ because of these differences.

For example, the submission from Dignitas (659) contains well-informed and strong arguments that apply equally to Australia. But it also demonstrates the different genesis and cultures in its description of the history and cultural attitudes to suicide in Switzerland that underpin their legal practices but which are very different from Australian history and culture. In the Netherlands it was doctors and doctor groups including the Royal Dutch Medical Association that drove the changes in practices and acceptance of doctor-provided assisted dying. This genesis is reflected in many aspects of their legislation and practice, particularly the review and monitoring of cases. The review committees effectively have two roles - a professional one to provide guidance, quality and consistency assurance and professional development; and a monitoring and reporting role, including referral of possible breaches of the Act for action by appropriate authorities. This combination would not be possible in Australia, nor would it be considered appropriate.

Understanding these requirements and differences is critically important to any valid assessment of voluntary assisted dying practices and decisions about a legislative framework in Victoria. Yet the differences are not well known or understood. Common inaccuracies and distortions in claims and arguments of those opposed to voluntary assisted dying occur because of the poor knowledge and understanding about them. Any claims made about any jurisdiction therefore do not necessarily and usually do not apply to any other. Lumping several jurisdictions together and applying the same criticism to all of them results in major fallacies and distortions.
This is particularly the case in relation to the concept of the ‘slippery slope’. For example, ‘terminal illness’ is not and has never been a requirement in the Netherlands and Belgium, whereas it is and has always been a requirement in Oregon and other US States. It is therefore wrong to claim as one of the proofs of the ‘slippery slope’ that the Netherlands or Belgium have slid down an imaginary slope by shifting away from a ‘terminal illness’ requirement. Similarly, many of the individual cases complained about by opponents are wrongly claimed to be proof of abuses because the people who obtained assistance to die were not eligible because they were not ‘terminally ill’ (eg Belgian twins).

Another common distortion is the claim that the eligibility has been expanded (illegally or unfairly) to a broader range of illnesses and people have obtained assistance to die “because” of a certain illness (eg psychiatric) or condition. The fact is the requirements in the Netherlands and Belgium have continued to focus largely on the lasting nature and level of suffering not on the cause of that suffering. The most common fallacy about Oregon seems to be that there is a requirement for compulsory psychiatric assessment and the ‘slippery slope’ is occurring because this requirement is not being adhered to, but there is no such requirement.

There are similarities and differences in outcomes in different jurisdictions. For example, the vast majority of those who choose assisted dying in all jurisdictions have cancer. It is also the case that deaths due to assisted dying also constitute very small percentages of total deaths in all jurisdictions. However, assisted deaths as a percentage of total deaths is greater in the Netherlands (3.4% on 2013 figures\textsuperscript{16}) than Oregon (0.3% on 2014 figures\textsuperscript{17}) but eligibility is also wider because of the focus on suffering rather than ‘terminal illness with death likely to occur within 6 months. Distortions occur when reference is made only to numbers and it is implied that they are increasing at an unacceptable rate. Similar distortions occur when claims are made about increases in numbers of deaths involving suffering due to psychiatric conditions, or dementia, or deaths assisted at the mobile clinics in the Netherlands. Information that they are a miniscule percentage of assisted deaths, and are carefully investigated\textsuperscript{18} also needs to be taken into account.

Inaccuracies and distortions also occur because of a lack of understanding or misrepresentations of statistical and other reports. The most common of these relate to:

- the issue of being a ‘burden’ especially the misunderstanding and distortion of the Oregon statistics. Only in a minority of cases was there a mention of concern about “the physical or emotional burden on family, friends and caregivers” as one of the concerns noted by the physicians involved.\textsuperscript{19}
- the issue of deaths ‘without an explicit request’ (not ‘without consent’ as sometimes claimed). This issue is very well covered in the Royal Society of Canada Expert Panel submission and the DwDv one. The distortion occurs largely because of the false assumption of ‘cause and effect’ when no such relationship exists. Deaths resulting from use of drugs without an explicit request occur in many places that do not have assisted dying legislation including Australia.

6. KEY ISSUES FOR VOLUNTARY ASSISTED DYING LEGISLATIVE FRAMEWORK
The key issues to be considered for any VAD legislative framework are indicated in the Tasmanian Proposal (2013) and Bill. They include core issues where there are significant differences between legislative frameworks elsewhere:

- The person’s condition and experience of suffering
- Type of assistance - whether provision of drugs only for self-administration, or doctor-administration, or limitations depending on the circumstances
- The number of doctors involved, the requirements related to those doctors (eg qualifications and experience) and the role of psychiatrists (and psychologists) in relation to competence
- Reporting and scrutiny of cases
- Age requirements.

Other issues include residency requirements, number and type of requests (oral and written), witnesses and interpreters, information that must be provided to persons, voluntariness and how the processes will assure it, waiting periods including any differences due to individual circumstances, family notifications, safe handling of prescription medicine, opportunities to rescind request, death certificates, insurance, offences in relation to reporting and other issues

DwDV has presented very carefully considered detailed recommendations for end of life choices in legislation. They address many of these issues and provide a very sound basis for a Victorian model.

**CONCLUSION**

We believe the primary questions for the inquiry to address are:

1. Do you accept that:
   - (a) there are people who have intolerable and unrelievable suffering as a result of incurable and irreversible medical conditions;
   - (b) their doctors run out of options to improve their conditions and relieve their suffering adequately and to the satisfaction of the people concerned;
   - (c) some of these people and their doctors accept that the only way their suffering is going to be ended is through death;
   - (d) some of these people make competent, well-informed, voluntary requests for active intervention to achieve this end of suffering at a time and in a way which provides them with a better death than is otherwise available; and
   - (e) there are doctors who support this intervention and are prepared to provide assistance through lethal drugs?

2. How, as a community, can we respond with empathy, compassion and respect to the needs of people in this situation?

We believe the only acceptable response is the provision of an additional option, of doctor-provided voluntary assisted dying, within a regulated and monitored system that puts the needs of people with profound suffering at the heart of all considerations of requirements and processes.
END NOTES


3 Margaret Sing is a former senior public servant with over 30 years’ experience in policy and legislation development, implementation, management, review and assessment. This has been in a wide range of policy areas and in different capacities including senior public sector policy and management, Head of a Ministerial Office, member and Chair of bodies including the Local Government Board, member of the Social Security Appeals Tribunal and community lobby groups.

4 Nick McKim is now a Senator having recently replaced Christine Milne. Ms Giddings has also recently commented that she would be prepared to delay moving a new Bill to allow time for a possible Liberal co-sponsor. (http://www.abc.net.au/news/2015-08-26/voluntary-euthanasia-bill-may-be-delayed/6725084)

5 http://www.brainyquote.com/quotes/quotes/r/robertkenn135395.html

6 For example, Catholic activist, Professor Margaret Somerville, and other anti-lobby groups such as the Euthanasia Prevention Coalition, HOPE (based in SA) and Real Dignity Tasmania.


8 The paper is available online at http://jme.bmj.com/content/41/8/577.full.pdf+html?sid=e46fe994-7f45-4820-817b-9c47da51d36e.

9 For example, a European survey in 2008 by GfK research found that 91% of respondents trusted doctors in the Netherlands, the highest in Europe with Sweden. Belgium was not far behind with 88% of respondents trusting doctors. This compared to 82% in the UK.

10 See Note 1.

11 See Note 2.

12 See Note 3.

13 See page 11 - 12 of the Proposal (2013) for details.

14 See Note 4.


16 The Netherlands Annual Report for 2013 is the last available full report and it can be accessed at https://www.euthanasiecommissie.nl/Images/Annual%20report%202013_tcm52-41743.pdf.


18 See Annual Report referred to in Note 16.

SUPPORT FOR VOLUNTARY ASSISTED DYING LAW REFORM

This is an update of Information Paper 1, distributed for the debate on the proposed voluntary assisted dying legislation in Tasmania in 2013 and available on the DwDTas website. It adds information from a 2013 EMRS Tasmanian poll, recent interstate ABC Vote Compass results and information on doctors' support for voluntary assisted dying.

This Paper provides information about the continuing very high level of support across the community for a voluntary assisted dying law in Tasmania, and elsewhere in Australia. There is no other social issue involving law reform - and possibly no other political issue - where the support is as high as it is for a legal last resort option of doctor-provided voluntary assisted dying in limited circumstances. The support is as strong across gender, age groups, people with different party voting intentions and those with and without a religious affiliation.

These facts have been established through well conducted surveys by reputable organisations, including the 2013 EMRS\(^2\) poll conducted for DwDTas, a number of Newspoll surveys and the ABC. Information from those surveys is included here, with comparisons to other surveys that add weight to their findings. The paper refutes ill-informed and unreasonable claims disparaging community views on this issue.

It is also clear from this information that the vast majority of the Tasmanian population support a 'last resort' voluntary assisted dying law of the kind advocated by Dying with Dignity Tasmania (DwDTas) and very similar to the Voluntary Assisted Dying 2013. The sponsors of that Bill, MPs Lara Giddings and Nick McKim, have announced they will move another Bill later in 2015. We expect it to be the same as or very similar to the 2013 Bill.

This paper also includes some information related to the views of doctors on this issue. No-one seems to know what the support for VAD legislation is among Australian doctors. However, based on Australian research and anecdotal evidence, and recent respected surveys of doctors in Canada and the US, we can reasonably assume that at least a significant minority of doctors support legalising VAD and many would be prepared to assist.

It continues to be of concern that there is such a gap between community support and voting by politicians, particularly Liberal Party ones, that in debates on Bills the only views cited are those of the tiny minority opposed to the legislation and that some of them continue to make false and misleading claims even when they have been provided with good quality information. DwDTas has consistently stated that politicians should not support assisted dying legislation simply because of this high level of community support. However, this level of support adds great weight to the need for law reform.
SUMMARY

- There is a gap between politicians voting and the high level of community support for VAD law reform, even though this high support and the support of many doctors increases the disrespect for the law, covert illegal activity and results in greater risks than a transparent, regulated and monitored system.

- Reputable opinion polling of the public on the issue of voluntary euthanasia/voluntary assisted dying has been conducted over many years. Results show a significant increase in community support for a legal option of doctor-provided voluntary assisted dying and approximately 80%, the vast majority of the Australian population, including Tasmanians, now support it. Support is now at a higher level than for any other similar social issue and other political issues.

- This level of support was confirmed again in the 2013 Enterprise Marketing and Research Services (EMRS) survey of 1,000 Tasmanians conducted for DwDTas, and the Newspoll national survey conducted in late 2012. The question asked in the EMRS and a series of Newspoll surveys is very clearly about a doctor providing voluntary assisted dying through a ‘lethal dose’ so there is no confusion with withdrawal of treatment, refusal of treatment, increased pain relief or terminal sedation.

- A key finding of the 2013 and 2012 surveys is that the vast majority of Tasmanians support a legal option very similar to that in the 2013 Tasmanian Voluntary Assisted Dying Bill - that is, doctor-provided assisted dying, in response to a patient’s request, when that patient is experiencing unrelievable suffering and has absolutely no chance of recovering. Nationally in 2012, 82.5% expressed support. Support for this option was expressed by 80% of Tasmanian respondents in the 2013 EMRS, 78% of Tasmanian respondents in the 2012 Newspoll and nationally, 82.5% of respondents.

- In both polls, support was similarly high across gender and age groups, across religion and party voting intentions. Support was very high amongst Liberal/National voters (EMRS - 74%; Newspoll - 82%) as well as ALP (EMRS - 84%; Newspoll - 84%) and Greens voters (EMRS - 96%; Newspoll - 88%).

- The EMRS poll did not collect information on religious affiliation. In the 2012 Newspoll, support was very high by those who identified as Anglicans (88%), Catholics (77%), no religion (89%) and spiritual belief but no formal religion (90%). The vast majority (81%) who opposed the legal option had a religion. Claims by church groups opposed to voluntary assisted dying that they represent the views of the majority of Christians are mistaken.

- ABC Voter Compass surveys before recent State elections in Victoria, Queensland and NSW found very strong support for voluntary assisted dying law.

- Doctor attitudes: There is much less known about the views of doctors not only in-principle about voluntary assisted dying law reform but also about alternative options for that reform. However, there are good reasons to believe that at least a significant minority support it in-principle and many would be prepared to provide assistance.
WHY IT MATTERS THAT POLITICIANS ARE OUT OF STEP WITH COMMUNITY AND DOCTOR SUPPORT FOR VOLUNTARY ASSISTED DYING LAW REFORM

DwDTas has consistently stated that politicians should not support assisted dying legislation simply because of the high level of community support. However, it continues to be of concern that there is such a gap between community support and voting by politicians, particularly Liberal Party ones. Not a single Liberal Party MP has voted for a voluntary assisted dying Bill in Tasmania (2009 and 2013), NSW (2013) or WA (2010) and only a small number voted for the 2012 SA Bill.

It is also very disturbing that in debates on Bills the only views cited are those of the tiny minority opposed to the legislation and that some MPs continue to make false and misleading claims to disparage soundly-based data on community support as part of their justification for voting against Bills.4

When a large percentage of the community no longer support a particular law, distrust in and disrespect for the law increases, along with covert, illegal behaviour that creates greater risks than in a transparent, regulated monitored system. Professor Margaret Otlowski, Dean of Law at the University of Tasmania has written extensively on this issue.5

ATTITUDES TO ASSISTED DYING LAW REFORM OVER 50 YEARS

Scientific opinion polls6 have been conducted in Australia for decades on the issue of voluntary euthanasia/voluntary assisted dying. This chart shows the results of national polls since 1962.

![Attitudes to voluntary euthanasia over 50 years](chart.png)

Research results from Roy Morgan, ASRBP and Newspoll national surveys
VAST MAJORITY ACROSS THE COMMUNITY SUPPORT
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RECENT SURVEYS

2013 EMRS Tasmanian poll: An opinion poll was conducted for DwDTas by the respected Tasmanian survey organisation, Enterprise Marketing & Research Services Pty Ltd (EMRS), between 14 and 18 September 2013. The poll was of 1,000 Tasmanians across the State (500 in South and 250 each in North and NW). Respondents to the 2013 poll were asked the same question as for Newspoll surveys:

Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?

2012 Newspoll national poll: The latest in a series of Newspoll surveys was conducted in 2012 via a national public opinion poll. Residents of all states were included in the sample of 2,521 people. Interviews were conducted by telephone late October through mid-November 2012. Respondents were asked the same question as that used in the 2013 EMRS poll.

OVERALL RESULTS

In common with the national trend, support by Tasmanians for a legal voluntary assisted dying option has increased significantly since the 1998 Parliamentary inquiry into the need for legislation on voluntary euthanasia. In the report of the inquiry (page 10), it is stated that the latest poll on the subject, specifically whether Tasmania should legalise voluntary euthanasia as the Northern Territory had done, 54% of respondents answered yes, 34% of respondents answered no and 10.8% were undecided.

The EMRS poll found 80% support, 14% opposed and 5% don’t know or unsure.

The 2012 Newspoll found an overwhelming national majority said yes (82.5%), outnumbering the small minority who said no (12.7%) by more than six to one, with 3.8% don’t knows and 1.0% refused. The Tasmanian sample was much smaller than in the EMRS poll and the results were 78% said yes, 17% said no and 5% don’t know or refused to answer.

National support for reform was increased from 2007 Newspoll results (79.7%) and was not significantly different from 2009 results (84.9%).

Important additional information is provided by the 2013 EMRS poll that was not collected in the Newspoll. This relates to the strength of support or opposition. A high 62% of the total agreed strongly with the need to change the law, and 18% somewhat agreed. This compared with only 9% who disagreed strongly and 6% who somewhat disagreed.

The overall results are comparable with other research such as a 2010 Australia Institute survey reported in January 2011, which surveyed 1,294 Australians. The question asked was:

This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?
75% said yes, just 13% said no, and 12% were undecided. The level of opposition was nearly identical to the 2012 Newspoll survey, although “don’t knows” were slightly more common in the Australia Institute study.

OTHER COMPARISONS

These comparisons are between the 2013 EMRS Tasmanian data and the 2012 Newspoll national data. Separate Tasmanian data was not available on some aspects in the national poll.

- **Gender:** Both polls found almost no differences between men and women in their support or opposition to the proposition.

- **Age:** There were some differences. In the EMRS poll, the highest level of support was 89% among 18 - 24 year old respondents, compared to support between 78% and 85% in all other age groups except over 70s where the support dropped to 68%. In the Newspoll, support for the voluntary assisted dying option was very high and similar in all age groups, but especially high among a key baby boomer group, those in their 50s (88%).

RESULTS BY PARTY VOTING INTENTION

Both polls show support for assisted dying law reform is very high across voters for all the mainstream parties. In the Newspoll the sample size for smaller parties was too small to permit specific statistical numbers to be reported, but support for assisted dying law reform was lower for the small, conservative and religiously-based parties Family First and the Christian Democratic Party.
This result compares to that in the Tasmanian EMRS poll which found those in favour of changing the law included 74% of Liberal voter respondents, 84% of Labor and 96% of Greens.

This compares to voting in favour of the 2013 Voluntary Assisted Dying Bill by 70% of Labor MPs (7/10) and 100% of Greens (all 5), but 0% of Liberal MPs (0/10).

RESULTS BY RELIGION

The EMRS poll did not collect information on religious affiliation of respondents. One of the most interesting aspects of the Newspoll results, given claims by representatives of religious groups, is the very high level of support for a voluntary assisted dying option by those with a religious affiliation, particularly by those respondents who claimed they were Anglicans (88% or nearly 9 out of 10) and Catholics (77%, more than 3 out of 4).

Opposition to reform was highest amongst smaller Christian groups, but overall, even amongst this group, opposition is a small minority. Owing to limited sample sizes amongst non-Christian-religion respondents, no specific statistics can be reported for these groups.

This chart shows the results by religion.

RELIGION: Doctor can provide a lethal dose

The 2012 results show an increase from the 2007 Newspoll survey in support by Anglicans (82%) and Catholics (74%). The Newspoll results are comparable with the 2010 survey by the Australia Institute that found 65% of Christians agreed that if someone with a terminal illness who is experiencing unrelievable suffering asks to die, a doctor should be allowed to assist them to die.
The findings of this survey also confirm the view that there is a strong correlation between opposition to voluntary assisted dying law reform and religious affiliation. Of the small percentage of respondents to the 2012 survey who opposed the legal option, the vast majority, 81%, had a religion compared to 15% with no religion (that is, nearly seven times more likely to have a religion than not). This was substantially than those who supported the option reform - 56% had a religion - and in the general population where approximately 60% have a religion. This result is similar to that found in the 2007 Newspoll that 84% of those who opposed the legal option were religious, 12% had no religion, and 4% refused the question or were undecided.

CHRISTIAN SUPPORT

The results from these reputable polls add research evidence to personal opinion and reports in the media and letters to the editor where the view is expressed that there is no single “Christian” viewpoint and that many Christians support voluntary assisted dying legislation, eg the Australian group, Christians Supporting Voluntary Euthanasia Choice. In 2014, the former Archbishop of Canterbury, Lord Carey, announced he had changed his mind and supported ‘right-to-die’ legislation. As he said in his reported comments: The current law fails to address the fundamental question of why we should force terminally ill patients to go on in unbearable pain and with little quality of life. It is the magnitude of their suffering that has been preying on my mind as the discussion over the right to die has intensified. The fact is that I have changed my mind. The old philosophical certainties have collapsed in the face of the reality of needless suffering.

Church leaders and religious groups opposing VAD law reform routinely fail to acknowledge that there are some people who experience intolerable and unrelieviable suffering and maintain the cruel pretence that palliative care can relieve all suffering. They also routinely overestimate the Christian opposition to VAD law. The Uniting Church is a notable exception and in its submission to the 2013 consultation on the proposal for voluntary assisted dying legislation acknowledged and expressed respect for the different viewpoints within the Church.

Church leaders who were signatories to what they called “the Salamanca Agreement” claimed in 2013 that they represent 170,000 Tasmanians in opposing social reforms including voluntary assisted dying law reform. This claim is certainly mistaken and they ought reasonably to have known this. It is not possible for the group to represent 170,000 without the support of the large majority of Anglicans and Catholics. Yet, as the Newspoll demonstrates, that is not a reasonable assumption to make.

The basis for their claim is stated as “according to latest census data on faith affiliation”. 2011 Census figures show that 128,711 (26%) of Tasmanians are Anglicans and 88,837 (18%) are Catholics but the other signatories represent churches with small numbers. For example, the largest of them in the group are Pentecostal (4,801; 0.9% of Tasmanians); Baptists (8,599; 1.7%); 12,064 (2.4%) are in the category Christian nfd which includes the Apostolic Church,
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Church of God and Australian Christian Churches; and 12,105 (2.4%) are in the ‘Presbyterian and reformed’ category.

Therefore when looked at in the light of the Newspoll data, the group’s assumption is poorly based and unreasonable speculation and a significant exaggeration of the support for their views, at least on the issue of legalisation of voluntary assisted dying.

ABC VOTE COMPASS

The ABC now conducts voter opinion surveys on a range of issues in the lead-up to national and State elections. This includes a survey on the proposition: "Terminally ill patients should be able to legally end their own lives with medical assistance". The results found in recent elections show high level support from large numbers of respondents.

They are not scientific polls and the ABC acknowledges that “Online surveys are inherently prone to selection bias” but points out that “statisticians have long been able to correct for this” and “the ABC applies sophisticated weighting techniques to the data to control for the selection effects of the sample, enabling us to make statistical inferences about the Australian population with a high degree of confidence.” Further information including graphs on political voting intention and religious affiliation is available on the ABC website.

Results were:
- **Victoria - State election in November 2014**: The ABC’s Vote Compass found 77% of 60,000 respondents supported the proposition.
- **Queensland 2015 State election**: 75.9% of 70,000 respondents agreed with the proposition
- **NSW 2015 State election**: 72% of 34,000 respondents strongly agreed or agreed with the proposition, compared with 16 per cent of respondents who did not. Eleven per cent of people said they were neutral.

COMPARISONS WITH OVERSEAS

Interestingly, Vote Compass returned a 77 per cent "yes" vote during the last Canadian general election. The results of the Australian surveys are consistent with public opinion overseas in showing the vast majority support for doctor-provided VAD.

None of the results are as high as the support in the Netherlands, which is the country with arguably the most experience of voluntary assisted dying and where the population has had the greatest opportunity to judge the effectiveness of safeguards and the safe and responsible implementation of the law by doctors. As reported in the 2013 Tasmanian consultation paper (p 8), the Royal Dutch Medical Association gave evidence to the Commission on Assisted Dying in the UK in 2011 that 92% of the population in the Netherlands support their euthanasia law and 84% of physicians have either performed self-administered assisted dying or doctor-administered assisted dying or are willing to do so.
A late 2012 European ISO Public\textsuperscript{15} study (p6) found overwhelming support for personal end-of-life choice from 71\% to 87\% across a range of European countries, and a small majority in Greece (52\%). A similar majority said they would consider assisted dying if faced with a serious incurable illness (p8).

The 2011 report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making contains a lengthy section on attitudes of Canadians towards voluntary assisted dying (voluntary euthanasia and assisted suicide) from the perspective of the general public, health care professionals and patients, and provides international comparisons that show significant public support, eg in a 2010 Angus Reid survey of a national sample of 1,003 Canadians, a large percentage (67\%) of respondents was in favour of legalising voluntary euthanasia.\textsuperscript{16}

**DOCTORS AND VOLUNTARY ASSISTED DYING LAW REFORM**

In the submission to the consultation on the 2013 detailed proposal for voluntary assisted dying legislation, AMA Tasmania states: “We clearly acknowledge that there are individual medical professionals who support assisted dying and believe the provision of relief of pain and/or suffering through assisted dying is consistent with providing good quality care. … The majority of doctors, however, do not share this belief and consider the deliberate taking of life by a doctor to be unethical and contrary to the profession’s ethic of care.” The AMA, however, recognises and supports the use by doctors of end-of-life practices to relieve suffering, such as increased pain relief and palliative (terminal) sedation, which are known to also hasten death.

Australian research on this issue is both limited and dated. The debate and decision-making by politicians would be greatly assisted by better research on Australian doctors’ attitudes, even if that was only of AMA members.\textsuperscript{17} We requested information from AMA Tasmania on the evidence for its claim but received no response. We are aware of doctors in Tasmania and elsewhere who support voluntary assisted dying legislation and a growing number of doctors are joining the national group, Doctors for VE Choice (http://drs4vechoice.org/). Their position was outlined in an article in the Medical Journal of Australia in 2013. As they say: “although the doctor may ‘try to ensure that death occurs with dignity and comfort’, this desirable outcome does not always occur. The code [the AMA Code of Ethics] leaves unstated the ethics of how to manage a patient when there is no treatment for certain forms of distress and suffering, when death is not imminent, or when a disorder is not terminal. It does not deal with all aspects of the reality of suffering and death”. (https://www.mJA.com.au/journal/2013/198/4/doctors-support-law-reform-voluntary-euthanasia)

There is an issue of whether there is still a majority of Tasmanian doctors opposed in principle to assisted dying legislation and, if so, whether it is only a slight majority. In-principle views are not the only issue relevant to legislation. The AMA has given no indication and we are not aware of any research about the likely differences in level of support by doctors for the two main methods of administration of the lethal drugs for assisted dying:
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(a) self-administration by the patient of drugs prescribed by the doctor. This is usually by oral ingestion and is the only method legal in Switzerland, Oregon and other US States. It may be called ‘assisted suicide’, ‘physician-assisted suicide’ or ‘physician-assisted dying’ (PAD).

(b) doctor-administration of the drugs, usually by injection. This is legal in the Netherlands, Belgium and Luxembourg, and in the Quebec Province of Canada. This is usually called ‘euthanasia’ or ‘voluntary euthanasia’.

Recent well-conducted overseas surveys provide information on the views of doctors in comparable countries, US and Canada. The Canadian study showed a difference in doctor support for these TWO options.

- **US:** A survey has shown growing support among US doctors for physician-assisted dying. The poll, reported in the Medscape Ethics Report released in December 2014, was a survey of 21,000 US and European doctors. A news report said the sample included 17,000 US doctors and that it found that 54 percent of US doctors surveyed think physician-assisted suicide should be allowed, up from 46 percent in 2010.

- **Canada:** The Canadian Medical Association has been very active on the issue of voluntary assisted dying including a series of public “town hall” meetings and a survey of 5,000 members. Findings of the survey were:
  - 44.8% said they were in favour of legalizing physician-assisted death
  - 36.3% said they felt euthanasia should be legalized
  - 26.7% said they would be likely or very likely to participate if physician-assisted death was legalized.

The CMA has adopted a new policy with 91% support recognising the right of doctors to act according to their own conscience on the issue. This is a stark contrast to the AMA that routinely cites a World Medical Association that assisted dying is unethical and does not acknowledge the right of doctors to their own ethical view.

The Association has acted responsibly to prepare for the likelihood of Canadian VAD legislation. It has started work on issues related to implementation of VAD legislation in recognition that Quebec legislation already exists and national legislation is highly likely following the February 2015 judgement of the Canadian Supreme Court that assisted dying should be legal in some circumstances.

A small NZ survey of GPs was reported on in February 2015 in a letter to the New Zealand Medical Journal. There were 78 responses to 200 letters to GPs in the Waikato District. Three different scenarios were put to doctors with greatest support - 47.3% - and equal opposition for doctor-provided assisted dying law with adequate safeguards for adult competent patients with end-stage terminal disease and irreversible unbearable suffering.
We recognise that, even if a majority of doctors oppose voluntary assisted dying and will exercise their right under the proposed legislation not to participate, there is anecdotal evidence that there will be enough doctors in Tasmania to provide the service although we foresee difficulties in some rural areas. Overseas experience has shown that very few people choose assisted dying and over time more doctors are prepared to provide the assistance.

CONCLUSION

There is substantial evidence that Tasmanians, like other Australians, support assisted dying law reform and that this is of the kind proposed in the 2013 Voluntary Assisted Dying Bill 2013 that will be the basis for the proposed 2015 Bill. We do not suggest that parliamentarians blindly follow opinion polls but the views of such a large percentage of the community need to be taken into account. When combined with a likely significant minority of doctors who also support VAD legislation, there are increased risks in the ‘status quo’.

ENDNOTES

1 A copy of the original paper can be found at http://dwdtas.org.au/wp-content/uploads/2013/05/DwDTas-Information-Paper-1-Community-Support.pdf
3 The 2012 Newspoll survey was commissioned by YourLastRight.com Limited. This paper includes information is based on a report prepared for YLR.com in December 2012 by the then CEO, Neil Francis, from a very detailed Newspoll report. YLR.com is the national peak body for dying with dignity/voluntary euthanasia organisations including DwDTas.
5 See for example http://amsterdamlawforum.org/article/viewFile/188/379
6 Note that online polls that are often by media organisations are not scientific. This is acknowledged by some, eg the Fairfax disclaimer states: These polls are not scientific and reflect the opinion only of visitors who have chosen to participate. Online readership polls, therefore, do not provide reliable or valid indicators of community opinion or meet the standard required for authoritative input to public policy.
9 http://christiansforve.org.au/
We will not comment about the other social issues because we do not have such detailed information about community opinion on those issues.


We don’t know what percentage of doctors in Tasmania are members of AMA and understand it could be as low as 30% if it is in line with the national picture. (Source: MJA Insight, 28 May 2012)

Whenever the term ‘euthanasia’ is used, great care needs to be taken to check the definition being used because it varies significantly. It may be a specific and limited definition in legislation or an all-encompassing term that includes all end-of-life practices that hasten death. This may include increase in pain relief and terminal sedation which are used to relieve suffering but although they also hasten death are not generally regarded as ‘euthanasia’ except by the group using this term.


http://www.detroitnews.com/story/opinion/2015/03/04/think-assisted-suicide/24410391/

https://www.cmaj.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-air.aspx

http://www.cmaj.ca/site/earlyreleases/19aug14_conscience-should-guide-doctors-at-end-of-life.xhtml

See for example, the 2014 AMA submission to the Senate inquiry into the Exposure Draft Medical Treatment (Dying with Dignity) Bill available from the Senate Committee website.


Reported at http://www.3news.co.nz/nznews/poll-voluntary-euthanasia-has-growing-support-2015011813#axzz3RpgFGP4k
## TABLE 1  SAFEGUARDS AND PROVISIONS IN EXISTING LEGISLATION

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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Doctor administered</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Terminal illness or condition</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Suffering</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mental competence</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Informed decision</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Voluntary request by patient</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Written request</td>
<td>Not specified but generally provided</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Request by advance directive</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age – only adults aged over 18</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Residency requirement</td>
<td>Not specified but required</td>
<td>Not specified but required</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Consultation requirement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Independent consulting doctor</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Voluntary participation by doctor</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Specified Waiting period</td>
<td>No</td>
<td>Yes†</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family notification recommended</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Opportunity to revoke request</td>
<td>Not specified</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reporting of cases</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

† For patients who are not expected to die in the near future, the attending physician must “allow at least one month between the patient’s written request and the act of euthanasia” (§3(3)(2)).
### TABLES OF COMPARISON: SAFEGUARDS AND PROVISIONS OF EXISTING VOLUNTARY ASSISTED DYING LEGISLATION AND PROPOSALS

#### THE PERSON’S CONDITION AND/OR EXPERIENCE OF SUFFERING

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)).</td>
<td>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)).</td>
<td>The patient’s suffering must be “lasting and unbearable” (§21(b)), and that there be “no other reasonable solution for the situation he was in” (§21(d)).</td>
<td>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.”</td>
<td>There is no requirement that the patient be terminally ill or suffering from a specified medical condition.</td>
<td>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)</td>
</tr>
</tbody>
</table>

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”. 

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**MENTAL COMPETENCE**

<table>
<thead>
<tr>
<th>Oregon</th>
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<th>Switzerland</th>
<th>Quebec, Canada</th>
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</thead>
<tbody>
<tr>
<td>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).</td>
<td>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).</td>
<td>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.”</td>
<td>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.” 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.”</td>
<td>To obtain medical aid in dying, a patient must “be capable of giving consent to care” (§26(1))</td>
<td></td>
</tr>
</tbody>
</table>

**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.”
<table>
<thead>
<tr>
<th>Oregon</th>
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<th>Switzerland</th>
<th>Quebec, Canada</th>
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</thead>
<tbody>
<tr>
<td>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)).</td>
<td>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)).</td>
<td>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)).</td>
<td>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).</td>
<td>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.”</td>
<td>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)).</td>
</tr>
</tbody>
</table>

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 –

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(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

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician assisted suicide (patient must self-administer the lethal dose). Voluntary euthanasia is not permitted.</td>
<td>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).</td>
<td>Voluntary euthanasia and assisted suicide.</td>
<td>Voluntary euthanasia which is defined as “intentionally terminating life by someone other than the person concerned, at the latter’s request” §2.</td>
<td>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.</td>
<td>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</td>
</tr>
</tbody>
</table>

**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.
## CONSULTATION AND REFERRAL REQUIREMENTS

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
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<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>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 “[i]n the consultation requirements are more stringent if the patient’s suffering is the result of a psychiatric disorder.”*</td>
<td>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).</td>
<td>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.”*</td>
<td></td>
</tr>
</tbody>
</table>

### 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

- **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”.

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*Lewis and Black, Voluntary Euthanasia: Is it a human right? 2013*
REPORTING AND SCRUTINY OF CASES

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>The Netherlands</th>
<th>Belgium</th>
<th>Switzerland</th>
<th>Quebec, Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3.11 sets out the reporting requirements to be undertaken by the Department of Human Services. Section 3.11 also requires &quot;any health care provider . . . to file a copy of the dispensing record with the department [of Human Services].&quot; The Department of Human Services is required to prepare an annual report on the operation of the Act (§3.11(3)).</td>
<td>Section 15 sets out the reporting requirements to be undertaken by the Department of Health. Section 15 also requires &quot;any health care provider . . . to file a copy of the dispensing record and other such administrative required documentation with the department.&quot; 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)).</td>
<td>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: &quot;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.&quot; The review committees are required to provide an annual report on their activities (§17).</td>
<td>The Belgian Act establishes a Federal Control and Evaluation Commission (§6). Section 5 states that &quot;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).</td>
<td>Individual right-to-die organisations produce their own reports on their activities. The only reporting requirement is that &quot;assisted suicides must be reported to the local authorities as unnatural deaths.&quot; 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.</td>
<td>&quot;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.&quot; (§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)</td>
</tr>
</tbody>
</table>

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

Tasmanian Voluntary Assisted Dying Bill 2013:
(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.
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.

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’.)

Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 6.


Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 7.

Ibid, p. 23.

Lewis and Black, ‘The effectiveness of legal safeguards in jurisdictions that allow assisted dying’, p. 10.

Ibid.

Ibid.