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Do The Safeguards in the Victorian Assisted-Dying Legislation Adequately Account for the Experiences of Other Nations?

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Do The Safeguards in the Victorian Assisted-Dying Legislation Adequately Account for the Experiences of Other Nations?

Submitted in fulfilment of the requirements for the Master of Laws

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Declaration

To the best of my knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made. This thesis is my own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

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17/10/2022

Abstract

In 2017 the Victorian State Parliament passed the *Voluntary Assisted Dying Act 2017*, making it the first Australian jurisdiction since 1996 to pass assisted dying legislation. The Victorian model was hailed by the Government of Victoria as the 'safest and most conservative in the world', and had the benefit of drawing on over 20 years of voluntary assisted dying experiences of other jurisdictions for its development. This thesis examines the experiences of other jurisdictions and how they informed the development of the Victorian model. It examines available data, reports, and criticisms of international experiences and applies them to the Victorian model to assess whether that model accounted for real and perceived issues in other jurisdictions. Through studying the discussions of the Ministerial Advisory Panel on Voluntary Assisted Dying's Final Report against the experiences of other jurisdictions, this thesis examines whether the Victorian model has adequately accounted for the experiences of other nations. Ultimately, the Victorian model does answer to certain issues found, particularly in the Belgian and Dutch models (such as reporting, compliance, and administering of the VAD drug), but ultimately the Victorian legislation fails to answer for persistent issues found in other jurisdictions such as mental health as eligibility criteria, and having a lethal drug out in the public, as well as creating issues with respect to the balancing of safety and accessibility. Since the passing of the Victorian model, Western Australia, Tasmania, and Queensland have passed their own voluntary assisted dying legislation. As the Victorian legislation has encouraged other jurisdictions to follow its lead, it is important to assess if the model suitably answers to expressed concerns and that is the purpose of this thesis.

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DO THE SAFEGUARDS IN THE VICTORIAN ASSISTED-DYING LEGISLATION ACCOUNT FOR EXPERIENCES OF OTHER NATIONS?

HEATH HARLEY-BELLEMORE*

I INTRODUCTION

Benjamin Franklin famously quipped that 'in this world, nothing is certain except death and taxes'. This thesis focusses on the former of Mr Franklin's certainties. For as long as mankind has walked the earth, it has wrestled with the concept of its own mortality. While death is a certainty, we all hope that suffering in death is not.

In 2015 the Victorian Legislative Council agreed to a motion for the Standing Committee on Legal and Social Issues to examine, consider, and provide a report on 'the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices'.[1]

In June 2016 the Standing Committee on Legal and Social Issues tabled its final report. The report made 48 recommendations in total, with the final recommendation being that Victoria should legalise assisted dying.[2] On 29 November 2017, the Parliament of Victoria passed the *Voluntary Assisted Dying Act 2017* which made it the first state in Australia to successfully legalise assisted dying. The Act takes into account the 49th recommendation of this report, and the recommendations of the Ministerial Advisory Panel in the Voluntary Assisted Dying Final Report,[3] to create what has been described as 'the most conservative regime in the world'.[4]

The Victorian Ministerial Advisory Panel's final report provides an appendix comparing the Victorian model's safeguards against that of 6 North American and 2 European jurisdictions.

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[1] Jill Hennessy, 'Voluntary Assisted Dying Bill 2017' (Research Note No 1, Parliamentary Library, Parliament of Victoria, 2017), 1.

[2] Ibid, 1.

[3] Ibid, 1.

[4] Gay Alcorn, 'Victoria's proposal on assisted dying is careful and rigorous. Let the debate begin', *The Guardian (Online)*, 21 July 2017 <https://www.theguardian.com/society/2017/jul/21/victorias-proposal-on-assisted-dying-is-careful-and-rigorous-let-the-debate-begin>.

For example under the category of 'Request', the report shows that the North American jurisdictions will not allow assisted dying as part of an 'advance directive', where the European jurisdictions will allow it. The Victorian model shows that it is in line with those North American safeguards. Similarly it notes that none of the compared jurisdictions prohibit a health practitioner from raising the topic of voluntary assisted dying with the patient, whereas the Victorian model does.[5] However, that is not to say that the Victorian model has necessarily accounted for the shortcomings of other jurisdictions. This appendix, appendix 3 of the report, is merely a comparison of the safeguards of the Victorian model against the aforementioned jurisdictions.

It is clear in the Expert Panel report that an attempt was made to cater for the experiences of other jurisdictions – although the thesis will test whether the Victorian model succeeds in this endeavour.

Prior to analysing the Victorian model, this thesis will examine the modern history of voluntary assisted dying ("VAD") legislation, culminating in the *Voluntary Assisted Dying Act 2017*. To answer the question of whether the Victorian model accounts for the experiences of other nations, it is vital that an examination of the various assisted dying models from other jurisdictions be conducted. These jurisdictions include the Canadian, Dutch, Belgian, Luxembourgian and various American models (Oregon, Washington, Vermont, California and Colorado[6]). These models will be examined against the criticisms levied against them.

The thesis then discusses criticisms of VAD (and its many forms), before turning to criticisms with the various models which influenced the Victorian model. Building on that discussion it is relevant to assess whether any such criticisms are pertinent, and if available data supports these arguments.

Following the discussion of general and international VAD criticism, this thesis discusses the Victorian model and what it has (and has not) learnt from its international predecessors. That is, which safeguards has Victoria imported into its model, which it has avoided, and where relevant, the reasoning of the Expert Panel behind that implementation or avoidance.

[5] Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying* Final Report (2017), 217 ('*Ministerial Report*').
[6] Ibid, 217 – 220.

The *Voluntary Assisted Dying Act 2017* (Vic) is the first of its kind in Australia to pass since the ill-fated *Rights of the Terminally Ill Act 1995* (NT). As it has sparked new vigour in the assisted dying debate within the nation, this thesis scrutinizes this new model of assisted dying. As the Act has recently come into effect there are few options for specific case studies at this early point. Nonetheless it is important to assess what data is available in Victoria in respect of voluntary assisted dying, and whether that model can be improved through identifying its strengths and weaknesses, particularly through the experiences of other jurisdictions.

This thesis is not a discussion as to whether a jurisdiction should adopt a VAD model of its own, nor is it a discussion as to whether VAD is right or wrong. It is an assessment of what exists, and how the Victorian model can be improved based on the lessons learnt from other jurisdictions.

II THE MODERN HISTORY OF VOLUNTARY ASSISTED DYING LEGISLATION

The topic of euthanasia and assisted suicide is a complicated issue which societies have wrestled with for centuries. These issues have been debated since at least the age of Hippocrates,[1] through the age of discovery,[2] and well into the 21st century. Between the end of the 20th century and into the beginning of the 21st century, some nations made legislative efforts to legalise euthanasia and/or assisted suicide (hereafter referred to broadly as 'assisted dying'/'voluntary assisted dying' or 'VAD').[3] The jurisdictions most often referred to in the debate of assisted dying laws are the Netherlands and Belgium, however assisted dying has been legalised in a number of other jurisdictions – some by a specific piece of legislation passed (such as the Netherlands, Belgium and United States Jurisdictions such as Oregon), and others through amendments to Criminal Codes and/or other legal instruments, such as Switzerland and Canada. Australia has joined the growing list of jurisdictions with assisted dying laws through the passing of the *Voluntary Assisted Dying Act 2017* in Victoria. First however, it is necessary to define what is meant by VAD.

A "*Voluntary Assisted Dying"*

'Voluntary assisted dying', despite its obvious name, can be difficult to accurately define. While the name itself is seemingly straightforward, its precise usage may vary from jurisdiction to jurisdiction. As Queensland University of Technology notes, the term varies in its meaning in Australian states, which differs from international jurisdictions:

> 'Voluntary assisted dying' (VAD) is commonly used in Australia to refer to the assistance provided to a person by a health practitioner to end their life. 'Voluntary' indicates that the practice is a voluntary choice of the person, and that they are competent (have capacity) to decide to access VAD.

The term VAD has evolved in recent years through State and Territory law reform inquiries into end of life choices, as well as parliamentary debates (such as in Victoria and Western Australia) of laws enabling a terminally ill person to seek medical assistance to die. Prior to

[1] John D Papadimitriou et al, 'Euthanasia and suicide in antiquity: viewpoint of the dramatists and philosophers' 100(1*) J R Soc med,* 35.
[2] Saint Thomas More wrote about assisted suicide in his 1516 political satire *Utopia*. It is often cited as being approving of VAD, see: Paul D Green, 'Suicide, Martyrdom and Thomas More' (1972) 19 *Studies in the Renaissance,* 137-138.
[3] While there may be examples of nations legalising (or having never outlawed) assisted dying, such as periods in Ancient Greece, the focus of this thesis is on the efficacy and safety of assisted dying laws which can readily be examined and assessed in the 20th and 21st centuries.

the emergence of the term VAD, 'euthanasia', 'physician-assisted suicide' and 'physician-assisted dying' were generally used in Australia to refer to practices involving assisted dying. Although these terms are still used within the community, the legal, medical and health professions, and governments more often use the term VAD.

Victoria's legislation defines VAD as the assistance provided by a medical practitioner to a person to end their life. This occurs either by a medical practitioner prescribing a VAD substance (i.e. VAD medication) to the person for self-administration or, in limited circumstances, through administration by that medical practitioner.

In Western Australia, VAD means the administration of a voluntary assisted dying substance for the purpose of causing a person's death, and the steps e.g. processes relating to its administration.

Different terms are used elsewhere in the world. For example, 'physician-assisted suicide' is used in Oregon and other States in the USA. 'Medical Assistance in Dying' is the term used in Canada, while 'euthanasia' is used in Belgium and the Netherlands.[4]

As can be seen, VAD is a term which varies among jurisdictions and users of the term. However, for the purpose of this thesis the term 'VAD' will be adopted generally, as while there are important distinctions between the delivery of VAD in each jurisdiction, this thesis shall focus on the system surrounding that final delivery.

B *The United States*

While the Northern Territory's legislation came into effect before Oregon, Oregon was the first jurisdiction in the post-war world to pass VAD legislation.

In 1994 the *Death with Dignity Act* was passed in Oregon by referendum by 51.3%,[5] however the Act's implementation was delayed by a string of litigation. The Act was challenged the year it passed and was prohibited from implementation by the US District Court for the District of Oregon.[6] In 1997 the Federal Court of Appeals for the Ninth Circuit Court lifted

[4] Queensland University of Technology, *End of Life Choices: Euthanasia and Assisted Dying* <https://end-of-life.qut.edu.au/euthanasia>. (Accessed 04 March 2020).
[5] Oregon Secretary of State, *Oregon Blue Book* (2019) <https://sos.oregon.gov/blue-book/Documents/elections/initiative.pdf>, 1.
[6] *Lee v. State of Oregon* 891 F. Supp. 1439 (D. Or. 1995).

the injunction allowing the Act to finally come into effect.[7] However this would not be the end to the difficulty this legislation faced.

In 1997 the Act survived a repeal proposal with voters voting in favour of keeping the legislation by 60%.[8] In 2001 the US Attorney General issued Interpretive Rules stating that assisting a person in committing suicide was not a 'legitimate medical purpose' in respect of the Code of Federal Regulations pertaining to providing a prescription of, or administering a federally controlled substance violated the Federal *Controlled Substances Act 1971*.[9] The State of Oregon successfully challenged the Interpretive Rule in the Supreme Court, the majority found that the *Controlled Substances Act* did not empower the Attorney General to 'prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under state law permitting the procedure'.[10]

Other American jurisdictions would follow Oregon in passing assisted dying legislation in the coming years. The Washington model came into effect in 2009, it was largely influenced by the Oregon model.[11] In 2013 Vermont enacted assisted dying legislation. Vermont was the first US State to pass a 'Death with Dignity' Bill without the use of a ballot initiative put to the public as Vermont law did not permit such an action. Its model largely follows the Oregon model.[12] In 2015 California passed its assisted dying legislation, which like other US jurisdictions closely resembled the Oregon model.[13] In May 2018 a successful challenge was mounted to the legislation,[14] however this decision was overturned in November of that

[7] *Lee v. State of Oregon* 107 F. 3d 1382.
[8] Mark C. Siegel, 'Lethal Pity: The Oregon Death with Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World' (1998) 16(1) *Law & Inequality: A Journal of Theory and Practice* 270, 270.
[9] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd Edition, 2018), 335.
[10] *Gonzales v. Oregon*, 546 U.S. 243 (2006).
[11] Owen Dyer, Caroline White and Aser García Rada, 'Assisted dying: law and practice around the world' (2015) *The BMJ* 351, 2.
[12] Patient Choices Vermont, *About PCV - History* (undated) <https://www.patientchoices.org/history.html>.
[13] Alex Dobuzinskis, 'California Lawmakers Introduce Oregon-Style Assisted Suicide Bill', *Scientific American (online)*, 22 January 2015 <https://www.scientificamerican.com/article/california-lawmakers-introduce-oregon-style-assisted-suicide-bill/>.
[14] Transcript of Proceedings, *Dr Sang-Hoon Ahn, Dr Laurence Boggeln, Dr George Delgado, Dr Phil Dreisbach, Br Vincent Fortanasce, Dr Vincent Nguyen and American Academy of Medical Ethics, d/b/a of Christian Medical and Dental Society v Michael Hestrin, in his official capacity as District Attorney of Riverside County, Attorney General of the State of California, Kamala D Harris and the State of California by and through the California Department of Health*, RIC 1607135,May 15, 2018 (Honorable Daniel A. Ottolia); Scott Neuman, 'Judge Overturns Assisted Suicide Law In California', *NPR News* (online), 16 May 2018 <https://www.npr.org/sections/thetwo-way/2018/05/16/611527757/judge-overturns-assisted-suicide-law-in-california>.

year.[15] In 2016 Colorado voters passed Proposition 106, the *End of Life Options Act 2016* (Colorado) via ballot, passing by 65 to 35. The law came into effect on December 13 2016, and like its other American counterparts followed the Oregon model.[16]

The Oregon model has perhaps been the most influential VAD legislation, inside and outside of the United States with the Victorian model itself leaning on it heavily.[17]

C *Australia: The Northern Territory*

In Australia, in 1995 the Northern Territory famously passed the ill-fated *Rights of the Terminally Ill Act 1995* ('the ROTI Act'). The *Rights of the Terminally Ill Bill* was submitted to the Parliament of the Northern Territory on 22 February 1995 by then Chief Minister Marshall Perron.[18]

Debate on the second reading was adjourned, and the Parliament established the 'Select Committee on Euthanasia' to examine the proposed law in greater detail. The report listed 20 recommendations, mostly concerning strengthening the criminal provisions of the Bill. The Committee tabled their report in the Legislative Assembly on 16 May 1995,[19] and the Bill passed into law on 25 May 1995.

The Act survived a challenge in the Supreme Court of the Northern Territory,[20] a later High Court challenge (however the case was stood down),[21] and a Bill to repeal the Act.[22] It was finally rendered invalid by the Commonwealth passing the *Euthanasia Laws Act 1997* (Cth). The *Euthanasia Laws Act* removed the ability of Australian territories to make laws as to euthanasia but did not infringe upon the rights of any Australian state to make any such laws.[23]

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[15] Brian Melley, 'California court reverses ruling against assisted suicide', *AP News* (online), 29 November 2018 <https://www.apnews.com/6705d8ae21154674a24acffa1f42ba47>.
[16] BallotPedia, *'Colorado Proposition 106, Physician-Assisted Death Initiative (2016)', Encyclopaedia of American Politics* (web page) <https://ballotpedia.org/Colorado_Proposition_106, Physician-Assisted_Death_Initiative (2016)>.
[17] Wendy Bonython, 'From Oregon to Belgium to Victoria – the different ways suffering patients are allowed to die', *The Conversation* (Online, December 2017), <https://theconversation.com/from-oregon-to-belgium-to-victoria-the-different-ways-suffering-patients-are-allowed-to-die-88324>.
[18] Northern Territory, *Parliamentary Debates*, Legislative Assembly, 22 February 1995 (Marshall Perron).
[19] Select Committee on Euthanasia, Northern Territory, *The Right of the Individual or the Common Good* (1995).
[20] *Wake & Anor v Northern Territory of Australia & Anor* [1996] NTSC 56
[21] *Wake & Anor v The Northern Territory & Anor* [1996] HCATrans 352
[22] *Rights of the Terminally Ill Amendments Act 1996* (NT).
[23] *Euthanasia Laws Act 1997* (Cth), schs 1-3.

While the Northern Territory's attempt may have been defeated by Commonwealth legislative action, it was the first jurisdiction in Australia, and the world, to make laws as to (physician) assisted dying.[24] In Europe, the Netherlands would be first to pass VAD legislation in 2001.

D *Europe*

1 *The Netherlands*

VAD laws were passed in the Netherlands in 2001. However prior to this legislation passing, VAD was practiced in some form since at least the 1970s, with practices slowly becoming uniform in the following decades through case law and the development of professional standards., Early in the VAD debate doctors were willing to report VAD and be held accountable if wrongdoing was found to have occurred. However in practice, until the mid-1980s, only a small number of cases were reported. In an attempt to alleviate this issue and create more transparency in the system, in 1990 the Ministry of Justice in collaboration with the Royal Dutch Medical Association agreed to devise a uniform notification procedure.

Under this model, the doctor who had provided VAD to the patient would inform the local medical examiner via a lengthy questionnaire. The medical examiner would then inform the public prosecutor, who would then consider whether the doctor had adhered to the criteria for due care.

This model was further developed in 1998 with the establishment of multidisciplinary review committees which would consist of a lawyer, a doctor, and an ethicist. These committees would then review reported VAD cases and report to the public prosecutor if they had found the due care criteria had not been adhered to. Rietjens et all state that this reporting procedure was widely endorsed by doctors and the review committees rarely found serious violations. [25]

Following the passing of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* in 2001, VAD was formally legalised in the Netherlands. If the due care

[24] Parliamentary Library, *Euthanasia - the Australian Law in an International Context*, Research Paper 4 (1996-1997).
[25] Judith A.C. Ritjens et al, 'Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?' (2009) 6(3) *J Bioeth Inq*, 273.

criteria are not adhered to, doctors who undertake VAD with their patient are liable for criminal prosecution.[26]

2 *Belgium*

Throughout the 1980's and 1990's multiple unsuccessful attempts at passing VAD legislation were made in Belgium, until VAD was finally legalised in Belgium in 2002. However, similar to the Netherlands, VAD in Belgium occurred in some form prior to the passing of the 2002 legislation. An example of this is noted in a study of physicians in Flanders, Belgium in 2000 by Daliens et al, which notes:

> The physicians' response rate was 1355 (52%). 1925 deaths were described. The results were corrected for non-response bias, and extrapolated to estimated annual rates after seasonal adjustment for death causes, and we estimate that 705 (1.3%, 95% Cl 1.0–1.6) deaths resulted from euthanasia or [physician assisted suicide]. In 1796 (3·2%, 2·7–3·8) cases, lethal drugs were given without the explicit request of the patient. Alleviation of pain and symptoms with opioids in doses with a potential life-shortening effect preceded death in 10 416 (18·.5%, 17.3–19.7) cases and non-treatment decisions in 9218 (16.4%, 15.3–17.5) cases, of which 3261 (5.8%, 5.1–6.5) with the explicit intention of ending the patient's life.[27]

In September 2002 Belgium passed the *The Belgian Act on Euthanasia of May, 28th 2002*,[28] making it the second country in the world to pass VAD legislation. Once enacted the law was subject to an unsuccessful challenge to the Constitutional Court on the basis that it violated the right to protect life enshrined in art 2 of the *European Convention on Human Rights*.[29]

3 *Luxembourg*

In February 2008 the Luxembourg Parliament passed the *Proposition de loi No. 4909 sur le droit de mourir en dignité* [Bill No. 4904 on the right to die with dignity] 30 votes to 26, making it the 3rd country in Europe to pass VAD legislation.[30]

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[26] Government of the Netherlands, *Euthanasia, assisted suicide and non-resuscitation on request* (undated) <https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>. See also, Regional Euthanasia Review Committees, *Due Care Criteria* (undated) <https://english.euthanasiecommissie.nl/due-care-criteria>.
[27] Luc Deliens et al, 'End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey' (2000) 356 *The Lancet* 9244, 1806.
[28] *The Belgian Act on Euthanasia of May, 28th 2002* (Belgium).
[29] Penney Lewis, 'Euthanasia in Belgium five years after legalisation' (2009) 16(2) *European Journal of Health Law* 126, 126.
[30] Nicole Atwill, 'Luxembourg: Right to Die with Dignity' *United States Library of Congress*, 02 March 2008 <https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/>.

At the time the Bill passed, the Grand Duke, who was required to sign it into law, refused to do so as he objected to VAD. In response the Parliament passed a constitutional amendment to remove the requirement for the Monarch to assent to Bills before they become law.[31]

4 *Switzerland*

In 1942 Switzerland passed legislation decriminalising assisted suicide in cases where there were no 'selfish motives'.[32]

The Swiss model is unique in lacking any regulatory framework. It only provides that a person does not commit a crime if they assist someone in taking their own lives if they do so without self-serving ends.

However, there are no legislative requirements outside this. Consequently there is no eligibility criteria, safeguards (outside the requirement of lacking malice), or official statistics.

E *Canada*

The Canadian experience is notably different from that of other jurisdictions. Canada has seen attempts to legislate for assisted dying both at the federal and provincial level, as well as legal challenges against the prohibition against assisted dying under s 14 and 241(b) of the Canadian *Criminal Code*. Quebec was the first Canadian Province to legislate for assisted dying. Following the landmark case of *Carter v Canada (Attorney General),* which overturned the Criminal Code prohibitions on assisted dying (outlined below),[33] the Canadian government would finally pass Bill C-14 '*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*' in 2015 legalising VAD in Canada.[34] *Carter* reversed the decision in *Rodriguez v. British Columbia (AG)* (1993) 107 DLR (4th) 342 which narrowly (5-4) upheld the prohibition on VAD.

In 2013 Quebec introduced '*An Act respecting end-of-life-care*', with the Bill receiving Royal Assent on June 5th 2014. The Bill ran into problems owing to the (then) current state of the

[31] Associated press in Luxembourg, 'Luxembourg strips monarch of legislative role' *The Guardian (online)*, 12 December 2008 <https://www.theguardian.com/world/2008/dec/12/luxembourg-monarchy>.
[32] Ezekiel Emmanuel, 'Euthanasia and physician-assisted suicide: focus on the data' (2017), 206(8) *Medical Journal of Australia* 339, 339.
[33] *Carter v Canada (Attorney General)* 2015 SCC 5.
[34] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying),* RSC, 2015.

Canadian *Criminal Code*. A 2015 Parliamentary Background Paper explains some issues the law faced:

> Most of the Act's provisions were scheduled to come into force on 10 December 2015. However, on December 2015, the Superior Court of Quebec declared that certain provisions of the law were in conflict with the federal *Criminal Code*, and that until the Supreme Court of Canada's declaration in *Carter* came into effect the paramountcy doctrine (which establishes that where there is an inconsistency or conflict between a federal and provincial law, the federal law prevails) applies, rendering the provisions of Bill 52 that relate to medical aid in dying inoperative. [35]

The Quebec Court of Appeal granted leave on 09 December 2015, suspending the procedures relating to the motion before the Superior Court of Quebec. The provisions in question however would remain in force, pending any further decision by the Court. While the Quebec government had issued guidelines for prosecution where a doctor provided VAD, a question would arise as to whether a doctor providing VAD would be subject to such a prosecution, although whether such a prosecution would occur was another matter.[36] Ultimately, the fate of the Quebec legislation would be decided in the Supreme Court, which ultimately led the way for the federal model of assisted dying legislation to pass.

In 2015 the Canadian Supreme Court handed down the landmark case in *Carter v Canada (Attorney General)*. The decision struck down ss 14 and 241(b) of the Canadian *Criminal Code* on the basis that those provisions infringed on s 7 of the Canadian *Charter of Rights and Freedoms*.[37]

The case concerned a challenge by two people suffering from terminal degenerative conditions who believed that the Canadian *Criminal Code* violated their rights under the Canadian *Charter of Rights and Freedoms.* Namely their s 15 equality rights, and their s 7 rights 'not to be deprived of life, liberty, and security of the person except in accordance with the principles of fundamental justice.'[38]

[35] Library of Parliament (Canada), *Euthanasia and Assisted Suicide in Canada*, Background Paper (2015), 10 (citations omitted).
[36] Ibid.
[37] Jocelyn Downie, 'Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions' (2016) 16(1) *Queensland University of Technology Law Review* 84, 96-97.
[38] Ibid.

The Court held:

> Section 241(*b*) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has 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.[39]

The Court found that the *Criminal Code* prohibitions infringed on ss 7 and 15 of the *Charter*.[40] Following the decision the Court issued a declaration stating:

> We have concluded that the laws prohibiting a physician's assistance in terminating life (*Criminal Code*, s. 241 (*b*) and s. 14) infringe Ms. Taylor's s. 7 rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice, and that the infringement is not justified under s. 1 of the *Charter*. To the extent that the impugned laws deny the s. 7 rights of people like Ms. Taylor they are void by operation of s. 52 of the *Constitution Act, 1982*. It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.[41]

The Court determined that the appropriate remedy was a declaration that ss 14 and 241(b) of the Criminal Code were void insofar as they prohibited VAD for a 'competent adult person' who met the criteria of consenting to the termination of their life, has a 'grievous and irremediable medical condition' (including a disease, disability or illness) which causes enduring and intolerable suffering to the patient. The Court clarified its description of this criteria:

> "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.[42]

[39] 2015 SCC 5.
[40] Jocelyn Downie, 'Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions' (2016) 16(1) *Queensland University of Technology Law Review* 84, 96-97.
[41] 2015 SCC 5, [126]-[127].
[42] Ibid.

This resulted in the Canadian Government being required to amend the affected legislation to bring it in line with the decision by order of the Court.[43] The House of Commons passed the C-14 Bill in 2016 which would allow for doctor-assisted suicide, which (after some amendments) received Royal Assent on 17 June 2016 thus 'legalising' assisted dying in Canada.

F *Other Countries & Jurisdictions*

The passing of the Victorian legislation has subsequently caused other Australian jurisdictions to review the legality of assisted dying. Most notably, the Parliament of Western Australia authorised the Joint Select Committee on End of Life Choices to table a report regarding assisted dying legislation, which similar to Victoria, found that the state should legislate for assisted dying.[44] Voluntary assisted dying legislation passed in Western Australia in 2019.[45] In 2021 Tasmania passed its own VAD legislation, the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021*,[46] with Queensland passing the *Voluntary Assisted Dying Bill 2021* on September 16.[47]Outside Australia, Spain has recently passed VAD legislation, which came into force in June of 2021. Previously, assisting the death of a patient was punishable by up to 10 years imprisonment. [48]

G *Conclusion*

As public support grows for VAD, more jurisdictions are seeking to pass laws to give patient's access to VAD. It is clear that support has grown exponentially since the first VAD legislation was passed in the 1990s with at least 3 jurisdictions passing their own VAD legislation in 2021 alone. Therefore, it is prudent to examine common criticisms of existing models to determine what works and what does not work. Understanding these concerns can assist legislators to pass better legislation which prevent potential abuses of the system

[43] Ibid.
[44] Joint Select Committee on End of Life Choices, *My Life, My Choice* (Report No 1, Parliamentary Library, Parliament of Western Australia, 2018), 206.
[45] *Voluntary Assisted Dying Act 2019* (WA).
[46] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas).
[47] *Voluntary Assisted Dying Act 2021* (Qld).
[48] Unknown, 'Spain passes law allowing euthanasia', *BBC News (online)*, 18 March 2021 <https://www.bbc.com/news/world-europe-56446631>.

III CRITICISMS OF INTERNATIONAL MODELS

A *General Criticisms of Voluntary Assisted Dying*

While every VAD model is unique, there are some arguments which frequently arise in respect of VAD generally. It is relevant to examine these criticisms to determine whether they are applicable or the mere manifestation of disapproval. Such an examination was undertaken in the United Kingdom in 2005, and forms a useful reference for such a debate.

In 2005 the *Assisted Dying for the Terminally Ill Bill* was submitted to the Parliament of the United Kingdom. A committee was convened to examine the Bill where advocates and interest groups of all sides could submit their arguments.

The Committee's report was published later that year. It identified a number of practical issues with respect to VAD and forms a helpful guide on these arguments. While a detailed discussion of every one of these arguments is beyond the scope of this thesis, their arguments are summarised with commentary where applicable.

1 *Covert Euthanasia*

Covert euthanasia, as its name suggests, is euthanasia in secret. It can occur in many ways and includes a doctor advising a patient on what to do to end their lives, to breaching the principle of 'double effect' (whereby a doctor in providing care and treatment of their patient, causes the death of that patient in the course of that care or treatment),[1] by intending to bring about the end of a patient's life.

The House of Lords noted the inconsistency of evidence in respect of doctors assisting in the death, intentionally causing the death of their patient, or advising their patient on how they might take their own life (as much is self-reported and difficult to define), and rejected the notion that it was as prevalent as some claimed. However they did also acknowledge that such a thing is likely to occur, stating:

[1] A doctor is not liable if they cause the death of a patient provided that medicine or treatment they provide is provided in good faith to the patient despite the knowledge that death may (or may not) occur as a side effect., see *R v Adams* [1957] Crim LR 365.

> While we are not able, for the reasons we have given, to accept as hard evidence the results of anonymous surveys or newspaper articles, this does not mean that we give no credence whatever to what they appear to be saying. Human experience shows that all laws are flouted to a greater or lesser extent, and we would be surprised if the law in this field were an exception. We recognise also the difficulties which medical practitioners may possibly feel about reporting malpractice on the part of colleagues, and this is certainly a factor to be taken into account. [2]

The Lords continue on to state that there are numerous factors which may inhibit covert euthanasia from occurring as frequently as has some surveys suggest, stating:

> Bearing in mind however the trend towards death taking place in hospital rather than at home, the increasing prevalence of team-working in clinical care, the greater tendency for people to litigate where they suspect malpractice, and the potential for confusion with the legal administration of drugs to prevent restlessness and anxiety in the last hours of life, we would be surprised if covert euthanasia were being practised on anything like the scale which some of these surveys suggest. [3]

This is a difficult issue to quantify as it is highly unlikely that a doctor, nurse, or person close to the patient would report such a thing if they are supportive of the patient's wish to die. Similarly, this is also difficult to determine with respect to the principle of double-effect.

2 *Palliative Care*

Palliative care is a term often used to describe the treatment and care of the terminally ill. It is often argued as an alternative to euthanasia or assisted suicide. However, palliative care is not exclusively end-of-life care, but rather care for those with life-threatening illnesses, not merely those in their final moments. The World Health Organisation defines palliative care as:

> [A]n approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering

[2] Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005) ('*House of Lords*').
[3] Ibid.

> by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[4]

The House of Lords notes that while expert palliative care can be effective for patients in respect of pain management, access to it remains difficult and it cannot answer for issues such as loss of autonomy, particularly in degenerative cases. It does not conclude on this but accepts the reality of the extreme difficulty in providing high quality palliative care to patients. [5]

3 *The Slippery Slope*

The House of Lords notes that the slippery slope argument varies, for convenience they broke it into five categories being, incremental extensions into the law, elastic interpretations of the laws provision, hidden pressures, abuse of the law, and the 'paradigm shift' of a society's acceptance of VAD.[6]

When they used the 'slippery slope' phrase, the House of Lords was referring to submissions that passing laws that introduced VAD in generally acceptable terms would desensitise the public to moral and ethical issues, and could precipitate further legislative change that would ignore ethical issues. For example, ensuring that vulnerable groups, such as, the elderly and disabled, were not tacitly coerced into making end of life decisions. Similarly, the 'slippery slope' could apply to expanding the eligibility criteria beyond that of the terminally ill.

The Lords do not conclude on the matter, but do note the most frequent concern is those within the 'hidden pressures' category, particularly in respect of vulnerable groups.[7] The issue of the slippery slope argument is discussed further in Chapter III.

3 *Doctor-Patient Relationships*

The House of Lords noted that there appears to not be a significant concern by patients according to opinion polls regarding the possible effects a policy of VAD may have on

[4] World Health Organisation, *WHO Definition of Palliative Care* <http://www.who.int/cancer/palliative/definition/en/>.
[5] Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005) ('*House of Lords*') [84]-[87].
[6] Ibid, [91] – [103].
[7] Ibid, [99].

doctor-patient relationships.[8] In respect of the relationship from the doctors' perspective they note:

> All the medical practitioners who spoke to us agreed that there had been a significant change in doctor-patient relationships over the last 30 years or so in favour of greater openness and patient autonomy. As Lord Walton put it, "The days of 'doctor's orders' are long passed and the practice of medicine is a partnership between the doctor and the patient, in which it is the doctor's responsibility and duty to indicate to the patient what he or she regards as being the best course of action to follow in the management of their condition, but it is up to the patient to decide whether or not to accept that advice".[9]

4 *Conscientious Objection*

The House of Lords explained that while the proposed VAD legislation they were examining at the time provided an exemption for doctors with conscientious objections, issues could arise with the legislation becoming unworkable due to a perceived large number of objections by doctors and nurses.[10] However the Bill in question provided that no person was required to participate in the VAD process if they objected to it.[11]

In their concluding remarks they note that it is possible that issues will arise in situations where treatment is required by a team of medical professionals.[12]

The Lords observed that:

> [A]ny new bill should not place on a physician with conscientious objection the duty to refer an applicant for assisted suicide or voluntary euthanasia to another physician without such objection; it should provide adequate protection for all health care professionals who may be involved in any way in such an application; and it should ensure that the position of persons working in multi-disciplinary teams is adequately protected.[13]

5 *Prognosis*

The House of Lords merely repeat the evidence they received in this section. They report a general consensus in respect of the difficulty of prognosis though. Prognoses were easier to

[8] Ibid, [105].
[9] Ibid, [106].
[10] Ibid, [113]-[114].
[11] *Assisted Dying for the Terminally Ill Bill* 2005 (UK), s 7.
[12] *House of Lords*, (n 6), [261]-[263].
[13] Ibid, [269][c][viii].

accurately determine in advanced illnesses. Overall however, the House of Lords report noted a great deal of input from the medical community regarding the inability to make an accurate prognosis, especially in cases of degenerative diseases.[14]

6 *Competence*

The House of Lords note that the competence of the patient to make decisions in respect of VAD is particularly difficult. They said:

> There was a general consensus among our expert witnesses on one point—that the attending and consulting physicians who are envisaged as being effectively the "gatekeepers" in regard to applications for assisted dying could not be expected to spot impairment of judgement in all cases.[15]

7 *Unbearable Suffering*

The issue of unbearable suffering was noted by the House of Lords as difficult to ascertain. They note 3 different arguments in respect of identifying what is unbearable to a patient.

The first argument was that a doctor cannot determine whether a patient is suffering unbearably in a single consult. The second argument was that doctors have no particular expertise for determining unbearable suffering, and the determination of unbearable suffering must be by the patient alone. The final argument was that while unbearable suffering may be present, it may not derive from the terminal illness but exist alongside it. They said that the loss of a loved one to a terminally ill patient may render the patient's suffering unbearable.[16]

8 *The Demand for Assisted Dying*

The Lords did not discuss the public demand for VAD. They note the differences in the international VAD Models. Oregon permits assisted suicide whereas the Netherlands permits assisted suicide and voluntary euthanasia, with voluntary euthanasia being more prevalent. They explain:

> It seems clear therefore that the demand for assisted suicide or voluntary euthanasia, if measured in terms of the numbers of applicants, will vary according to what the law permits. Indeed, it is this which causes most concern to some of the Bill's critics. They are prepared to

[14] Ibid, [118]-[122].
[15] Ibid, [126].
[16] Ibid, [128]-[130].

> accept that, if moral objections to the principle underlying the Bill are laid aside, there could well be a very small number of serious and determined people who are not going to change their resolve and who might be allowed to take their own lives without undue damage to the fabric of society.[17]

9 *Vulnerable Groups*

The Lords separated vulnerable groups into two categories; the disabled, and the elderly.

With respect to the disabled they noted there are differing opinions. Arguments presented were that in respect to people's perception of life with disability, 'that it is absolutely better to be dead than to be disabled'. The Lords stated that it is likely that such people would feel pressured, or have a sense of duty, to seek VAD so as to not become a burden on others.[18]

Another argument presented in respect of the disabled was that many would not view themselves as needing to seek VAD. The attitude of the disabled often changes over time with many feeling glad to be alive.[19]

10 *Conclusion*

While not a comprehensive review of all criticisms of VAD in practice, the House of Lords identified common arguments and discussed the validity of those arguments. They identified key issues which ultimately informed their recommendations on what a future VAD model should include, if one were re-introduced in the United Kingdom.

B *The Northern Territory*

The ROTI Act was the first of its type and, consequently, was an imperfect piece of legislation. The long title of the Act reads:

> AN ACT to confirm the right of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life in a humane manner; to allow for such assistance to be given in certain circumstances without *legal impediment* to the person rendering the assistance; to *provide procedural protection against the possibility of abuse of the rights recognised by this Act*; and for related purposes.[20] [emphasis added]

[17] Ibid, [132].
[18] Ibid. [136].
[19] Ibid [137].
[20] *Rights of the Terminally Ill Act 1995* (NT).

As noted by the WA Parliament in 2018:

> At the time that the Northern Territory legislation became law, it was the first of its type anywhere in the world – Oregon's law had not yet come into force …and the Netherlands would only enact its legislative framework for assisted dying in 2002. As a prototype, it did not have the benefit of drawing upon the experiences in other jurisdictions'.[21]

While well intentioned, the ROTI Act suffered from a number of issues in its short life. In particular, the vagueness of the 'second opinion' requirements, the lack of a residency requirement for patients, the 'treatable clinical depression' requirements (and lack of enforcement), the consideration and availability of palliative care, and the prevention of coronial inquiry into VAD deaths. Such shortcomings are a useful starting point in assessing subsequent VAD models, and should be examined.

1 *Second Opinion*

Section 7(c)(i) of the ROTI Act requires a patient to be confirmed to be eligible by a second doctor. However as the section noted, only one of the two medical practitioners was required to hold 'prescribed qualifications, or [have] prescribed experience, in the treatment of the terminal illness from which the patient is suffering'.[22]

While the policy intention was clear, the lack of specificity in the legislation meant that only one of the two doctors involved must hold relevant qualifications in the treatment of the patient's illness, not both. This oversight did not go unnoticed.

In 2008 the Standing Committee on Legal and Constitutional Affairs provided a report on the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*. Citing the ROTI Act, they quoted a submission received from, Professor Kissane, who said:

> [W]hen an orthopaedic surgeon came forward following [a patient's] public appeal for a certifying specialist, and he did not have expert knowledge of mycosis fungoides, a rare tumour involving both the skin and lymphatic systems but not the bones, this was ignored by relevant authorities. Such breaches of the Regulations were permitted by a legal system

[21] Joint Select Committee on End of Life Choices, 'My Life, My Choice' (Report No 1, Parliamentary Library, Parliament of Western Australia, 2018), 186.
[22] Ibid, s7.

> wanting to facilitate the legislation, thus removing the very safety features that had been designed to protect the vulnerable.[23]

This raises two issues. First, as noted above by Professor Kissane, the flaw in the legislation which permitted an opinion from a medical practitioner with no knowledge or experience in the ailment concerned. Secondly, it shows that the Northern Territory model permitted the system to be legally used in ways not intended by Parliament. That is, the policy intention may have been breached, but the law itself was not.

2 *Residency of Patient*

The ROTI Act did not require a patient to be a resident of the Northern Territory. However, it did require that both the certifying specialist and psychiatrist (who both had to certify the patient's eligibility) had to be resident and practicing in the Northern Territory. As s 3 of the ROTI Act noted, the 'medical practitioner' was person who had been a medical practitioner 'however described' in a State or Territory of Australia for at least 5 years and was resident in, and entitled under the law to practice in the Northern Territory. The definition of 'qualified psychiatrist' was more specific than that of a medical practitioner, being:

> (a) a person entitled under a law of a State or Territory of the Commonwealth to practise as a specialist in the medical specialty of psychiatry;
> (b) a specialist whose qualifications are recognised by the Royal Australian and New Zealand College of Psychiatrists as entitling the person to fellowship of that College;
> (c) a person employed by the Commonwealth or a State or Territory of the Commonwealth, or an Agency or authority of the Commonwealth or a State or Territory, as a specialist or consultant in the medical specialty of psychiatry; [24]

Yet despite this requirement, as noted by Professor Kissane (above), a patient was able to access VAD in the Northern Territory. Even though the doctor having certified them was an orthopaedic surgeon, an area of medicine unrelated to the patient's illness. Further, the requirement of being resident in the Northern Territory was not included in the definition of 'qualified psychiatrist' under the Act. Which raises questions as to how a psychiatrist could have made an accurate assessment of a patient who they would have had little to no in-person contact with. Ultimately this lack of residency requirement means that if the Act were to

[23] Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* (2008), 83 ('*ROTI Committee'*).
[24] *Rights of the Terminally Act 1995* (NT), s 3.

remain in force, the Northern Territory could have become merely a place to die (i.e., suicide tourism) as neither the patient, nor the psychiatrist need be an ordinary resident of the Northern Territory.

3 *Treatable Clinical Depression*

The ROTI Act required a qualified psychiatrist (who did not need to be practicing in the Northern Territory) to confirm that the patient was not suffering from a treatable form of clinical depression in respect of the (terminal) illness.[25] This did not account for untreatable depression or depression caused by something unrelated to the illness – for example a divorce, or loss of a loved one, thus meaning that a person could very easily be 'depressed' and still qualify for assisted dying.[26] This is identified as a flaw in 'Seven Deaths in Darwin'[27] because a number of the patients who sought VAD under the ROTI Act were experiencing depression (or had a history of depression) and were socially isolated.[28]

Further, a psychiatrist was not required under the Act to make a determination as to whether the patient was suffering from another form of mental illness other than a treatable form of depression.[29] The ROTI Act required the medical practitioners who had to sign the certificate of request to be satisfied that the patient was of sound mind. This standard of satisfaction was a very vague and broad standard, which had to be made by a doctor with potentially no training or experience in psychological issues.[30] Such determinations would be yet more difficult in cases where the doctor(s) do not have a history with the patient and understand their circumstances, and potential other issues or ailments. A practical example of the problems that can flow from such vague standards is found in *Justins v Regina* where the wife of a patient with Alzheimer's disease took her husband to a new doctor to have that doctor write a letter certifying that the patient was of sound mind. The patient was then taken

[25] Ibid, s 7(1)(c)(iv).
[26] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd Edition, 2018), 335 ("*Euthanasia, Ethics and Public Policy"*).
[27] 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' is an article written by David W Kissane, Annette Street and Philip Nitschke. It provides case studies of all 7 patients who sought VAD under the *Northern Territory's Rights of the Terminally Ill Act 1996*. The authors of that article note that depression, or symptoms of depression was noted in four of the 7 seven cases.
[28] David W Kissane, Annette Street and Philip Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' (1998) 353 *The Lancet* 1097, 1101 ('*Seven Deaths in Darwin'*)
[29] Ibid.
[30] Ibid.

to a solicitor to have his Will redrafted, leaving almost the entire estate to his wife and 5% to each of his children, as opposed to splitting the estate evenly as under his previous Will.[31]

4 *Terminal Illness*

Section 3 of the ROTI Act defined 'terminal illness' as 'an illness which, in reasonable medical judgment would, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.'[32]

The 'extraordinary measures' were not defined. More curiously however 'treatment unacceptable to the patient' was also not defined. As such a person could refuse treatment or medication which could save their lives – for example, 'a diabetic refusing insulin, apparently qualified as having a terminal illness',[33] because when left untreated diabetes could qualify as a 'disease, illness or medical condition that is expected to cause death within weeks or months, not exceeding 6 months' under the definition in the Act.[34]

Section 4 of the ROTI Act required that a patient 'in the course of a terminal illness' be experiencing unacceptable pain, suffering or distress in order to make a request to end his or her life.[35] Section 7(1)(d) required a second doctor to confirm that the patient's illness was causing the patient severe pain or suffering.[36] However, as John Keown notes, the legislation did not require that source of pain to be the basis of the patient's request. There was also no provision that prevented the relevant suffering of the patient from being the anticipation of future pain. A patient whose terminal illness was causing no pain but was suffering at the thought of future pain (and that suffering was unacceptable to the patient), or who was experiencing unacceptable suffering from a cause not related to the illness would therefore qualify for assisted dying.[37] As noted above, pain, or the fear of pain was a significant factor in Case 3 of 'the Seven Deaths in Darwin' (above).

[31] *Justins v Regina* [2010] NSWCCA 242
[32] *Rights of the Terminally Act 1995* (NT), s 3.
[33]Euthanasia, Ethics and Public Policy (n 25) 335.
[34] *Voluntary Assisted Dying Act 2017* (Vic), s 9(d)(iii).
[35] *Rights of the Terminally Act 1995* (NT), s 4.
[36] Ibid, s 7(1)(d).
[37] Euthanasia, Ethics and Public Policy (n 25) 335.

5 *Palliative Care*

The ROTI Act in s 8(1) stated that the first doctor must not assist a patient in accessing VAD if 'in his or her opinion and after considering the advice of the medical practitioner referred to in s 7(1)(c)(i), there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient'.[38] That is, if the doctor believed that palliative care options were available to the patient and in the doctors opinion would be able to manage the patient's suffering to an acceptable level, they must not continue the VAD process.

While supporters of palliative care may have found some consolation in this provision, it was quite vague in its wording. It required the doctor only to consider palliative care and decide that there is no such care 'reasonably available' which could 'alleviate the patient's pain and suffering to levels acceptable to the patient'. The alleviation of pain to levels acceptable to the patient was a potentially impossible feat if patients were unwavering in their decision to seek assisted dying. As John Keown has noted:

> At the time of the passage of the Act there appears to have been very little in the way of expert palliative care in the NT. Would such care some 2,000 miles away in Sydney have qualified as 'reasonably available'? What if such palliative care as might have been available, whether in the NT or elsewhere, had been refused by a patient as a result of clinical depression from a cause unrelated to the illness? Or if a patient regarded any level of suffering, however, minor, as unacceptable? Would section 8 have been satisfied?[39]

Ultimately, this section, and indeed much of the Act suffered from this issue of vagueness and relied largely on subjective opinion of the patient and doctor(s).[40]

6 *Coronial Inquiry*

Section 13 of the ROTI Act deals with certification of death. Because the medical practitioner who assisted in the death of the patient was 'taken to have attended the patient during the patient's last illness', the assisted death was not considered a reportable death under the *Coroners Act.*[41] As John Keown noted:

[38] *Rights of the Terminally Act 1995* (NT), s 8(1).
[39] Euthanasia, Ethics and Public Policy (n 25) 336.
[40] Ibid, 337.
[41] *Rights of the Terminally Act 1995* (NT), s 13 (1)-(2).

> The coroner normally has the power to investigate unnatural deaths. However the Act deprived the coroner of the power to investigate deaths assisted under the Act. Section 13(2) provided that deaths assisted under the Act should not, for that reason only, be taken to be 'unexpected, unnatural or violent' for the purposes of being a 'reportable death' within the Coroner's Act 1993 [sic].[42]

Therefore, as Keown notes, 'in the absence of evidence indicating a failure to comply with the Act coming to the attention of the coroner, the coroner's role was limited to filing a report with the Attorney General'.[43] That is, the coroner was powerless to examine the deaths of anyone who died under the ROTI Act, regardless of whether their death was suspicious or if the Act was not correctly followed.[44]

It is unlikely that the coroner would be able to uncover much upon investigation of a patient who died under the Act. Evidently the policy intention was to avoid having the coroner investigate every death under the Act as it was likely unnecessary. However, only allowing the coroner to investigate in rare circumstances prevented investigations into deaths where such an investigation might be warranted, such as if there was evidence of physical abuse to the patient.

7 *Conclusion*

Ultimately the ROTI Act suffered from a critical vagueness in its provisions, and did not ensure effective control and safety of its operation. John Keown compared the Northern Territory model to that of the Netherlands but argued that the ROTI Act was far more lax than its Dutch counterpart. He stated:

> The Dutch guidelines at least required the doctor to call in the medical examiner after the death to examine the deceased and to file a report with a review committee. In the NT there was to be no investigation by the coroner in the absence of evidence of non-compliance with the Act. Given that the relevant documentation was prepared by the doctor concerned and that the patient need only have signed a standard form request, it is most unlikely that any such evidence would have emerged from that source.[45]

[42] Euthanasia, Ethics and Public Policy (n 25) 336.
[43] Ibid, 337.
[44] Ibid.
[45] Euthanasia, Ethics and Public Policy (n 25) 337.

In sum, the ROTI Act lacked in adequate safeguards. Its lack of specificity allowed for determined patients to access VAD even if they may have otherwise been ineligible. One example is that the patient in Case 3 in 'Seven Deaths in Darwin' was openly suicidal, however a psychiatrist from outside the Northern Territory certified that no form of treatable clinical depression was present with the patient.[46] The subjective nature of the ROTI consequently permitted its 'misuse' from patients and, in one case, medical practitioners – however this is not necessarily the fault of the parties, but the vagueness of the ROTI Act itself. The ROTI Act would only remain in effect for 9 months before being rendered invalid by the *Euthanasia Laws Act 1997* (Cth).[47] Despite this short lifespan it demonstrates an example of VAD legislation in action and its unintended consequences and shortcomings, and creates a valuable lesson for Victoria, Australia, and other jurisdictions.

C *Oregon*

Oregon was the first jurisdiction after the Northern Territory to legalise VAD. As it has been in force since the late 1990s a great deal of learned commentary and debate has been spilt on its language and operation. That discussion makes it possible to identify weaknesses in this model.

Like many other VAD models, Oregon attracts the typical arguments (i.e., slippery slope), however there are a number of criticisms specific to the Oregon model. These include reporting methods, protection of doctors over patients, terminal illness not being a requirement, incomplete data on palliative care, insufficient data regarding the VAD medication, lack of data on psychological assessments, evidence regarding 'informed decisions', how voluntary a request was, economic factors, and doctor shopping.[48]

1 *Terminal Illness & Suffering*

One criticism of the Oregon model is that although it requires a terminal illness with a prognosis of 6 months (or less) to live. It does not require the patient to be 'suffering'. This is disingenuous as anyone with a terminal illness is, whether in pain or not, suffering to some

[46] *Seven Deaths in Darwin* (n 27) 1099.
[47] George Williams and Matthew Darke, 'Euthanasia Laws and the Australian Constitution' (1997) 20(3) *University of New South Wales Law Journal* 647, 1.
[48] James L Werth JR & Howard Wineberg, 'A Critical Analysis of Criticism of the Oregon Death with Dignity Act' 29(1) *Death Studies* 1 ('A Critical Analysis of Criticism of the Oregon Death with Dignity Act').

extent by the nature of having an ailment which will take their life. As noted by Werth and Wineberg:

> [B]ecause there is always the possibility of deception when one must rely on self-reports, there is nothing to prevent patients from lying to physicians regarding why they want a prescription. The difficulty with making prognoses is often noted.[49]

Werth and Wineberg explain that there is however more to this, stating that critics of the Oregon model fail to acknowledge that errors typically occur in the following ways:

> (a) believing the person has longer to live than she or he does, or (b) telling a person she or he has longer to live than she or he actually does. For example, 63% of patients were given a prognosis that was too optimistic whereas only 17% died sooner than expected. Although a minority of terminally ill patients may be classified pessimistically regarding their survival time, this should have a minimal impact on the [VAD law] because there is evidence from hospice utilization data and from those hastening their death under the Act suggesting that people wait until they are near death to stop trying curative treatments.[50]

This criticism is similar to that advanced by John Keown who suggested that under the Oregon definition of terminal illness, treatable illnesses that a patient can survive but which may cause death if left untreated, such as diabetes, would qualify a patient for access to VAD.[51]

Later reports from the Oregon Health Authority seem to support this hypothesis, as noted in the WA Parliament Minority report:

> Oregon's [Death with Dignity] Act requires that a person be certified by two physicians as suffering from a terminal illness before a lethal dose of medication can be lawfully prescribed. The annual report released in February 2017 shows that conditions that have been accepted as meeting this definition include benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, and alcoholic liver disease.

The Minority Report then identifies that earlier Oregon annual reports specifically mentioned some diseases which typically would not be considered a terminal illness, such as

[49] Ibid, 12-13.
[50] Ibid, 12-13.
[51] Euthanasia, Ethics and Public Policy (n 25) 351.

myelodyoplastic syndrome (which is not terminal but may develop into acute myeloid leukaemia, which also may not be terminal), Hepatitis C, 'and digestive organ neoplasm of unknown behaviour, among others'.[52] The Report goes on to state that it was suggested to the WA parliamentary committee that this is evidence that the requirements of an illness being terminal is not being strictly applied in Oregon.[53]

2 *Psychological Assessment*

The Oregon legislation does not require that a patient undergo a psychological assessment before having access to VAD, unless either doctor involved in the process believes the patient's decision-making abilities are being impaired by a psychiatric or psychological disorder.[54]

In the first year of its operation, 4 of the 21 patients who received the VAD drug had had a psychiatric/psychological consultation. In 2019 only 1 of the 290 patients who received the VAD drug had a psychiatric/psychological consultation. Evidently, such referrals are rather uncommon. However this does not necessarily mean that doctors are not referring patients, as Werth and Wineberg note:

> [T]he research conducted in Oregon with individuals requesting medication under the Act demonstrates that clinical depression is not a major factor in requests for medication and, if present, it could be detected and the depressed individual screened out of the process. For example, a survey of Oregon physicians who had experience with the [Oregon Death with Dignity Act] found that 17% of the persons requesting medication had had "a mental disorder such as depression which impaired his/her judgment." None of those patients was given a prescription under the Act.

Werth and Wineberg continue to explain that the authors of the study concluded that vulnerable groups, including the mentally ill, did not seek VAD disproportionately to other groups 'or receive lethal prescriptions in place of palliative care'. They also cite a survey of hospice social workers and nurses which stated that depression was considered among the lease important reasons 'for requesting medication'[55]

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[52] Hon Nick Goiran MLC, *The safe approach to End of Life Choices: License to Care not License to Kill,* Joint Select Committee on End of Life Choices (Minority Report) (August 2018), 200-201 ('*WA Minority Report*').
[53] Ibid.
[54] Oregon Health Authority, 'Death with Dignity Act Requirements' (undated) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/requirements.pdf>.
[55] *A Critical Analysis of Criticism of the Oregon Death with Dignity Act* (n 47) 18.

Such a notion is difficult to reconcile as in cases of chronic pain, depression is frequently present.[56] On the other hand however, in studies following the legalisation of VAD in Oregon, only 6% of psychiatrists and 7% of psychologists believed they could be an effective 'gatekeeper' after only 1 session with a patient.[57] It is very possible that referrals are not made on that basis, or more simply, doctors involved in the process do not necessarily have the requisite training to assess the full complexities of mental illness. A United States National Council on Disability report provides an example of the failure to refer for mental illness:

> People with the disability of depression are subject to harm where assisted suicide is legal. Yet the law's supporters frequently suggest that, as a key safeguard, depressed people are ineligible for assisted suicide. Michael Freeland of Oregon was a case study of the potential for harm. With his permission, his case was extensively documented by Dr. Gregory Hamilton, a Distinguished Fellow of the American Psychiatric Association. [58]

The report then goes on to account the story of Michael Freeland's as excerpted from Hamilton's documentation:

> At age 62, Michael Freeland had a 43-year medical history of significant depression and suicide attempts. After receiving a diagnosis of terminal lung cancer, he requested assisted suicide. Dr. Peter Reagan, an assisted suicide advocate who was associated with the group Compassion in Dying […], a leading pro-assisted suicide organization, prescribed lethal drugs to Michael Freeland without even a cursory psychological evaluation. Reagan commented that he did not think such a consultation would be "necessary" for Mr. Freeland, according to Freeland's daughter, who accompanied him to an appointment.[59]

It thus appears that there may be some difficulty in obtaining accurate data in respect of psychological assessment in VAD cases in Oregon. That may be a consequence of the biases of treating physicians who believe they are doing what they believe is right for their patient, even if such a notion may be against the law, or such patients are being 'weeded out' early in the process.

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[56] Alex Holmes, Nicholas Christelis and Carolyn Arnold, 'Depression and chronic pain' (2013) 199(6) *Med J Aust*, 17.
[57] James A Bourgeois et al, 'Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act' (2018) 59 *Psychosomatics* 441, 442.
[58] National Council on Disability, 'The Danger of Assisted Suicide' (2019) <https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf>, 23.
[59] Ibid.

3 *Other Issues*

Oregon is often used as an example of doctor shopping in practice, however it is not the only jurisdiction to attract this criticism, particularly as all other VAD models in the US are based on the Oregon model.[60] This criticism has been noted above in Chapter III.

The Oregon model has also attracted criticism for the period in which patients obtain, and then consume the VAD drug. As discussed below in Chapter IV, in prognosis, there have been a number of reported cases of patients consuming the VAD drug more than 2 years after their request for the drug, which is in stark contrast to the 6 month prognosis required for eligibility under the Oregon law.

D *The Netherlands*

Because of its relatively long history, it is best to consider the Dutch experience with VAD in practice in two distinct eras: pre-VAD legislation, and post-VAD legislation.

1 *Pre-Legislation Era*

The Dutch pre-legislation era has attracted the most debate. Those results are revealed in the Remmelink report and the Van der Maas Survey.

According to Dr John Keown, the Remmelink Report unintentionally revealed that the Dutch regulations 'had failed to prevent major non-compliance with the guidelines',[61] and shows the issues faced when reporting (and defining) euthanasia, as Dr Keown describes the issue as follows:

> A doctor might end life not by intentionally administering a lethal drug, which the guidelines would require to be reported, but by an overdose of morphine or withdrawing treatment, and then claim (in the most unlikely event of being challenged) that this was not 'euthanasia' but 'normal medical practice'.[62]

[60] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, 'Voluntary assisted dying' (Report No 34, Parliamentary Library, Parliament of Queensland, 2020), 35.
[61] Euthanasia, Ethics and Public Policy (n 25) 115.
[62] Ibid.

This of course raises the question of how a reporting mechanism would work within the regulatory framework. That is, when does 'normal medical practice' become 'euthanasia'? Consequently, there is an argument to be made that it would be impossible to get accurate statistics on assisted dying, and the actual number of assisted deaths may be much higher than those being reported.

The Remmelink report showed a considerable failure to report VAD suggesting that only 18% of cases were reported. The 1995 Van der Maas survey showed an improved 41% of reporting. Whilst this is an improvement it shows that a clear majority of cases of assisted dying went unreported, thus meaning that most cases were not scrutinised as the regulations intended.[63]

In addition, Dr Keown argues that throughout these reports questionable reporting procedures are merely the tip of the iceberg. According to the Dutch model, assisted dying must be a 'last resort'. However Dr Keown notes that the studies show that in 21% of cases there were other options available to patients (which they refused), and that one third of general practitioners who decided that there were no alternatives failed to seek advice from a colleague, as required under the Dutch guidelines.[64]

2 *Post-Legislation Era*

In 2001 the Netherlands passed its VAD legislation,[65] making it the first country in the world to legalise VAD. While under the Dutch criminal code, inciting or assisting a person to commit suicide remains a crime.[66] The VAD legislation, the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* contains 24 articles, of which only article 2, which is comprised of 4 sections, sets out the VAD process in the Netherlands, notably it does not provide any guidance as to how the assisted death is to occur.[67] In practice, the Dutch legislation appears to largely follow the policy of the pre-legislation era. As such, it has attracted many of the same criticisms.

As noted above, in the Van der Maas survey, in the pre-legislation era, non-compliance with the prosecution guidelines was not a rare occurrence. As noted by Kumar Amarasekera:

[63] Ibid, 134-135.
[64] Ibid, 110.
[65] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (Netherlands)
[66] *Wetboek van Strafrecht 1881* [Criminal Law 1881] (Netherlands), art 293-294.
[67] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (Netherlands), art 2(4).

> The new law offers no basis for confidence that the conditions precedent to lawful killing will be observed. A conspicuous defect in the legislation is that no express provision is made for ascertaining whether the statutory conditions are being observed, as distinct from ex post facto reportage. In a matter involving life and death it is vital that there should be a contemporaneous verification that the statutory procedures are followed.[68]

Prosecutions in the pre-legislation era were rare, and to date only one prosecution in the post-legislation period has occurred. In 2017 a doctor had euthanized a patient who suffered from severe dementia. The patient had signed an advance euthanasia directive 5 years earlier stating that she wanted euthanasia if she was mentally competent at the time of receiving VAD.

Prosecutors alleged that the patient had given differing statements on her desire for VAD, and her mental health had deteriorated by the time of her passing. On the day of the patient's passing the doctor had put a dose of sedative into the patient's morning drink, approximately half an hour later the doctor injected the patient with a further dose. While the patient was asleep later, the doctor attempted a third dose via injection. The patient woke up and attempted to stand. She was restrained by her family which allowed the doctor to administer the rest of the dose.

The doctor had already been found by the medical complaints board to have breached official guidelines in her treatment of the patient and was said to have 'overstepped the line'.[69]

The Regional Review Committees for Termination of Life on Request and Assisted Suicide determined that the doctor had failed to meet the due care criteria. The Medical Disciplinary Court agreed with the Review Committees finding. However they considered a warning appropriate because the doctor 'had done extensive research and consultation before she came to her conclusions and she had been open and transparent about her actions and the reasons she had for them'.[70]

In 2019 the case was brought before the Criminal Court, who ultimately determined that the doctor had met all the due care criteria. Consequently, this case meant that dementia patients

[68] Kumar Amarasekara and Mirko Bagaric, 'The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt' 27(2) *Monash Law Review* 179, 189.
[69] Daniel Boffey, 'Doctor to face Dutch prosecution for breach of euthanasia law', *The Guardian* (online), 10 November 2018 <https://www.theguardian.com/world/2018/nov/09/doctor-to-face-dutch-prosecution-for-breach-of-euthanasia-law>.
[70] Eva Constance Alida Asscher, 'First prosecution of a Dutch doctor since the Euthanasia Act of 2002: what does the verdict mean' (2020) 46 *Journal of Medical Ethics* 71, 72-73.

who had signed an advance euthanasia directive can be granted VAD, even if they later lack the capacity to make such a decision, provided that the directive was signed while they were still capable of decision making.[71]

The Dutch legislation has also received criticism for not requiring the patient to be suffering from a terminal illness, which is similar to the position in the pre-legislative era.[72] Further, it is not limited to requiring a patient to be suffering from incurable physical pain, again adopting the pre-legislative era approach.[73]

In 2003 the Dutch Supreme Court ruled that 'doctors may not perform euthanasia or help with suicide unless the request comes from a patient suffering from a medically classifiable physical or psychiatric sickness or disorder. Simply being 'tired of life' is no basis for doctors to act.'[74] In 2016,[75] and again in 2020, attempts were made to expand the eligibility provisions to elderly persons who did not have a terminal illness, but were 'tired of life'.[76]

In 2020 the Dutch law was expanded to allow VAD for children aged between 1 and 12 with mandatory consent from the patient and their parents. However, as noted by the BBC, VAD is legal in the Netherlands for children older than 12 (patient parental consent is required), babies up to 1 year old (with parental consent), but was not accessible for those aged 1-12 with a terminal illness:

> … [F]ollowing the government's approval of the plans, [the Dutch Minister for Health] said he would draft new regulations for the practice. He said a study by experts had noted a need for the rule change.
>
> "The study shows that there is a need for active termination of life among doctors and parents of incurably ill children, who are suffering hopelessly and unbearably and will die within the foreseeable future," [the Dutch Minister for Health] said in a letter to parliament.

[71] Ibid, 73.
[72] Kumar Amarasekara and Mirko Bagaric (n 61) 192.
[73] Ibid, 193.s
[74] Tony Sheldon, 'Being "tired of life" is not grounds for euthanasia' (2003) 326(73) *BMJ* 71.
[75] Reuters, 'Netherlands may extend assisted dying to those who feel life is complete' *The Guardian* (Online), 13 October 2016 < https://www.theguardian.com/world/2016/oct/13/netherlands-may-allow-assisted-dying-for-those-who-feel-life-is-complete>.
[76] Senay Voztas, 'Dutch MP backs euthanasia for over-75s who are tired of life', *The Times* (Online), 19 July 2020 <https://www.thetimes.co.uk/article/dutch-mp-backs-euthanasia-for-over-75s-who-are-tired-of-life-z8bdp6685>.

The Minister stated that the study showed 5-10 children a year would be affected by the change, adding that the current law would not need to be changed, but doctors would be exempt from prosecution 'for carrying out an approved euthanasia on someone in this age range'.[77]

Critics of the Dutch model have identified this as an example of the slippery slope (discussed below), particularly that of euthanizing those unable to make such a decision for themself.[78]

E *Belgium*

Many of the criticisms of the Dutch model are also extended to Belgium. Much like its Dutch counterpart an illness need not be terminal to attract VAD eligibility. The legislation notes that to be eligible (among other things):

> [T]he patient is in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident.[79]

This requirement allows situations where a patient is not terminal, or is suffering from psychological trauma to access VAD. However, in the event the patient is not expected to 'die in the near future', the doctor must consult a psychiatrist or specialist in the patient's illness, who must be satisfied the patient's suffering cannot be alleviated, and allow one month between the patient's written request for VAD and the death of the patient.[80] A 2020 survey noted that 74.5% of psychiatrists agreed that VAD should remain permissible for adults with psychiatric conditions. However their willingness to take a formal role in the VAD process is limited.[81]

In 2010 a 38 year old Belgian woman was given a lethal injection after she had been diagnosed with autism. The lethal injection was certified by three doctors. The patient was given the lethal injection two months after her diagnosis. The family of the victim, who were at her bedside at the time of her death, claimed that the law was broken as the patient

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[77] BBC, 'Netherlands backs euthanasia for terminally ill children under-12' *BBC* (Online), 14 October 2020 <https://www.bbc.com/news/world-europe-54538288>.
[78] New York Times, 'Netherlands to Allow Doctors to Help End Lives of Terminally Ill' New York Times (Online) 16 October 2020.
[79] *The Belgian Act on Euthanasia of May, 28th 2002,* s 3(1).
[80] Ibid, s 3(3).
[81] Monica Verhostadt et al, 'Belgian psychiatrists' attitudes towards, and readiness to engage in, euthanasia assessment procedures with adults with psychiatric conditions: a survey' (2020) 20 *BMJ Psychiatry* 374.

received no treatment for autism, nor had it been established that the patient was suffering 'unbearably and incurably' – which are essential criteria for an assisted death to proceed.[82] The doctors were charged with failing to comply with the legal conditions for assisted dying. It is the first criminal case since legalisation of assisted suicide in Belgium in 2002.[83] The doctors were cleared in 2020. The first doctor, who administered the VAD drug was acquitted on grounds of reasonable doubt. The second doctor was acquitted as he was not aware that the euthanasia would occur that day. Finally, the psychiatrist had met 'all the conditions required of her'.[84]

The lack of prosecutions in Belgium has also given rise to criticisms that the system fails to respond to breaches and/or fails to prosecute breaches. One example is the role of nurses in VAD. While the Belgian law requires a doctor to administer any lethal dosage, the drugs are sometimes administered by nurses instead. As noted in a 2010 study of 1678 nurses in Flanders Belgium by Inghelbrecht, Bilsen, Mortier and Deliens:

> Overall, 128 nurses reported having cared for a patient who received euthanasia and 120 for a patient who received life-ending drugs without his or her explicit request. Respectively, 64% (75/117) and 69% (81/118) of these nurses were involved in the physician's decision-making process. More often this entailed an exchange of information on the patient's condition or the patient's or relatives' wishes (45% [34/117] and 51% [41/118]) than sharing in the decision-making (24% [18/117] and 31% [25/118]). [85]

The authors note that in 12% of cases where VAD occurred, the life-ending drug was administered by a nurse, compared to 45% where assisted death occurred without an explicit request. In both situations the nurses acted upon the doctor's orders, but in most cases performed the procedure in the doctor's absence.[86]

The Belgian model has also attracted claims of descent down the 'slippery slope'. For example, when VAD became available in Belgium in 2002, the law required that a patient seeking VAD must have reached the age of majority (or in rare cases 'emancipated

[82] *The Belgian Act on Euthanasia of May, 28th 2002*, s 3(3).
[83] Simon Caldwell, 'Doctors who certified a woman as autistic so she could get a lethal injection face jail under euthanasia laws as family insist she was just broken hearted', *The Daily Mail* (online), 25 November 2018 <https://www.dailymail.co.uk/news/article-6425417/Doctors-allowed-woman-lethal-injection-face-jail-euthanasia-laws.html>.
[84] BBC, 'Belgium euthanasia: Three doctors cleared in landmark trial'. *BBC News* (online) 31 January 2020 <https://www.bbc.com/news/world-europe-51322781>.
[85] Els Inghelbrecht, Johan Bilsen, Freddy Mortier and Luc Deliens, 'The role of nurses in physician-assisted deaths in Belgium' (2010), 182(9) *Canadian Medical Association Journal* 905, 905.
[86] Ibid.

minors').[87] However, in 2014 this law was amended to allow for minors (regardless of age) to pursue VAD provided certain criteria were met. Those criteria included that a minor possessing 'the capacity of discernment' and was suffering in a 'medically futile condition' which will result in the death in the short term, if that suffering stems from 'a serious and incurable disorder caused by illness or accident'.[88] The parent(s)/guardian(s) of the minor patient were also required to provide their written consent for VAD to be made available to the minor.[89]

F *Luxembourg*

Between its legalisation in 2009 and 2019, 71 patients have chosen to end their lives via VAD in Luxembourg.[90] The Luxembourgish model is similar to its Dutch and Belgian counterparts. However, Luxembourg has, for whatever reason, attracted little attention in the VAD debate, and typically only attracts a passing mention when it's Dutch and Belgian cousins are discussed.

It appears that there is no official English translation of the Luxembourg *Legislation Reglementant Les Soins Palliatifs Ainsi Que L'euthanasie Et L'assistance Au Suicide (2009)* [Legislation Regulating Palliative Care as Well as Euthanasia And Assistance to Suicide], despite this useful information can be gathered from what is available or can be translated.

Article 2 of the Luxembourg law notes that it is not illegal, and gives no rise to civil action, for a doctor to refuse or refrain from giving treatment to a patient at the end of the patient's life. Article 3 provides for double-effect, but noticeably states that a doctor must inform the patient that they are unable to relieve the suffering of the patient, and that alternative treatments may result with the death of the patient. Articles 5-7 deal with advance directives, which have the effect of enabling VAD through the use of advance directives. Discussing advance directives in a Dutch context JJM van Delden identifies a number of issues, including:

- How will a doctor know that the advance directive was informed and made free from duress or undue influence;

[87] *The Belgian Act on Euthanasia of May, 28th 2002,* s 3(1).
[88] *Act amending the Act of 28 May 2002 on euthanasia, sanctioning euthanasia for minors*, s 3(1).
[89] Ibid, 7.
[90] BBC, 'A decade on: more than 70 people choose euthanasia in Luxembourg', *Luxembourg Times (Online)*, 21 May 2019. <https://www.luxtimes.lu/en/luxembourg/a-decade-on-more-than-70-people-choose-euthanasia-in-luxembourg-602d6949de135b9236ab2834>.

- At what point would an advance directive come into effect?;
- If the patient is unable to communicate how will a doctor know the extent of the patient's suffering (ie, if it is unbearable to the patient)?; and
- Difficulties arising from misinterpretation of the directive.[91]

The obvious predicament with advance directives, as JJm van Delden notes is that they typically will come into effect when the patient is unable to communicate their wishes:

> At the moment precedent autonomy is invoked, the patient involved will no longer be able to deliberate or choose. As soon as the advance directive becomes relevant, it is this directive that determines what needs to be done, not the patient.

While Luxembourg is often a footnote in the VAD debate, it is evident that criticisms applied to other models can similarly be adapted to the Luxembourgish model.

G *Switzerland*

The Swiss model has attracted criticism for a number of reasons, most commonly because it is a 'permissive' example of VAD and allows 'suicide tourism'.

In respect of the Swiss model Hurst and Mauron state:

> The involvement of a physician is usually considered a necessary safeguard in assisted suicide and euthanasia. Legislation in Holland, Belgium, and the US state of Oregon all require it, as did the legalisation of euthanasia in Australia's Northern Territories [sic]. Physicians are trusted not to misuse these practices; along with pharmacists they are in control of prescription drugs. Physicians are believed to know how to ensure a painless death, and they are in a position to offer palliative care knowledgeably. [92]

The authors note that Switzerland is the only country in which the crime of assisted suicide is limited. They explain:

> Switzerland seems to be the only country in which the law limits the circumstances in which assisted suicide is a crime, thereby decriminalising it in other cases, without requiring the involvement of a physician. Consequently, non-physicians have participated in assisted suicide. The law has explicitly separated the issue of whether or not assisting death should be

[91] JJM van Delden, 'The unfeasibility of requests for euthanasia in advance directives' (2004), 30 *BMJ* 447, 448-450.
[92] Samia A Hurst and Alex Mauron, 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians' (2003), 326 (7383) *BMJ* 271, 271 (citations omitted).

> allowed in some circumstances, from that of whether physicians should do it. This separation has not resulted in moral desensitisation of assisted suicide and euthanasia.[93]

The 'Swiss model' is dictated by articles 114-115 of its criminal code. The *Swiss Criminal Code* states in article 114 under '[h]omicide at the request of the victim':

> Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person's own genuine and insistent request shall be liable to a custodial sentence not exceeding three years or to a monetary penalty.[94]

That is, to kill the patient (ie, a 'mercy killing') is to have committed an offence, punishable by a prison sentence or a fine. Article 115 of the Swiss Criminal Code provides for 'inciting and assisting suicide':

> Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.[95]

Notably, the assistance is caveated by the expression 'selfish motives', if that element is not established, such an act is not illegal under Swiss law, similarly the death of a patient as a result of double-effect, or withholding treatment remains legal.[96]. As noted by Roberto Andonro, there are two significant differences between the Swiss model and its other European counterparts. Firstly, he identifies the legality of assisted suicide where those providing such assisted are not doctors:

> Whereas in the Netherlands and Belgium only physicians are allowed to assist in a suicide, in Switzerland this assistance is provided by (nonphysician) volunteers working for nonprofit organizations. The role of doctors is limited to prescribing the lethal drug and assessing the patient's decisional capacity; they do not perform the assistance in the suicide themselves. In this regard, the practice of assisted suicide in Switzerland is similar to the one in the U.S. state Oregon [sic]. [97]

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[93] Ibid, 271.
[94] *Swiss Criminal Code (1937)*, article 114.
[95] Ibid, 115.
[96] The *Swiss Criminal Code (1937)* does provide for 'homicide through negligence' in article 117, however withholding treatment (or double-effect) is not negligence per se, and would require analysis on a case-by-case basis.
[97] Roberto Andorno, 'Nonphysician-Assisted Suicide in Switzerland' (2013) 22(3) *Cambridge Quarterly of Healthcare Ethics* 246, 246 (citations omitted).

Secondly he notes that while the Dutch and Belgian models require terminal illness and/or unbearable suffering, the Swiss model places no such requirement on patients, stating:

> One need not have a particular medical condition (such as a terminal illness or an unbearable suffering) to request assistance with suicide. The only requirement is that the individual must have decisional capacity, because in the absence of it his or her act cannot be considered a "suicide" in legal terms. In fact, at present, according to a recent study, around 25% percent of people who die by assisted suicide in Switzerland do not have any serious or terminal illness but are just old, or are simply "tired of life." … [98]

Consequently, under the Swiss model, any person can potentially assist a patient in VAD, and any competent person can request such assistance. In practice this means VAD is often performed by volunteers in non-governmental organisations, not doctors:

> Interestingly, according to a study conducted in 2009, 80.4 percent of Swiss doctors are reluctant to be directly involved in this practice, which they consider to be a "nonmedical intervention" (although the majority of them do not regard the practice itself as morally reprehensible).[99]

For these reasons, organisations have been formed in Switzerland to make use of this apparent 'loophole' to assist patients in seeking VAD, and the formation of these organisations has attracted criticism of Switzerland as a suicide tourism destination.

'Suicide tourism' is an observable phenomenon, with organisations such as Dignitas and Life Circle aiding those seeking assisted dying there. An Australian example of 'suicide tourism' in practice is the case of Perth Academic Dr David Goodall who successfully sought VAD in Switzerland, 'due to old age rather than a terminal illness'. He was reported as having stated that '[a]t my age, or less than my age, one wants to be free to choose the death when the death is an appropriate time.'[100]

According to the Guardian newspaper, over 1000 people have chosen to travel to Switzerland to end their lives. They describe how Dignitas operates in providing assistance to those seeking VAD:

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[98] Ibid.
[99] Ibid.
[100] Charlotte Hamlyn and Briana Shepherd, 'David Goodall ends his life at 104 with a final powerful statement on euthanasia', *ABC News (online)*, 11 May 2018 <https://www.abc.net.au/news/2018-05-10/david-goodall-ends-life-in-a-powerful-statement-on-euthanasia/9742528>.

> First, you need to become a member of Dignitas; anyone can join if they pay an annual fee of 80 Swiss francs (£47). When you are ready to die, you need to send in copies of your medical records, a letter explaining why things have become intolerable and £1,860. These files are dispatched to one of Dignitas's affiliated doctors, who considers on the basis of the medical history whether or not he would be ready to write a prescription for the fatal dose. If he agrees in principle, then a "green light" is given to the member, and they can contact staff at the Dignitas headquarters, who will schedule a date and offer advice on hotels. [101]

Once the patient has gone through this process, they can then fly to Switzerland to receive VAD:

> Once they arrive in Zurich, the individual must pay £620 for two appointments with the doctor (to check their records and prescribe the drugs) and a further £1,860 to pay for two Dignitas staff members to organise and witness the death. Those who cannot afford the fees may pay less.[102]

Consequently this leaves the Swiss model ripe for criticisms of these organisations charging (and possibly making profit) for assisting in the death of people, regardless of their health.[103] The commercial aspect seems obvious and, for some, still objectionable.

H *Canada*

In 1995 the Royal Society of Canada commissioned an expert panel on end-of-life decision-making, the majority finding that VAD remain a criminal offence.[104] Ultimately this prohibition would be removed when the Canadian Government passed Bill C-14 on June of 2016.[105] Section 241.2 (1) of Bill C-14 provides that patient may receive assisted dying if they meet all of the following criteria:

a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
b) they are at least 18 years of age and capable of making decisions with respect to their health;

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[101] Amelia Gentleman, 'Inside the Dignitas House', *the Guardian (Online),* 18 November 2009 <https://www.theguardian.com/society/2009/nov/18/assisted-suicide-dignitas-house>.
[102] Ibid.
[103] Journal Article, 'https://www.smh.com.au/world/dealing-in-the-desire-for-death-20070203-gdpe4s.html', *Sydney Morning Herald (Online),* 03 February 2007 < https://www.smh.com.au/world/dealing-in-the-desire-for-death-20070203-gdpe4s.html>.
[104] Special Senate Committee on Euthanasia and Assisted Suicide (Canada), *Of Life and Death – Final Report* (1995). < https://sencanada.ca/content/sen/committee/351/euth/rep/lad-e.htm>.
[105] *An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying), C 2016, C-14, 241.2(1) ('*Medical Assistance in Dying Act'*).

c) they have a grievous and irremediable medical condition;
d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.[106]

It is notable that the Canadian model does not require a terminal illness, only a 'grievous and irremediable' medical condition. Presumably, this may mean that any particularly serious disease or illness may make a patient eligible for assisted dying.

The College of Physicians and Surgeons of Nova Scotia issued a professional standards publication for medical practitioners to provide some guidance since the legislation lacks specificity. The Nova Scotia publication states that the patient must have a 'grievous and irremediable medical condition', the conditions of which are not met until the treating doctor forms the view that the patient meets all of the following criteria:

(a) the patient has a serious and incurable illness, disease or disability;
(b) the patient is in an advanced state of irreversible decline in capacity;
(c) the illness, disease or disability or that state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable; and
(d) the patient's natural death has become reasonably foreseeable, taking to account all of the patient's medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the patient has remaining.[107]

While these guidelines provide some much needed specificity, they unintentionally create more room for confusion or misuse. For example, these guidelines only require the patient to be suffering physical or psychological suffering which is intolerable to the patient. Depression is not mentioned at all, nor is there reference to any treatment for psychological distress as a result of the illness. The legislation is also silent on this issue.

[106] Ibid, s 241.2 (1)(a)-(e).

[107] College of Physicians & Surgeons of Nova Scotia, *Professional Standard Regarding Medical Assistance in Dying* (December 14, 2018) <https://cpsns.ns.ca/wp-content/uploads/2016/06/Medical-Assistance-in-Dying-Standard.pdf>, 5 (citations omitted).

In 2021 amendments were passed to extend the definition of 'grievous and irremediable medical condition' to include psychological suffering.[108]

A safeguard in the Canadian model provided mandatory waiting period between requests with a 10 day reflection period between request and VAD (unless death or loss of capacity is imminent). According to Herx, Cottle, and Scott, this 10 day period was often waived. They state:

> In one cohort study of euthanasia deaths in Ontario, 26% of euthanasia deaths had the ten-day reflection period expedited. In Quebec, it has been reported that 60% of euthanasia cases had the ten-day reflection period waived and, of these cases, 48% did not meet the criminal code criteria for removal (i.e., imminent risk of death or imminent loss of decisional capacity) and 26% had no documented reason for waiving the reflection period.[109]

2021 amendments to the Canadian model removed this 10 day period.[110]

A further criticism can be found in respect of the reporting processes in the Canadian model. The second doctor can see the first doctor's assessment report prior to seeing the patient (or indeed drafting their own report). Further, there is no mechanism to record incidences where a second assessor disagrees with the first assessor or how many assessments were obtained.[111]

Criticism can be drawn in respect of determining the decision making capacity of the patient. As Herx, Cottle, and Scott note:

> In Canada, both telemedicine (video) and telephone (voice) are allowed to be used for euthanasia assessments. Determination of a person's decisional capacity is not straightforward and may require advanced skills and tools, but there are no formal requirements for training to assess decisional capacity and no requirement for psychiatric consultation in complex cases.[112]

Under s 9.1 of the Act, the Minister for Health must make regulations that they deem necessary with respect to monitoring requirements,[113] and respecting the use, and disposal of

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[108] *An Act to amend the Criminal Code (medical assistance in dying)*, (Canada), C 2021, C-7, 241.2(2).
[109] Leonie Herx, Margaret Cottle and John Scott, 'The "Normalization" of Euthanasia in Canada: the Cautionary Tale Continues' (2020) 66(2) *World Medical Journal*, 31 ('*The Normalization of Euthanasia in Canada*'). (citations omitted).
[110] *An Act to amend the Criminal Code (medical assistance in dying)*, C 2021, C-7.
[111] *The Normalization of Euthanasia in Canada* (n 93) 31 (citations omitted).
[112] Ibid.
[113] *Medical Assistance in Dying Act* (n 89) s 4.

that information.[114] The draft regulations were first published on December 16, 2017 with feedback closing on February of 2018.[115] Based on the feedback received, the first guidelines were published on August 8, 2018.[116]

While the regulations require that records be kept pertaining to the request made by the patient – that is, a record of a practitioner being asked by a patient for VAD, and who that patient is – the regulations do not state where this information is to be kept and require that it be made readily available for practitioners to access. For example, neither the legislation or the regulations prevent a patient making requests to many doctors in the hope of finding one who would accept the request ('doctor shopping').

Finally, under ss 227(1) and (2) of the Act, no nurse or practitioner, or person assisting a practitioner will be held to have committed 'culpable homicide' if they provide a person with medical assistance in dying.[117] This includes those under a 'reasonable but mistaken belief' that the legislation and regulations have been complied with.[118] Therefore, unlike the Belgian and Dutch models, a nurse, or any other person could provide a patient assistance in dying, provided a doctor has approved the administration of the VAD drug under these broad exceptions.

The Canadian legislation suffers from an issue of a lack of specificity in its provisions. While a broad definition may be desirable because there are many illnesses which can become terminal, the loose language potentially allows non-terminal or treatable patients access to VAD. Nor does the legislation prevent 'doctor shopping', or third party involvement in the administration of assisted dying drugs. Most tragically it does little to prevent a person under duress from being unduly influenced in the VAD decision.

I *Conclusion*

VAD is a complex issue a number of jurisdictions have attempted to tackle. Each jurisdiction attempts to answer to the difficulties that VAD creates. With these international models examined, it becomes clear that there are consistent issues appearing, despite the differences

[114] Ibid, s 241.31(a)-(c).
[115] Government of Canada, *Monitoring System for Medical Assistance in Dying in Canada* (undated) <https://www.canada.ca/en/health-canada/services/publications/health-system-services/monitoring-system-medical-assistance-dying.html>.
[116] Ibid.
[117] Ibid, s 227(2)-(3).
[118] Ibid, s 227(3).

in how each model operates. A prime example of a common issue is patient eligibility and the expansion of who may become eligible. As such, it is necessary to examine these issues and criticisms to determine whether many of these common criticisms withstand scrutiny and are worthy of consideration in VAD legislation

IV THE VALIDITY OF INTERNATIONAL CRITICISMS

VAD is a highly controversial topic. Debate surrounding it is particularly heated and difficult to navigate. Unfortunately due to the highly emotive and often political, ethical, moral, and religious nature of the debate a fervour develops where neither side is willing to concede. Common ground is difficult to find where one side says 'yes' and another says 'no'. There is seemingly no 'maybe' in the VAD debate.

While criticisms of each jurisdiction have been addressed above, to discuss them again is unnecessary. The most common and generally relevant criticisms have been discussed with reference to various jurisdictions. Similarly, many criticisms, whether valid or not, bleed into each other and overlap between issues is to be expected. However, one of the commonly raised criticisms of VAD in international literature in the so-called slippery slope. That issue is now explained and separately discussed.

A *The 'Slippery Slope'*

The slippery slope argument is perhaps the most prevalent argument in the VAD debate. It assumes that if something such as VAD is to become permissible, other illegal acts will become permissible in due course. Rietjens et al describe the slippery slope as:

> [I]f we allow A (the use euthanasia at the request of terminally ill patients), B (abuse of euthanasia, that is, ending the life of vulnerable patient groups without their consent) will necessarily or very likely follow. B is morally not acceptable; therefore, we must not allow A.[1]

The slippery slope argument has attracted criticism, as Dr Benatar notes:

> It is, of course, easier to assert the existence of a slippery slope than to prove that it exists. Opponents of a legal right to die thus point to the Netherlands, for example, and note how the law permitting euthanasia and doctor-assisted suicide in that country has become steadily more permissive. At first, euthanasia was permitted only for the terminally ill who requested

[1] Judith A.C. Rietjens et al, 'Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?' (2002) 6 *Journal of Bioethical Inquiry* 271, 279.

> it, but then it was permitted for the chronically ill, for those whose suffering was psychological, and for incompetent patients, including children.[2]

Dr Benatar agrees that the Dutch VAD laws have become more permissive over time, but argues that the increase in permissiveness in the Dutch model is insufficient to demonstrate that a 'slippery slope' exists.[3]

This perhaps illustrates the difficulty of the slippery slope argument. That is, it largely becomes a question of semantics and personal interpretation. Perhaps it is therefore best to avoid invoking the 'slippery slope' and examine the expansion of VAD laws and whether such an expansion is suitable in light of the intention of the legislation.

Dr Benatar's comments are also relevant to the position in Belgium. When VAD became available in Belgium in 2002, the law required that a patient seeking VAD must have reached the age of majority (or in rare cases 'emancipated minors').[4] However, in 2014 this law was amended to allow for minors (regardless of age) to pursue VAD provided certain criteria were met, such as the minor possessing 'the capacity of discernment' with suffering from a 'medically futile condition' that stems from 'a serious and incurable disorder caused by illness or accident' which will result in the death in the short term.[5] The parent(s)/guardian(s) of the minor patient must also provide their written consent for VAD to be available to the minor.[6]

While children were unable to access VAD (but for rare circumstances), the law has expanded in Belgium to allow access for children if the parents' consent. It is hypothetically possible, albeit unlikely, that the law may be expanded in the future to remove the parental consent for children over a certain age.

Similarly, in Canada 2021 amendments expanded legal VAD to make it accessible to patients suffering from unbearable psychological suffering. The amendment also removed the 10 day cool down period for patients between request and VAD. Earlier, in 2018 the Guardian reported a patient accessing VAD before she believed herself to be ready as the patient feared she would lose access to VAD due to loss of cognitive ability over time due to her condition.

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[2] D Benatar, 'A legal right to die: responding to slippery slope and abuse arguments' (2011), 18(5) *Current Oncology* 206, 206.
[3] Ibid.
[4] *The Belgian Act on Euthanasia of May, 28th 2002*, s 3(1).
[5] *Act amending the Act of 28 May 2002 on euthanasia, sanctioning euthanasia for minors*, s 3(1).
[6] Ibid, 7.

This sparked debate as to expanding VAD eligibility to include VAD requests via advance directives or other end of life planning. Curiously, the day after the patient passed away, the Canadian Federal Justice Minister told reporters that the Canadian Government was not considering making changes to the Canadian model, and was confident in the legislation as it then stood.[7]

It is evident that there is always the possibility of expansion of VAD legislation, but such laws are normally a reflection of the wishes of the society concerned. However, it is submitted that expansion should always be treated with caution, particularly in respect to those suffering only from psychological ailments (which may be treatable) and those who do not have capacity to make decisions.

As noted above, in both Belgium and the Netherlands there have been prosecutions for ending the life of a patient who lost decision-making capabilities. Even though both of these cases ultimately led to the accused being acquitted, there is room for concern regarding patients who cannot consent. As noted by bioethicist Chris Kaposy:

> You have to walk that line between honouring legitimate directives, where people are suffering … But also you want to be able to avoid situations where you're obligated to essentially kill people who are happy.[8]

While the 'slippery slope' may be only identifiable to those who oppose VAD, there is indeed merit to the argument that VAD models may expand (and have expanded) to other classes of people. While there is no evidence as yet to suggest that any particular group may be subject to victimisation,[9] prosecutions from Belgium and the Netherlands show that expansion of VAD eligibility can occur to those who are unable to give consent at the time of VAD (but did give consent some time before). Valid questions can be raised in respect to expanding VAD eligibility to those who are unable, or should not be considered able to make such serious decisions, such as those suffering from neurodegenerative conditions, those suffering from psychological conditions, and minors.

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[7] Leyland Cecco, 'Canada debates assisted death laws after woman is forced to end life early', *The Guardian (Online)*, 06 November 2018 <https://www.theguardian.com/world/2018/nov/06/canada-debates-assisted-death-laws>.

[8] Ibid.

[9] As discussed in this chapter, the slippery slope argument often rests on the ideological presuppositions of the party making or rejecting the argument, and what that person defines as a slippery slope.

B *Doctor Shopping*

Doctor shopping is when a patient, dissatisfied with the opinion of one doctor, attends upon another to get an opinion they prefer. Golden and Zoanni note an example of this in Oregon, stating:

> [P]hysicians are not permitted to write a lethal prescription under a set of inappropriate conditions defined in the law, such as when a patient is incompetent or when a request is involuntary. But in many instances, patients have engaged in "doctor shopping" which can circumvent these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient did not meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and fourth, until someone finally agreed. [10]

Golden and Zoanni continue to state that doctor shopping occurred in over half of the cases in the first three years of operation in Oregon:

> In fact, in the first three years assisted suicide was legal in Oregon, patients had to ask at least two physicians before receiving lethal drugs in 59% of cases; with the fourth year, officials dropped this disturbing data from the annual reports.[11]

A similar example can be found in the experience of the ROTI Act. As noted by Philip Nitschke:

> [B]ecause we needed a Territory specialist, and there are not many, we got Stephen Badley, who was an orthopaedic surgeon, who, out of compassion said, "I cannot possibly stand to see this suffering going on any longer. I will sign it and take the heat," and by hell he took the heat.[12]

The issue of doctor shopping ties into issues in respect of diagnosis and psychological ailment. It is not wrong of a patient to seek a second opinion from a different doctor if they believe they are not receiving appropriate treatment or have concerns about their diagnosis. Doctor shopping however is seeking a doctor who will hopefully agree with the patient's

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[10] Marilyn Golden and Tyler Zoanni, '*Killing us softly: the dangers of legalizing assisted suicide'* (2010) 3(1) Disability Health Journal 16, 21.
[11] Ibid, 21.
[12] Hon Nick Goiran MLC, *The safe approach to End of Life Choices: License to Care not License to Kill,* (Joint Select Committee on End of Life Choices, Minority Report, August 2018), 156 ('*WA Minority Report*').

view as to their illness and life expectancy. While that is not to say doctors would participate in such an exercise by a patient knowingly. Medical opinions will inevitably differ.

To prevent a patient from seeking a second opinion would of course be infringing on the patient's rights. However, to allow patients to doctor shop to seek VAD is a cause for concern. If a patient is dogged in their search for VAD there may be legitimate questions about the mental health of that patient, and those issues should be addressed so as to allow the patient to receive appropriate treatment and advice before making what could be their final decision.

C *Psychological Suffering*

The issues that connect psychological suffering and VAD are twofold. First, there are issues in respect to whether a patient should undergo a psychological assessment before being eligible for VAD. Secondly, there are questions about allowing patients suffering from psychological illness access to VAD.

1 *Psychological Assessment*

The Tasmanian ROTI Act required that a psychiatrist assess the patient to determine whether the person is 'suffering from a treatable clinical depression in respect of the illness'.[13]

Depression was a common theme among the patients in 'Seven Deaths in Darwin'. Yet, as Kissane, Street and Nitschke noted (above), a survey of psychiatrists in Oregon found only 6% considered themselves competent to diagnose clinical depressions after a single assessment of a patient. They state:

> This finding illustrates the difficulty of legislation of this sort—there is an important role for psychiatry in oncology and palliative care to ensure that depression is actively treated, but a gatekeeping role may be flawed if seen as adversarial by patients and viewed as blocking successful treatment, rather than being one part of proper multidisciplinary care.[14]

Preventing undue suffering is of course a significant policy consideration when VAD legislation is drafted.[15] However, it seems to be a significant flaw if a VAD policy fails to

[13] *Rights of the Terminally Ill Act 1995* (NT), s 7.
[14] David W Kissane, Annette Street and Philip Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' (1998) 353 *The Lancet* 1097, 1101.
[15] Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying* Final Report (2017), 63-65.

require an assessment of the mental health of a patient who has likely been informed they only have a short time left to live. It would thus be an intelligent addition to any VAD policy to ensure that mental illness is not a significant factor behind a patient's decision to end their lives. To not assess a patient's mental health where they are seeking death (due to an illness) runs contrary to the common belief and understanding that a person who wishes to end their life is under severe psychological suffering.

However, it must also be recognised that expediency can dictate policy. It would be unfair to require a patient to undergo treatment where cost and/or access would render it inaccessible. Further, making a psychologist a gatekeeper in a patient's access to VAD may place undue pressure on the psychologist and create a hurdle which a patient may lie to overcome.

It is thus difficult to balance access and wisdom when VAD policy is created. However, it is submitted that the mental health of a patient should always be a factor considered when VAD policy and laws are formed.

2 *Psychological Suffering as Eligibility Criteria*

As noted above, some jurisdictions including Belgium and Canada allow access to VAD where a patient reports unbearable psychological suffering. While this criteria typically responds to an incurable illness,[16] it is worth questioning whether a non-specialist doctor, such as a general practitioner, would have sufficient skill to identify the specialised psychological issues involved in the case of a patient seeking VAD, whether or not an incurable illness is involved.

This eligibility appears to run contrary to societal attitudes towards suicide – that is, if a person wishes to end their lives, large elements of society consider they are suffering from a mental illness and require specialised medical treatment. To allow VAD in these circumstances is concerning because a 'permissive' or lax policy could arguably be used as a pathway to suicide. As noted by Kim and Lemmens:

> If assisted dying is legalized for patients with psychiatric conditions, it will not be just for severe, refractory depression. In Belgium and the Netherlands, medical assistance in dying has been provided to people with chronic schizophrenia, posttraumatic stress disorder, severe eating disorders, autism, personality disorders and even prolonged grief. Women are more

[16] See for example *The Belgian Act on Euthanasia of May, 28th 2002* (Belgium), ss (2)-(3).

> than twice as likely as men to request and receive assisted dying for psychiatric disorders, but we do not know why. Most people who request it for such reasons have characteristics that compromise their ability to cope with adversity, including personality disorders and social disconnection. Discussions, much less evidence-based guidance, of how to evaluate people who request assisted dying because of prolonged grief, autism, schizophrenia or personality disorders are lacking.
>
> Furthermore, the key eligibility criterion of "irremediable" condition is inherently vague and unreliable, even when applied to the types of severe cases usually mentioned by those who advocate for including psychiatric disorders in the legislation for assisted dying. Consider a patient who has been suffering from chronic depression for 20 years, has tried more than a dozen different medications as well as electroconvulsive therapy and is currently in a depressive episode that has lasted several years. Based on published cases in Belgium and the Netherlands, such a patient would likely be deemed to meet the "irremediable" criterion. However, evidence suggests that most such patients can achieve remission if given high-quality treatment.[17]

A particular difficulty with respect to psychological issues is lack of data. If jurisdictions do not gather specialised data in respect of the patients' ailments in 100% of cases, it is particularly difficult to ascertain how frequently this may occur. It is also difficult to see why psychological suffering alone should justify VAD and not lead to treatment of the underlying psychological or psychiatric illness.

D *Vulnerable Groups*

Vulnerable groups are often cited as being the most at risk in jurisdictions where VAD is legalised. 'Vulnerable groups' vary in definition, however typical examples include the elderly, and the disabled. Sometimes children, those suffering from psychiatric illnesses, women, and the uninsured are also included as a vulnerable group. Much like other aspects of VAD, this issue is hotly debated, particularly in respect of who may be part of a vulnerable group. This difficulty was summarised by J Perriera:

> Battin et al. examined data from Oregon and the Netherlands and concluded, as have others, that there was no evidence that vulnerable people, except for people with aids, are euthanized disproportionately more. "Vulnerable" was defined in that study as individuals who are elderly, female, uninsured, of low educational status, poor, physically disabled or chronically

[17] Scott Y.H Kim and Trudo Lemmens, 'Should assisted dying for psychiatric disorders be legalized in Canada?' (2016) 188(14) *CMAJ* 337 (citations omitted).

> ill, younger than the age of majority, affected with psychiatric illnesses including depression, or of a racial or ethnic minority. [18]

As the author notes, the classification of particular groups of people as vulnerable based on race, sex, disability, or class, has been challenged as an imprecise metric to assess, and that '[o]ther characteristics, such as emotional state, reaction to loss, personality type, and the sense of being a burden are also important.' [19]

Patients in a vulnerable group may have a number of ailments which gives them eligibility to VAD. That does not necessarily mean that a patient who belongs to a vulnerable group will feel pressured to end their life. However such a possibility should not be ignored. Indeed, as Kissane noted above, a VAD model must provide protections for the vulnerable. To put policy intention before protection is to risk the vulnerable falling through the cracks.[20]

E *Prognosis & Diagnosis*

The accuracy of diagnosis and prognosis are also frequently cited arguments in the VAD debate, of which there is some merit. 'Diagnosis' is the act of identifying a disease and its symptoms,[21] whereas 'prognosis' is the judgment as to the expected course of an illness.[22] While there is significant overlap between criticisms of diagnosis and prognosis, it is relevant to discuss both issues individually.

1 *Diagnosis*

The issue of error in diagnosis was discussed during the hearings conducted by the Western Australian Joint Select Committee on End of Life Choices. Avant Mutual, a large medical indemnity insurer provided evidence to the Committee that in 2017 in Western Australia, 16 closed matters cited diagnostic error as the primary allegation against the doctor. Of those approximately one third were not decided in the doctor's favour. While that number is small,

[18] J. Pereira, 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls' (2011), 18(2) *Current Oncology* 38, 42.
[19] Ibid.
[20] Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* (2008), 83
[21] Merriam-Webster Dictionary, 'Diagnosis', *Merriam-Webster (Online)*, Accessed 23 November 2021 < https://www.merriam-webster.com/dictionary/diagnosis>.
[22] Merriam-Webster Dictionary, 'Prognosis', *Merriam-Webster (Online)*, Accessed 23 November 2021 < https://www.merriam-webster.com/dictionary/diagnosis>.

it does highlight an issue with respect to the accuracy of diagnosing any illness. Avant Mutual's evidence continued:

> Accurate diagnosis is key to understanding a patient's health concern and making appropriate care decisions. However, diagnosis is estimated to be incorrect roughly 10% of the time. Although true incidence data are lacking, mounting evidence suggests diagnostic errors result in an alarming rate of patient harm and death.

The insurer continued to note that diagnostic errors are common and appear in every healthcare setting, and can occur in both common and uncommon conditions. They accept that there are indeed errors stemming from factors outside a doctor's knowledge or control, or 'are simply unavoidable (e.g. an undetectable malignancy, a typical presentation of a disease, incorrect information from a patient)', however the majority of diagnostic errors 'involve a doctor making a cognitive error, usually several types':

> Our analysis also highlighted the seriousness of injuries seen in diagnostic error claims. In almost half (46%) of all matters where a doctor's actions allegedly resulted in serious permanent physical injury or death, diagnostic error was alleged to be the cause. This rate was higher than all other types of allegation. For general practitioners, the rate was particularly high.[23]

2 *Prognosis*

The Minority Report from the Parliament of Western Australia identified a number of issues with the Oregon model. From their analysis of the annual data (1995 to 2017) they found that of the 17 years reviewed there were numerous instances of patients taking the VAD drug well after the period of their life expectancy:

- In every year reviewed there were patients who took the VAD drug 9 months after their request for VAD;
- In 14 of the 17 years reviewed in the Minority Report, there was at least one reported case where patients consumed the VAD drug more than a year after their request for VAD;
- In 10 of the 17 years reviewed in the Minority Report, there was at least one reported case where patients consumed the VAD drug more than 15 months after their request for VAD;

[23] *WA Minority Report* (n 13) 122-123.

- In 6 of the 17 years reviewed in the Minority Report, there was at least one reported case where patients consumed the VAD drug more than a 18 months after their request for VAD; and
- In 4 of the 17 years reviewed in the Minority Report, there was at least one reported case where patients consumed the VAD drug more than two years after their request for VAD.[24]

This is noteworthy given that the Oregon model requires that a patient's prognosis must be that the patient has no more than 6 months left to live.[25] While doctors can make educated guesses built on years of study and training, the nebulous variables in medicine make it next to impossible to make accurate prognoses in all cases. Put simply, even the best doctor cannot foresee miraculous improvement or sudden deterioration. As further noted in the WA report:

> Although Washington state's Death With Dignity Act specifies that only persons with 'six months or less to live' may request lethal doses of medication from a physician, the data shows that in each year between 5 and 17 per cent of those who die after requesting a lethal dose do so 25 weeks or more later, with one person in 2012 dying nearly 3 years (150 weeks) later, and one person in 2015 dying nearly two years later (95 weeks).[26]

Realistically however, this error of prognosis is to be expected. The further into the future the prognosis looks, the more inaccurate it is likely to be. As noted by the House of Lords:

> The evidence which we have taken from medical practitioners suggests that the prognosis of a terminal illness is far from being an exact science. "It is possible," we were told by the Royal College of General Practitioners, "to make reasonably accurate prognoses of death within minutes, hours or a few days. When this stretches to months, then the scope for error can extend into years".

The Lords then discuss further submissions received in respect of prognosis:

> Professor Tallis, for the Royal College of Physicians, told us that "medicine is a probabilistic art… In most cases the vast majority of prognoses are right, but there will always be situations where the diagnosis is wrong". Professor John Saunders, also speaking for the Royal College of Physicians, said that "prognosticating may be better when somebody is

[24] *Ibid*, 119.
[25] *Death with Dignity Act 1993* (Oregon), §3.06, ORS, 127.840, Oregon Health Authority (2017).
[26] *WA Minority Report* (n 13) 119.

> within the last two or three weeks of their life. I have to say that, when they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor".[27]

The Lords then acknowledged submissions from the Royal College of Pathologists, which stated that there was approximately a 30% error rate in medically-certified causes of death with 'significant errors (i.e. misdiagnosis of a terminal illness resulting in inappropriate treatment)' occurring in approximately 5% of cases. [28]

Therefore, in VAD models such as those used in Oregon and Victoria, where death is expected within 6 months, a prognosis of 6 months is unlikely to be accurate. For the unfortunate patient it may be weeks. For the fortunate patient it could be years. If such legislation is to rely on accuracy in prognosis, the time periods allowed would have to be far closer to the patient's passing to be accurate. However, such a requirement would likely be at odds with the policy objective to minimise suffering.

3 *Conclusion*

It is well understood that accurate diagnoses and prognoses can be difficult and no doctor is capable of being absolutely correct in all cases. As such, it is clear that difficulties with respect to diagnosis and prognosis will occur, that is diagnosis and/or prognosis may be inaccurate or simply wrong. Therefore, it is important to have safeguards whereby more than one doctor is consulted. While a number of jurisdictions (including Victoria) already account for this and require a second opinion, it is important to recognise that such issues as to diagnosis and prognosis accuracy can and do occur.

F *Reporting & Enforcement*

A patient applying to access VAD has made a very serious decision. It is therefore important that the patient is free from undue influence or duress and that their decision is informed. Similarly, obligations, such as a duty to report adherence to the legislated process, are placed on those (typically doctors) who would assist a patient in accessing VAD. It is therefore important that any VAD model enable the investigation of breaches of its system and, where necessary, the prosecution of offenders.

[27] Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005), [118].
[28] Ibid, [118].

As noted above, the Remmelink report and Van der Maas survey found that the majority of VAD deaths that they investigated did not meet the reporting requirements set out by the guidelines. Despite those findings, it seems that no prosecutions resulted.

This issue of reporting was also noted in the first year of operation of VAD legislation in Oregon. The Oregon Health Division reported:

> As best we could determine, all participating physicians complied with the provisions of the Act. Although the Health Division is not a regulatory agency for physicians, it does report to Oregon's Board of Medical Examiners any cases of non-compliance. Under reporting and noncompliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division. [29]

That is, the self-reporting method is evidently inadequate as a means of enforcing a jurisdiction's VAD system. However the retrospective approach, where a review of the process occurs after VAD has been approved (and typically, after the patient has died), has been adopted in most jurisdictions with VAD reporting requirements such as the Netherlands, and more recently Victoria. The logic for retrospective review is explained by White and Willmott:

> There are two main options for oversight mechanisms: prospective or retrospective review. As their description suggests, a prospective oversight mechanism requires an independent party to review the facts before the provision of assistance to die, while a retrospective model will review evidence after death occurs. There are also a range of possibilities in terms of the body that is charged with the oversight: should existing structures be used, or new bodies established? [30]

In the authors' view, the reduction of suffering is key to the question of timing a review of the patient's decision under VAD law, which leads them to support a retrospective model, as a more efficient and less bureaucratic (and therefore faster) method, they state:

> As was the case for safeguards, while the articulated values point to establishing robust oversight mechanisms, they do not necessarily provide precise guidance as to what that system might look like. That said, we suggest that one value - reducing suffering - is relevant to the question of the timing of the review of decision-making. The proposed legislative

[29] Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-based Model for Reform' in Ian Freckelton and Kerry Petersen (eds), *Tensions and Traumas in Health Law* (2017, Federation Press), 508.
[30] Ibid, 508.

> model requires at least two independent doctors to be satisfied of eligibility, part of which is to be satisfied of the intolerable nature of the patient's suffering. Given this safeguard, the value of reducing suffering points us towards a retrospective model rather than requiring further delay for the person who is in this intolerable state while yet another body be satisfied that he or she is eligible to receive assistance.[31]

As White and Willmott suggest above, there is an issue with both prospective and retrospective review process; the balancing of safeguards versus the intention of assisted dying – to alleviate suffering for terminal patients.

In the WA Parliamentary minority report, the retrospective approach to investigation was criticised for its inability to detect undue influence until after the fact. As the report stated:

> Within the jurisdictions considered above, where assisted suicide has been legalised, there have been practitioners who have breached the framework established within those jurisdictions. This begs the question, how are such deaths to be investigated in Western Australia should assisted suicide also be legalised here?
>
> …Even if a review model such as that adopted in Victoria were to be introduced here in Western Australia, such a review would only be conducted upon the application of a family member where the assessment process is believed by that person to have been compromised. Retrospective review of cases would still be necessary for all other cases.[32]

This process obviously requires that first a patient must die, and another person must seek a review, which would be unlikely in the case of friends/family who supported the patient's decision, leaving little evidence outside of the proscribed forms for the Voluntary Assisted Dying Review Board ('the Board') to review.

As the WA minority report also noted that there are significant hurdles with regards to the burden of proof in cases where investigations and/or prosecutions are carried out in respect of wrongful deaths. As submitted by the WA Director of Public Prosecutions:

> In all of these cases the trouble is working out the facts. It is all well and good for allegations to be made, and part of the problem is that there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem for us. If you have a situation where you have a doctor administering this treatment and the patient who says, "I want you to administer this

[31] Ibid, 508.
[32] *WA Minority Report* (n 13) 206, 208.

> treatment," it depends on whether that is recorded and how it is recorded, but at the end of the day it is one person's say-so and that is the person administering the treatment. The patient, of course, is deceased.[33]

Consequently, the reporting safeguards in practice are unlikely to protect a patient in cases such as where the patient is under duress. They are more likely to merely retain more accurate records than other jurisdictions. Should an investigation occur following the death of a patient, it would typically require a request by a family member, and as noted above, would be particularly difficult to investigate given the best witness would be deceased. Furthermore, if the family members are generally supportive of the patient's decision, or the patient lacks friends or family, it is highly unlikely that any reports of wrongdoing would be made.

It is also particularly difficult to determine the length and breadth of such breaches. A system without onerous reporting obligations (or at least one that fails to enforce such obligations) is unlikely to catch breaches. For example, there have been no prosecutions under Oregon's VAD legislation.[34] Similarly as noted above the very few prosecutions in Belgium and the Netherlands (at least those that made news headlines) ultimately failed.

Thus it becomes a difficult issue to discern whether the legislative safeguards can effectively prevent misuse in a retrospective model. Where there is no adequate method for investigation, the ineffectiveness of the best safeguards is exposed and allows arguments that the inclusion of those safeguards was window dressing that did not take the protection of vulnerable people in society seriously. Proponents of VAD will argue that the lack of prosecutions is evidence that the model is safe. However, the lack of successful prosecutions does not necessarily mean that a crime has not occurred, it simply means the system has failed to identify, or failed to obtain the necessary evidence to pursue (or succeed in) the prosecution of those crimes.

G *Conclusion*

The assessment of issues and safeguards in various VAD models will continue to be debated. However there are merits to some of these criticisms. While certain concerns may be

[33] Ibid, 211-212 (citations omitted).
[34] Emma Dickinson, 'No evidence physician-assisted death leads to 'slippery slope'', *Eureka Alert! (Online)*, 26 September 2007 <https://www.eurekalert.org/news-releases/820734>.

overemphasised in the literature because VAD raises so much emotion in commentators, the evidence suggests that some of the concerns raised are legitimate.

The ‘slippery slope’ argument may not justify some of the extreme claims that some of its advocates make. However, some jurisdictions have expanded eligibility to VAD beyond terminal illness into psychiatric suffering, and some have extended VAD access to those who have lost decision-making capabilities.

Doctor shopping may not lead to the bypassing of legislative safeguards, but it does raise concerns that access to VAD may be manipulated by a determined patient who may require treatment for psychological issues. Similarly, if psychological suffering alone makes a patient eligible for access to VAD, there are legitimate concerns whether the screening required in legislation adequately prevents access by patients who could live long and healthy lives if their psychological illness were treated. However, the requirement of mandatory psychological assessment risks delay for genuine patients which would increase their suffering contrary to policy intention. Nonetheless, the House of Lords has suggested that it is better for patient mental health to be considered at the time of seeking VAD. This is particularly important for vulnerable groups who may be more inclined to seek access to VAD for inappropriate reasons.

There are also legitimate concerns about the accuracy of diagnosis and prognosis in jurisdictions where death is expected within 6-12 months. In particular the frequency in which diagnoses and prognoses lack accuracy. Put simply, the longer the diagnosis/prognosis, the more likely it is to be incorrect. Under an incorrect diagnosis/prognosis a patient may have significantly more or less time to live than believed, and in the former, end their lives prematurely, or, as noted above in Oregon, take the VAD drug years after they obtain it leaving lethal drugs out in the public with no meaningful oversight.

Finally, it is submitted that self-reporting does not provide sufficient data in respect of VAD, to enable the investigation in cases where the law may have been broken. The fact that few prosecutions or investigations occur in jurisdictions where self-reporting arguably leads to perfunctory compliance with VAD law, does not mean that the law is being complied with or that the intended safeguards are working. While there may be compliance in most cases, a lack of prosecutions may also suggest that a system lacks appropriate measures to enforce breaches.

While there are weaknesses in some of these criticisms, they do provide a useful guide for what legislators should consider when drafting any VAD laws. By 2017 Victorian legislators had the benefit of mature VAD systems to learn from and improve.

V THE VICTORIAN RESPONSE TO THE INTERNATIONAL EXPERIENCE

The Victorian model is contained within the *Voluntary Assisted Dying Act 2017* (Vic). However, to assess the legislation purely by its provision is to miss the policy intention behind those provisions. It is therefore necessary to examine the Victorian model through the lens of the Ministerial Advisory Panel on Voluntary Assisted Dying's Final Report. Contained within this report is the framework and discussion on the policy intention and reasoning behind the Victorian model's provisions.

A prominent feature the Victorian government stressed about its VAD model was its large number of safeguards.[1] As noted above, Appendix 3 of the Panel's Final Report includes a list of the safeguards in place compared against a number of assisted dying models – namely The Netherlands, Belgium, Oregon, Vermont, Washington, California, Colorado, and Canada.[2]

Therefore, at face value it would appear that Victoria has undoubtedly learnt from the experiences of these other jurisdictions. However, the Panel's report only reported the safeguards as present. There is no analysis or discussion as to how the Victorian model uses these safeguards or why they are effective. The Panel's report simply shows what has been done in Victoria versus what has or has not been done in select other jurisdictions (discussed below in Chapter VII). It does not show in its safeguard appendix (Appendix 3) what provisions of other models have been adopted or modified.

The Expert Panel report breaks the Victorian model into 5 categories: 'Access', 'request', 'assessment', 'medication management', and 'administration'.[3] While this thesis does not provide in-depth discussion of every aspect of the Victorian model, there is discussion of 'safeguards' used in other jurisdictions, and the reasoning of the Panel in adopting those safeguards. There is also discussion of whether the resulting Victorian version of those safeguards will be effective.

[1] Hon Daniel Andrews MLA, 'Assisted Dying Bill Now In Parliament' (Media Release, 20 September 2017).
[2] Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying* Final Report (2017), 217 ('*Ministerial Report*').
[3] Ibid, 217 – 220.

A *Access*

Victoria's eligibility criteria is markedly similar to that of Oregon. However, the Victorian model follows Canada in requiring that VAD not be accessible unless there is both reduced life expectancy as well as intolerable suffering. There is also a prohibition on any VAD applicant gaining access simply on grounds of mental illness.[4]

The Panel also adopts the requirement that a patient be ordinarily resident in Victoria. The panel notes ordinary residency is a common requirement of the American jurisdictions. [5] While not mentioned in the discussion this requirement, appears to have been designed to prevent the possibility of 'suicide tourism' as under the Swiss model and referenced in some critiques of the original Northern Territory scheme.

The Panel has also noted the Victorian availability of VAD in accordance with advanced care directives, reasoning that should Victorian law recognise that patients are able to express a wish that VAD be accessed on their behalf if at some future time they lost capacity to make that decision themselves. The reasoning seems to have been that the Board would need to somehow identify at what point in their decline (upon presumably losing capacity) patients should be allowed to access VAD. The Panel also identified the difficulty in working out how such a request would operate in the framework, particularly how the assessment process would occur. The Panel noted that there is particular difficulty in respect of patients with dementia (or other neurodegenerative diseases) because those illnesses are so unpredictable. That is, some patients with dementia can function quite satisfactorily for years recognising relatives though not remembering the past, while others objectively appear to suffer great pain and others become violent and unmanageable some of the time despite having placid and cooperative temperaments at other times. Difficulties arise where an advanced care directive exists in a dementia patient case where the patient is only violent some of the time because patient violence arguably should not be a consideration for those making a VAD decision under an advanced care directive. The Panel has also observed that in Oregon 30% of patients do not consume the VAD drug. The have noted:

> The Panel has made this decision noting that, in other jurisdictions, a significant percentage of people do not take the lethal dose of medication after they have filled the prescription. In Oregon, for example, 30 per cent of people who have the medication prescribed do not take it.

[4] Ibid, 217.
[5] Ibid, 56.

> The Panel notes that there is no ability to check with a person who does not have decision-making capacity whether they still want to administer the lethal dose of medication and at what point. The timing of this would always be a subjective judgement made by another person. Requiring a person to have decisionmaking capacity to choose to administer or not administer the lethal dose of medication is a fundamental safeguard.[6]

Additionally, the Panel identifies further mental health issues arising in respect of decision-making capacity. The Panel recommended that in cases where a doctor is unsure of a patient's decision-making capacity due to mental illness, the doctor should refer them to a psychiatrist or psychologist, adopting the same solution as Oregon (and other American jurisdictions).[7]

The Panel concluded this point however noting that a psychiatric assessment for all patients is 'likely to create an unnecessary access barrier for people, particularly those living in rural areas, and make the voluntary assisted dying process more onerous then it needs to be [sic]'.[8]

In respect of the eligibility requirement of 'suffering' the Panel noted:

> The existence of a requirement that a person is suffering in order to access voluntary assisted dying varies among other jurisdictions that have implemented voluntary assisted dying frameworks. The European jurisdictions of the Netherlands, Belgium and Luxembourg all require that a person be experiencing some degree of suffering to be eligible to access voluntary assisted dying. On the other hand, the US jurisdictions of California, Oregon and Washington only refer to a requirement that a person have a 'terminal disease'. There is no additional requirement that a person be suffering.[9]

Evidently, the Oregon model had an influence on the Victorian eligibility criteria, with the added requirement of 'suffering' being imported from the Canadian model.[10]

The Panel has taken notice of European experience and denied VAD access unless a patient finds their circumstances particularly painful or distressing to the point that it is unbearable to them. [11] While the Panel noted that such a requirement appears in the Canadian model, they did not make any mention of this in their discussion.

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[6] Ibid, 62.
[7] Ibid, 63.
[8] Ibid, 65.
[9] Ibid, 75 (citations omitted).
[10] Ibid, 217.
[11] Ibid, 77.

Finally, in respect to mental illness, the Panel did not cite any other jurisdiction in respect of their recommendation that mental illness alone should not satisfy the VAD eligibility criteria even though VAD through mental suffering alone can qualify a patient for VAD in Belgium and Canada. However, the Victorian Panel did recognise that mental illness is not uncommon for those seeking VAD. They stated:

> The Panel acknowledges that many people at the end of their lives may experience psychological or emotional distress because of the disease, illness or medical condition that will cause their death. It is of the view that if a person meets all of the eligibility criteria, they should not be denied access to voluntary assisted dying just because they are experiencing this psychological or emotional distress about their suffering and impending death.[12]

As can be seen, the Oregon experience provided particular assistance in shaping the view of the Panel in respect of eligibility criteria, but with certain aspects borrowed from European jurisdictions. Evidently, the Panel attempted to address issues it identified in other models, and provide answers for them in Victoria. However, the Panel also alludes to a need to balance policy intention against certain safeguards, particularly where mental health assessments might be required.

B *Request*

The Panel noted that the requirement for a request to be voluntary is absolutely necessary within the policy framework. They note that in a number of jurisdictions VAD requests must be enduring (ie, multiple requests must be made in the process). However, a requirement for multiple requests does not appear in the Dutch and Belgian models.[13]

When formulating the request process it is again clear that the Oregon model was particularly influential with the Panel. The only safeguards which Oregon did not implement but which were adopted in the Victorian model are the prohibition on doctors raising VAD with their patient (which no other compared jurisdiction has), and the requirement that an accredited interpreter be used in certain circumstances (only being shared by the Californian model).[14]

The Panel noted the policy intention of preventing medical practitioners from raising VAD with their patients, stating that such the policy was intended to ‘ensure a person is not coerced

[12] Ibid, 81.
[13] Ibid, 87.
[14] Ibid, 217.

or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person's own voluntary decision.'[15] However, the Panel's Report does not contain a discussion on this policy intention. While the reasoning of the Panel can only be speculated because of the absence of such discussion, the Panel does appear to have considered that patients may be inclined to think that in some cases a doctor is suggesting VAD to the patient (whether or not they actually do so). The patient consequently follows what they believe to be (or is actually) the recommendation of their doctor. In such cases a request would not truly be voluntary, but that lack of voluntariness would be unlikely to be detected, particularly if that doctor is involved in the VAD process with the patient.

With respect to the role of interpreters, the Panel's Report makes no reference to other jurisdictions. It does note however that access to interpreters is an existing policy in Victorian healthcare,[16] and as such this recommendation was to extend that assistance to VAD.

Further, the Panel discussed the issue of voluntariness, particularly in respect to vulnerable groups. They note that in the Netherlands between 2008-2011 3.5% of VAD requests were denied due to a lack of voluntariness.[17] They also noted that in Oregon 42.2% of people cite feeling like a burden to their loved ones as a reason for VAD.[18] Despite this, the Panel stated that the risk of vulnerable groups is overblown, citing a study on 10 groups of patients vulnerable to abuse, where there was said to be no disproportionate impact.[19]

It therefore appears that the Oregon safeguards have particularly informed the Panel in their report, with the Dutch and Belgian experiences providing guidance. Despite this reliance on Dutch and Belgian data, the Panel noted

> [A] rigorous request and assessment process ensures that potentially vulnerable groups of people are not over-represented in those who access voluntary assisted dying, and fears that people from particular groups will be pushed into making such requests are ill-founded. Instead, rigorous request and assessment process provide protection from abuse.[20]

This conclusion came despite the fact that the Panel relied on Dutch data where the Panel previously identified that there was no enduring request requirement. Nonetheless, it is clear

[15] Ibid, 91.
[16] Ibid 96.
[17] Ibid, 88.
[18] Ibid, 89.
[19] Ibid 88.
[20] Ibid, 88.

that the experience of other jurisdictions has informed the Panel's reasoning in respect of the 'request' requirements, particularly experience from the North American jurisdictions.

C *Assessment*

Under the Victorian model, following the request step, a patient must be assessed for eligibility. The Victorian model requires a verbal first request, a written second declaration, and a third and final request made verbally.[21] The methods adopted by the Panel largely reflect the American models, with the addition of doctors requiring a high level of training and/or experience, and a doctor to assess a patient for VAD must have undertaken prescribed training.[22]

The Panel notes that the Oregon model requires the doctor who takes the first request be the primary doctor in treating the patient,[23] which has been adopted into the Victorian model. A unique extension on this however is the requirement of a higher level of experience or expertise. As the Panel notes:

> The Panel is of the view that a high level of expertise is required to have sensitive discussions about death and dying and to identify the person's preferences and values in relation to the end of their life. The assessing medical practitioner must also have the appropriate expertise to conduct a complex assessment and to make a considered prognosis.[24]

The other unique aspect of this step in the Victorian VAD model is the requirement for further training. The Panel states that medical practitioners should be required to undertake assessment training prior to assessing a patient to determine whether that patient is eligible to access VAD:

> This means that a medical practitioner will be able to undertake the training after a request has been made and allows the therapeutic medical practitioner-patient relationship to be maintained. While the Netherlands provides training only to the consulting medical practitioner, the Panel recognises the importance of high-quality and consistent assessments of whether people meet the eligibility criteria for voluntary assisted dying at each step of the

[21] *Voluntary Assisted Dying Act 2017* (Vic), Div 2, 5, 6.
[22] Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying* Final Report (2017) ('Ministerial Report'), 62, 218.
[23] Ibid, 99.
[24] Ibid, 103.

> process. It is therefore important to ensure the assessments by both the coordinating and consulting medical practitioners are as accurate as possible.[25]

The influence of the Dutch and Oregon models are notable within this section of the Victorian model. The Panel notes the obligations these new additions place on doctors stating that it is important that doctors understand their obligations under the law before commencing the VAD process with a patient, the Panel states:

> In the Netherlands the Support and Consultation on Euthanasia in the Netherlands program provides training to consulting medical practitioners. These specifically trained medical practitioners provide a second independent assessment of people requesting voluntary assisted dying to determine whether they meet the eligibility criteria in 80 per cent of cases. In around 25 per cent of cases in the Netherlands, medical practitioners determine that the person does not meet the eligibility criteria. A study of the assessments of consulting medical practitioners specifically trained under the program found consistency across the practitioners' assessments.[26]

It is evident that the Panel has adopted the consulting doctor requirement of the Oregon model. However, data obtained from Dutch studies appears to have informed the Panel's view that further training as to the obligations of the doctors will improve consistency and compliance.

D *Medication Management*

The Panel's comparison chart notes that the 'medication management' aspect of the Victorian model is completely original with only Canada sharing one of its 5 parts.[27] The Panel discusses the differing ways in which other jurisdictions deal with the issue of the return of VAD medication:

> Other jurisdictions that provide for self-administration of a lethal dose of medication generally rely on existing laws for the safe disposal of the medication. For example, in California, a person who has custody or control of an unused lethal dose of medication must dispose of it in accordance with existing drug take-back programs. In Vermont unused medications must be sent to a disposal centre in accordance with existing drug take-back

[25] Ibid, 105.
[26] Ibid, 105 (citations omitted).
[27] Ibid, 218.

> programs, mixed with another substance such as ground coffee beans or cat litter to make it unusable, or disposed of in accordance with any other instructions on the label. [28]

The Panel acknowledges that while the jurisdictions they referred to have drug take-back programs, a study suggests that only a small percentage of unused medications are disposed through those programs.[29] The Panel also notes that while available data shows few issues occur with the authorisation process of proscribing the VAD drug, issues do occasionally occur:

> In the Netherlands in 2015 there were 5,516 cases of voluntary assisted dying. Of these, there were four cases in which the due care criteria were not complied with. In Oregon in 2015 no referrals were made to the Oregon Medical Board for a failure to comply with voluntary assisted dying legislative requirements. While the Panel is confident that medical practitioners will comply with their professional obligations and act in the interests of their patients, an independent authorisation process will ensure the voluntary assisted dying process has been correctly completed.[30]

While the Panel observed that there are few recorded instances of errors or wrongdoing, the panellists recognised that errors can occur and suggested that an independent authorisation process was a way to ensure such errors do not occur.

As to the VAD drug itself, the Panel noted that the role of the pharmacist was minimal in other jurisdictions. They stated:

> In other jurisdictions there is minimal recognition of the role of pharmacists. In Oregon, any health practitioner who dispenses the medication must provide a copy of the dispensing record to the Oregon Health Authority. In Canada, the dispensing pharmacist must also report on this. Other jurisdictions do not discuss the role of pharmacists in providing information to people at the time the medication is dispensed.[31]

Under the Victorian model the dispensing pharmacist must provide instruction as to the safe handling, storage, and ingestion of the medication, much like their existing obligations under Victorian law. Similarly, the pharmacist must attach a clear label to the VAD drug, provide the drug in a locked box and provide advice to the contact person and patient that they are

[28] Ibid, 129-130 (citations omitted).
[29] Ibid.
[30] Ibid, 133 (citations omitted).
[31] Ibid, 135 (citations omitted).

responsible for the medication and must keep it within the locked box. Further, the pharmacist is also required to provide information about the return of the drug.[32]

It is evident that the medication management process is unique to the Victorian model, with the Panel identifying a lack of management in this area in other jurisdictions and therefore making their own new rules. This shows the Victorian model has, at least in respect to medication management, identified a key area lacking in other jurisdictions. However, the Panel was at a disadvantage in making its own new rules in relation to medication management because it had no data or models from which to draw.

E *Administration*

For the administration of the VAD drug, the Panel drew from the US jurisdictions with respect to the requirement for the drug to be self-administered, and from Canada, the Netherlands and Belgium when patients were physically incapable of administering the drug themselves and required a doctor's assistance. The requirement for further certification for an administration permit and requirement for a witness to be present in the event a doctor administers the drug are original to the Victorian model.[33]

The Panel noted that it is likely that throughout the VAD process patients will feel comforted by the presence of their doctor. They noted:

> In Oregon in 2016, health practitioners reported being present 41 per cent of the time when the lethal dose of medication was self-administered. In Washington in 2015 there was a medical practitioner present in 75 per cent of cases. Many people may like to have a health practitioner present at the time they self-administer the medication, and the legislation should not preclude this. It is, however, important that the obligations of health practitioners are clear so that they are reassured that it is appropriate for them to be present if the person wishes.[34]

The Panel noted that while a doctor should be able to be present for the comfort of the patient, they should be precluded from administering the drug, except in special circumstances. The Panel noted that in the Vermont model, the legislation explicitly states that a person shall face no liability for being present during the process and is not required to take any action to prevent self-administration of the VAD drug. The Panel noted that other

[32] Ibid.
[33] Ibid, 218.
[34] Ibid, 137 (citations omitted).

jurisdictions provide more specific instructions to doctors 'when the medication is regurgitated or a family member calls an ambulance after the person has administered the medication'.[35]

The Panels' report was drafted before a particular VAD drug had been decided upon by the Government. The VAD drug's information has been kept quiet by the Victorian Government, so exact information as to the drug is difficult to obtain. As it is understood, the VAD drug is consumed orally in most cases, but can be administered by other means, such as by injection by a medical practitioner (if an administration permit has been granted).[36]

As noted by the Panel, in Oregon there have only been 6 recorded case (of 1127 over 20 years) where a patient has regained consciousness after ingesting the VAD drug. It is clear that while these circumstances are rare, the Panel has identified that issues can occur when things do not go to plan and stress the importance of providing doctors with guidance in unusual cases.[37] They have stated:

> Given that a person who self-administered the lethal dose of medication has a clear intention to end their life, a health practitioner should not be under any obligation to attempt to revive the person. If the person is experiencing pain and distress, a health practitioner should provide symptom relief in the manner they ordinarily would to a dying person. This must not, however, include intentionally hastening the person's death.[38]

Under the Victorian model, the Panel noted that there is only one exception to when a doctor should administer the VAD drug – which is when the patient is physically incapable of doing so. The policy intention clearly stresses that all actions by the patient must be voluntary and not caused by another – except for in this one circumstance. As noted by the Panel, the US jurisdictions only allow for self-administration of the VAD drug whereas in Canada and the European jurisdictions, the patient may decide if they would like to self-administer the VAD drug, or have a medical practitioner administer or assist, stating:

> The Panel recognises that people who are physically unable to self-administer the lethal dose of medication should not be discriminated against and that it is reasonable for them to request

[35] Ibid, 138.
[36] Aisha Dow, 'Lethal medication sourced for Victoria's voluntary euthanasia scheme', *The Age (online)*, (January 14 2019) <https://www.theage.com.au/national/victoria/lethal-medication-sourced-for-victoria-s-voluntary-euthanasia-scheme-20190104-p50pnl.html>.
[37] Ibid, 139.
[38] Ibid.

> assistance. The Panel also notes that for some people the issue may not be physically placing the medication in their mouth, but actually absorbing and digesting it. These people should not be excluded from accessing voluntary assisted dying, but medical practitioners should only be able to administer a lethal dose of medication in very limited circumstances and, where this occurs, it should be closely monitored.[39]

In the Victorian model this is done by the coordinating doctor (or consulting doctor, if the patient so requests) applying for a permit to administer the medication. The policy intention is so that it is known who is administering the lethal dose, and it is only conducted by the doctors involved in the process. It also provides the additional benefit of the patient being familiar and comfortable with their doctor, as noted above. What the Panel does not note, but which has been indirectly addressed in a limited capacity in this policy, is what should happen where a nurse administers the VAD drug in the place of a doctor. As noted above in Chapter III, a 2010 study found in Belgium that in 12% of the cases of euthanasia, and 45% of the cases of assisted death without an explicit request, the VAD drug was administered by a nurse, and not a doctor as the law required.[40]

Further, this gap in direction exists even though the Panel has noted that an independent witness should be present when a third party administers the VAD drugs to ensure that the patient's decision is voluntary and enduring.[41] The policy intention is intended to protect doctors from claims of impropriety, but it also forms a safeguard (albeit a weak one) from a third party administering the VAD drug on behalf of the doctor. As noted above, nurses have administered VAD drugs in Belgium, despite that being against Belgian law. The Victorian model does have the added safeguard of the presence of a witness, however this safeguard is merely the optional right of the witness to report a breach, which is unlikely to occur if the witness supports the patient's decision, as is aware of the legal obligations of medical practitioners under the model.[42]

F *Practitioner Protection*

The 'practitioner protection' aspect of the Victorian model bears a number of similarities to the US jurisdictions. However, there are 2 further safeguards. They are mandatory

[39] Ibid, 140.
[40] Els Inghelbrecht, Johan Bilsen, Freddy Mortier and Luc Deliens, 'The role of nurses in physician-assisted deaths in Belgium' (2010), 182(9) *Canadian Medical Association Journal* 905, 905.
[41] *Ministerial Report* (n 22) 150.
[42] *Voluntary Assisted Dying Act 2017* (Vic), s 77.

notification by any doctor if they recognise another acting outside the legislation, and the voluntary notification by other persons who may recognise a doctor acting outside of the law.[43]

The policy reasoning behind these protections is simple. They are intended to protect doctors from prosecution when they act within the law and in good faith. This is common among the compared jurisdictions. As the Panel notes:

> Oregon sets out that 'no person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance'. This immunity is similarly reflected in California, Colorado, Vermont and Washington. The Canadian legislation sets out a series of amendments to its criminal code to ensure exemptions for those acting in accordance with their medical assistance in dying law.[44]

These safeguards are required as otherwise a doctor could be prosecuted for committing a murder under s 3 of the *Crimes Act 1958* (Vic).[45]

Unfortunately, the Panel does not provide a discussion about this aspect of the Victorian model. However it is submitted that the policy intention is obvious.

As for the original additional safeguards, these reflect protections that already exist under analogous Australian law. There are already guidelines for reporting a doctor acting illegally, for example the Australian Health Practitioner Regulation Agency in its 2020 guidelines notes:

> A mandatory notification about a practitioner can be triggered by concerns about:
>
> - Impairment;
> - intoxication while practising;
> - a significant departure from accepted professional standards, and
> - sexual misconduct.

[43] Ibid, 219.
[44] Ibid, 176 (citations omitted).
[45] Ibid.

> Depending on the type of concern, you must assess the risk of harm to the public when deciding whether to make a notification. In this context, 'the public' means a practitioner's patients or clients, and the wider community that could be put at risk of harm.[46]

While any person is at liberty to report a crime, it is clear that this policy is intended to ensure as far as any law can, that all parties act in accordance with the law.

G *Mandatory Reporting*

The Victorian model requires extensive reporting of the VAD process. As the Panel notes the Victorian model has considerably more requirements than other models. Of the 10 requirements in the Victorian model under this arm of the process, the jurisdiction with the greatest similarity is the Californian model with 4 of the same obligations.[47] The unique aspects of the Victorian model are the mandated reporting at various steps in the process, additional form requirements for administering the VAD drug by a doctor, prescription to be authorised by the Department of Health and Human Services, the required return of the VAD drug, and the recording of death notification by the registry. Mandatory reporting is routine in medical practice, as the Panel notes:

> [M]edical practitioners have obligations to report a range of notifiable conditions under the *Public Health and Wellbeing Act 2008* and there are criminal penalties for a failure to report. ….The Panel is mindful of the need not to impose too onerous or complex an administrative burden, but recommends that reporting be mandated to provide clear obligations on medical practitioners operating under the framework. The Panel notes that mandatory reporting ensures adherence to procedural requirements of the framework, but also recognises that reporting supports quality assurance and the oversight role of the Board.[48]

The Panel continues to state that mandatory reporting will ensure adherence to the procedural requirements of the Victorian model, and such reporting provides quality assurance and the oversight role of the Board. This policy provides further strength to the management and tracking of the VAD drug, as noted by the Panel:

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[46] Australian Health Practitioner Regulation Agency, 'Mandatory notifications about registered health practitioners' (March 2020), <https://www.ahpra.gov.au/documents/default.aspx?record=WD20/29515&dbid=AP&chksum=YMVsT2Py%2bC0erSWK0OqAhg%3d%3d>.
[47] *Ministerial Report* (n 22) 219.
[48] Ibid, 167 (citations omitted).

> In Washington the legislation states that 'any medication dispensed…that was not self-administered shall be disposed of by lawful means'. Whereas Vermont sets out that the Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed. In California the legislation specifies that a person who has custody or control of any unused medication arrange for its return or disposal. Colorado has a similar provision. [49]

The Panel stated that their consultation affirmed the view that 'administrative burden should be avoided'. The Californian requirement for a patient to complete a form within 48 hours before ingesting the VAD drug was noted by all stakeholders before the Panel, who acknowledged that 'it is important not to unduly intrude into the life of a person who is dying', as well as citing concerns about monitoring the VAD medication should not put unnecessary pressure on a patient to ingest the drug:

> To support appropriate community safety the Panel considered that monitoring the prescription, dispensing and return of the lethal medication would be a practical safeguard. Oregon similarly requires the prescription and dispensing record to be submitted to the Health Authority. Collection of this information will assist in tracking the lethal medication and its use and as such the Panel recommends that there be a mandatory reporting requirement.[50]

With respect to the proscriptive forms, the Panel notes that Oregon and Washington both set out the 'request for medication form' within the legislation. California also does his, but includes three further forms, 'attending doctor checklist and compliance form', 'consulting doctor compliance form', and 'attending doctor follow-up form'. The Panel has noted that Belgium and Luxembourg take a less prescriptive approach setting out the types of information that must be included in submissions to their respective Commissions. The Panel has opted to follow the American (particularly Californian) approach with the requisite forms appearing in the legislation.[51]

The Panel believed that setting out the information that will be collected in the legislation would provide transparency and clarity regarding the operation of the Victorian model, and recommended that the forms parties must use also be included in the legislation:

> This will ensure clarity and transparency when the legislation is debated by Parliament. Setting out the compliance requirements in forms included in the legislation will also ensure that these forms are not altered unless Parliament considers and passes an amendment to the

[49] Ibid, 170 (citations omitted).
[50] Ibid, 170 (citations omitted).
[51] Ibid, 171.

> legislation. The Panel also notes that once the Board is established, it may identify further information that will help improve quality and safety and the Board will be able to require this. The Board should also be able to request information from participating health practitioners in order to fulfil its functions.[52]

While it is not discussed by the Panel, the addition of these strict reporting requirements addresses issues with respect to reporting in other jurisdictions. As noted in the Remmelink report and Van der Maas survey (above), compliance was lacking and the requirement for VAD, only be accessible when these strict reporting requirements are met. The Victorian model addresses this issue.

H *Offences*

The Victorian model implements a number of offences for breaches of the law. It shares all of its 'offences' with the North American models. These new offences operate in addition to the existing criminal law of the State. The Panel discusses the international influences to which it responded:

> Offences have been created in other jurisdictions with the introduction of voluntary assisted dying legislation. Most of the North American jurisdictions criminalise the alteration or forgery of a request for voluntary assisted dying, or concealing or destroying a withdrawal of a request. These jurisdictions also set out a clear offence for a person who coerces or exerts undue influence on a person to request or self-administer the medication. The Panel proposes that the Victorian legislation reflect the clear protections that are provided in the US jurisdictions that ensure a person who requests voluntary assisted dying has not been coerced nor had their request interfered with.[53]

The Panel also suggested the creation of new offences for inducing a person to self-administer the VAD drug. While the Panel noted that prosecutions for such actions are rare in other jurisdictions (perhaps due to the near impossibility of determining if the drug was taken under duress), it clearly recognised that such a thing could occur and that offences should be created as a deterrent for such actions.[54] They also recommended the creation of an offence for those who administer a VAD drug to those who lack decision-making capacity. The Panel stressed that all actions should be voluntary by the patient, and said that '[j]ust because a

[52] Ibid, 172.
[53] Ibid, 179 (citations omitted).
[54] Ibid.

person has the lethal dose of medication in their possession, it is not acceptable for a family member or a friend to make the final decision to end the person's life.'[55]

It is thus clear that the Panel adopted the American models' approach to criminal offences within their systems and identified areas for improvement by recommending further offences in cases of duress or impugned decision-making.

I *Oversight*

The oversight aspect of the Victorian model is particularly broad with the Panel identifying 11 areas in their report. In their comparison, it is evident that the Panel has adopted the Belgian and Dutch approaches with all but 3 oversight mechanisms appearing in the European models – those missing being guiding principles included in the legislation, five year review of the law, and guidelines to be developed to support implementation of the system – all of which appear in the Canadian model.[56]

The Panel does not provide significant discussions of these provisions. However it is clear that they have taken a transparent approach, such as those of the European models, with the addendum of a review process and guidance for the purpose and implementation of VAD.

This approach is particularly useful in conjunction with the reporting requirements insofar as it will collect significantly more data than its American and European counterparts and allow for a more detailed study of the complex issue and process which is VAD.

J *Conclusion*

As can be seen from the Appendix 3 safeguard summary in the Final Report of the Panel, the Victorian model was developed with the experiences of other jurisdictions in mind. It is evident that many of the Victorian model's provisions come from the Oregon model and its subsequent modifications by other American jurisdictions, with further aspects borrowed from Belgium and the Netherlands to create an internationally influenced model.

It is noteworthy however that in the Panel's report there is very little discussion of issues identified in other jurisdictions. It appears however that the Panel was likely aware of these criticisms and flaws in other jurisdictions by their development of certain aspects of the

[55] Ibid, 180.
[56] Ibid, 220.

Victorian model, such as the Board requiring all paperwork before the VAD drug can be accessed, requiring further permits for doctors to administer the drug and reports of who is doing the administering (if not the patient).

However, while the Victorian model is arguably more robust than its international counterparts, it is not perfect and has attracted criticism. Further it may have failed to learn from failures in other jurisdictions by not providing a discussion as to these issues.

VI THE VICTORIAN MODEL IN PRACTICE: DOES IT WORK?

The Victorian model has only been in operation for a very short period, and as such there is little lived experience from which to draw. Nonetheless, it is possible to draw on what is available to assess areas where the model appears to be working, and areas where the model appears to be lacking.

A *What Works*

On July 15 2019 Kerry Robertson, aged 61 was the first Victorian to be granted, and the first to make use of, a VAD Permit. Mrs Robertson was diagnosed with breast cancer in 2010, which had metastasised into her bones, lungs and brain. After stopping treatment in 2019, the cancer then spread to her liver.[1]

It is undeniable that Mrs Robertson's illness was a severe and tragic one. She was, perhaps, a prime example of why this legislation was drafted. The media reported that it was a peaceful passing and the case was shown as proof that the system worked.[2]

Since the passing of Mrs Robertson, there was little to no reporting of any other cases of VAD, until the VAD Review Panel published its first report in February 2020.

The Australian newspaper reported in 2019 that the Victorian Government expected approximately a dozen people were to end their lives via VAD within the first 6 months.[3]The first report by the Voluntary Assisted Dying Review board was published in February 2020, outlining the first six months of operation from June to December 2019. The report showed that the demand for VAD was significantly higher than the Victorian Government expected, it found that:

- Of 136 first assessments, one was found to be ineligible;
- Of 102 consulting assessments, two were not approved;
- All 70 self-administration permits were approved;

[1] Unknown, 'Bendigo woman Kerry Robertson becomes first Victorian to use Voluntary Assisted Dying Act', *ABC News* (online 05 August 2019) <https://www.abc.net.au/news/2019-08-04/bendigo-woman-first-victorian-use-voluntary-assisted-dying-law/11382332>.
[2] Ibid.
[3] Rachel Baxendale, 'First Victorian euthanasia figures released', *The Australian* (Online), 20 February 2020 <https://www.theaustralian.com.au/nation/victorian-euthanasia-figures-released-for-first-time/news-story/7b2ae73ae595f7b3b719e8af77b83255>.

- All 11 practitioner administration permits were approved;
- 19 permits were withdrawn – either by administrative error, or confirmation of the death of the patient other than by VAD;
- 66 medications were dispensed, 57 for self-administration, 9 for administration by a practitioner;
- 52 deaths were confirmed, 43 by self-administration, 9 by administration by a practitioner.[4]

Despite the significantly larger number of deaths than expected, Victorian Health Minister Jenny Mikakos stated:

> We do anticipate that as more Victorians understand that this choice is available to them and as more people understand how the legislation operates and more doctors undertake the mandatory training, that there may well be a further increase in these numbers, but this is a very reassuring start in the first six months of the legislation, that the scheme is working as it was intended.

The report also noted that 83% of cases required forms to be returned to patients 'for clarification or provision of missing eligibility information',[5] with 649 individual forms being submitted online.[6]

Despite this, the Board noted that 100% of cases at the time were compliant. The report shows that the Victorian model appears to be functioning as intended. The Board has identified when applications are deficient and has acted to ensure any defects are rectified.

On this basis, it appears that the reporting aspect of the Victorian model has been shown to be effective, and because there is no evidence to the contrary, it appears that the law is being adhered to and that errors are being rectified when detected.

B *What Does Not Work*

The Victorian VAD law is still in its infancy. There have been few reports by the Board and those which exist contain very little information beyond the raw numbers and there are only a handful of comments as to the status of VAD. Despite this limited information, some issues

[4] Voluntary Assisted Dying Review Board, *Report of Operations June to June December*, (2020), 11. ('June to December 2020').
[5] Ibid, 8.
[6] Ibid, 7.

have arisen. In particular, there have been criticisms as to accessibility, inconsistency with federal law, issues with dispensing the VAD drug, and there have been some compliance issues.

1 Accessibility - '*Beg and Grovel'*

The Victorian model is more proscriptive than its European and North American counterparts. Consequently, the Victorian VAD process is more onerous.

Dr Philip Nitschke has called it 'beg and grovel' legislation because of its large number of requirements.[7] Similarly Rosalind McDougall and Bridget Pratt have argued that its highly proscriptive nature interferes with equal access. They concluded that the Victorian model emphasised 'safety at the expense of equal access', warning other jurisdictions against the implementation of such a system. While they acknowledged that safety is an important aspect of VAD legislation, 'safety' can adversely affect the accessibility of such a model, stressing that a better balance is needed in the Victorian model:

> Developing voluntary assisted dying legislation requires attention to all four aspects of equal access: horizontal equity, patient agency, high quality care, and a normative environment that does not stigmatise this option. In our view, other jurisdictions developing VAD legislation should firstly consider avoiding the legislative features of the Victorian Act which we have identified as in tension with equal access, in order to reduce likely inequalities in access generated by these features. Secondly, from an ethical perspective, engaging in a discourse of maximizing safety is unhelpful in creating an approach to VAD that promotes equal access for all eligible patients.[8]

During the parliamentary debate regarding Western Australia's passing of its own VAD laws, which are heavily modelled on the Victorian model, Nick Goiran MLC suggested that criticism of the safety focus of the Victorian legislation was misplaced or obstructive. He noted that while the WA government stressed the WA model contained 102 safeguards, the term 'safeguard' was being used liberally to describe what are obligations of parties and not, in his view, actual safeguards for patients, in respect of which he stated:

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[7] Thomas Manch, 'Euthanasia pioneer warns of 'beg and grovel' legislation', Stuff.co.nz (online, November 8 2018) <https://www.stuff.co.nz/national/health/euthanasia-debate/108441737/euthanasia-pioneer--warns-of-beg-and-grovel-legislation>.

[8] Rosalind McDougall and Bridget Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation' (2020) 21 (38) *BMC Med Ethics* 1, 8-9.

> It has been suggested that a person will be able to access this regime only if they have been given a prognosis of six months to live. That is not a safeguard. That is a requirement. There is a difference between a requirement and a safeguard. The truth is that the only safeguard in this legislation is the two doctors who will determine the outcome. Neither of those doctors will be required to have any specialty or experience in the condition that the patient is said to have. Therefore, it could well be two general practitioners. That is the only safeguard in the bill before the house.[9]

In effect, Mr Goiran argued, through the WA model, that the Victorian approach did not go far enough (as these obligations are largely the same). He criticised its failure to insist on expert medical oversight of individual VAD applications. He considered there was insufficient emphasis on the protection of vulnerable persons seeking VAD. There is certainly an argument that many of the 'safeguards' realistically are bureaucratic requirements rather than a way to meaningfully prevent misuse. In this sense there is some harmony in the position or Dr Nitschke and Mr Goiran – that is, the number of so-called safeguards are arguably merely bureaucratic obligations more so than meaningful ways of protecting a patient.

2 *Accessibility*

A significant hurdle the Panel encountered when developing the Victorian model was the need to balance accessibility and unnecessary delays against a robust system of checks and balances. The Panel did not expect to achieve a perfect balance and instead strove for active scrutiny so as not to add the weight of bureaucracy to the undue suffering of the patient.

Approximately 30% of patients who qualify for VAD, die before they receive it. The ABC has reported that Betty King QC who chairs the Board Panel expect the Panel to review the legislation and practice in light of those access criticisms. She stated:

> "At the moment, doctors cannot tell patients that voluntary assisted dying is available. Western Australia has drawn their legislation and they have said that doctors can, so we will look at how it goes in WA and see if that's an improvement that could help Victoria, for example," Ms King said.

[9] Western Australia, *Parliamentary Debates*, Legislative Council, 15 October 2019, p7533c-7550a [3] (Hon Nick Goiran MLC) <https://parliament.wa.gov.au/Hansard/hansard.nsf/0/01d6fbb00098e4e9482584d5002081e3/$FILE/C40+S1+20191015+p7533c-7550a.pdf>.

> She said because of a lack of information, or a reluctance to face mortality, many people come to the VAD program late.

Ms King continued to state that when patients enter the VAD program, they do so late and must travel for medical assistance. Under Commonwealth law doctors cannot use telehealth to assist patients seeking VAD.

> "And then when they do come, and they're very sick by that stage, it's very hard for them to access the doctors. They have to travel. Doctors can't use telehealth because of Commonwealth legislation," she said.
>
> Federal law restricts telehealth from being used in situations involving voluntary assisted dying.
>
> "So there's a lot of impediments that weren't intended that I think we'll be looking at and trying to find answers for," Ms King said. [10]

Dr Philip Parente, in the same article, added that being unable to discuss VAD with a patient is a 'major inhibition', stating:

> "The foundation of a good doctor-patient relationship is enabling the patient to have all the information in front of them to make an informed decision," he said, noting particular access issues with marginalised groups, including those without internet access or English fluency. [11]

As noted above by Betty King QC and Dr Parente, for different reasons, access to VAD is an ongoing issue with the Victorian model, and ties into issues that arise because of inconsistencies with federal law.

3 *Inconsistency with Federal Law*

The Victorian model requires that the VAD drug be delivered to the patient.[12] As noted in the first (and subsequent) VAD report of operations, the Board noted that Victoria's mandated delivery of VAD drugs may be inconsistent with ss 474.29A and 474.29B of the *Criminal*

[10] Anna Kelsey-Sugg, 'It's been two years since Victoria introduced assisted dying laws, so how well are they working?' *ABC News (Online)*, 07 March 2021 <https://www.abc.net.au/news/2021-05-07/voluntary-euthanasia-laws-how-well-are-they-working/100117058>.
[11] Ibid.
[12] Department of Health (Victoria), *What process do my doctor and I need to follow?* (undated) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/process-to-follow>.

Code 1995 (Cth). Section s 474.29A states that a person commits an offence if they use a 'carriage service' (ie, Telehealth)[13] to access, cause to be transmitted to another person, transmit material, make material available, or publish or otherwise distribute material which 'directly or indirectly counsels or incites committing or attempting to commit suicide'. This is supported by s 474.29B which states that a person commits an offence if they have possession of (or control of, or produces, supplies or obtains) a material, that material directly or indirectly counsels or incites suicide (or promotes 'a particular method' of suicide or provides instruction on 'a particular method' of suicide), and that person who has possession (or egages in production, supply or the obtaining) of that material to be used by that or another person is committing an offence against s 474.29A. As noted by the Board:

> The Board continues to acknowledge the impact of the Commonwealth Criminal Code and the inability for medical practitioners to complete assessments via a carriage service such as telehealth. Some medical practitioners have indicated that telehealth is not always adequate for conducting assessments, but there have also been stories about the impact this is having on Victorians who are unable to travel for both health and geographical reasons. This Board continues to urge the Commonwealth to reconsider making an exemption from the Criminal Code for Victorians wishing to access voluntary assisted dying.[14]

The Victorian model thus cannot operate fully as intended, without breaching federal law, namely ss 474.29A and 474.29B, as the usage of a carriage service for 'suicide-related material. This inconsistency may offend s 109 of the *Australian Constitution* which would risk making the relevant provisions of an inconsistent state law inoperative if challenged.[15] While an in-depth analysis of this issue is beyond the scope of this thesis, the risk of intersection and inconsistency with federal law is an issue that other Australian jurisdictions wishing to implement a similar system will need to consider if they decide to implement VAD legislation.[16]

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[13] A 'carriage service' in the *Criminal Code 1995* (Cth) has the same meaning as that found in the *Telecommunications Act 1997* (Cth) which defines 'carriage service' as 'a service for carrying communications by means of guided and/or unguided electromagnetic energy'.

[14] Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020,* (2021), 4

[15] *Australian Constitution,* s 109.

[16] The resolution of this issue may not be so clear-cut as the Commonwealth has no general power to legislate as to crime. The Constitutional basis of laws such as the *Criminal Code Act 1995* (Cth) are piecemeal within ss 51 (xxxix) 52, and 61. It is therefore possible that the Victorian VAD law could survive a challenge, defeating the relevant sections of the *Criminal Code Act 1995* (Cth), although such a discussion is beyond the scope of this thesis. See Parliament of Australia, 'history of criminal law' (undated) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Browse_by_Topic/Crimlaw/Historycriminallaw>.

4 *Dispensing Pharmacy*

In the July-December 2020 Report of Operations the Board noted that 'the number of applicants receiving the medication increased by 30.9 per cent. Despite this, most applicants received their medication on the day they preferred'.[17]

While this data and the note of concern in the words '[d]espite this' is not elaborated upon in the report, it suggests that there may be an issue in respect of the punctual delivery of the VAD drug. The report does not state the length of the delays merely that 'most' received their medication on a date of their preference.

The Victorian model does not require a centralised approach to dispensing the VAD drug, since it only refers to a 'dispensing pharmacy' with no specific reference to a single pharmacy. [18] However, the VAD drug is currently only obtainable from the Alfred Hospital in Melbourne. It is therefore possible that if VAD access requests continue to grow, the number of dispensing pharmacies will need to increase to avoid untimely availability. That untimeliness will likely continue until the issues of inconsistency with the Commonwealth *Criminal Code* noted above are resolved, especially for patients in rural areas who are impeded by the need to travel to Melbourne to obtain VAD drugs.

4 *Compliance*

The ability of the Victorian model to respond to errors is paramount in its ability to police misconduct. While 'compliance' is a particularly broad topic in respect of the highly proscriptive Victorian model, issues of compliance have arisen.

From June to December 2019 compliance was reported at 100%.[19] In the January-June 2020 Report of Operations, the Board reported one case of non-compliance. [20] In the July to December 2020 report, the Board did not state how many cases of non-compliance they found nor the nature of the non-compliance, but noted that 95% of cases retrospectively reviewed were compliant.[21] In the January to June 2021 report, the Board noted two permits

[17] Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020*, (2021), 3.
[18] *Voluntary Assisted Dying Act* (Vic), s 3.
[19] Voluntary Assisted Dying Review Board, *Report of Operations January-June 2019*, (2020), 9.
[20] Voluntary Assisted Dying Review Board, *Report of Operations January-June 2020*, (2020), 15.
[21] Voluntary Assisted Dying Review Board, *Report of Operations July-December 2020*, (2021), 3.

were not issued due to non-compliance with the Act (one being later approved once resubmitted).[22]

While compliance is high and the Board has managed to identify cases where compliance is lacking, there are compliance failures. The lack of detail provided in these reports is unhelpful in determining the severity of these failures. Further, the fact that these compliance checks are done retrospectively raises concerns that existing regulation cannot prevent wrongful deaths as discussed below in Chapter VII.

C *Conclusion*

The Victorian model is still in its infancy. While the reports from the Board show that in most cases the model is operating as intended, the lack of detail in 'non-compliance' instances shows a lack of transparency, despite transparency being a major policy objective of the Panel which recommended the passage of the legislation.

The bi-annual reports of the Board suggest that the Victorian model is generally working as intended. Those reports show that the process is overwhelmingly followed and when issues are identified they are rectified or access to VAD drugs is denied.

However, despite the high level of general compliance the Victorian model is said to be hampered by its highly proscriptive nature, there are problems with VAD drug distribution (namely its accessibility and distribution method lacking), and inconsistency with federal law. Since the Board reports do not reveal what non-compliance is being uncovered, and because non-compliance is only uncovered by retrospective assessments, it is difficult to make a comprehensive assessment. The following discussion considers how these issues with the Victorian model might be appropriately responded to and questions whether there are residual concerns with protecting the vulnerable.

[22] Voluntary Assisted Dying Review Board, *Report of Operations January-June 2021*, (2021), 13.

VII FIXING THE VICTORIAN MODEL?

Comparing the Victorian provisions against those of other jurisdictions is a useful way to assess the Victorian model against other jurisdictions. However such comparison cannot provide a complete picture. It is also relevant to discuss procedural issues including safeguards which feature in other jurisdictions but not in Victoria.

1 *Presence of Support Person not Mentioned*

Under the *Medical Treatment Planning and Decisions Act 2016* (Vic), a patient can appoint a support person in respect of medical decisions. However s 8A specifically precludes the provisions of this Act applying to the *Voluntary Assisted Dying Act 2017*.[1]

The Victorian model is silent on whether a patient is permitted to have someone present when making a request or receiving information in respect of that request from a doctor. That is, it is not clear whether a VAD patient can have a person present to provide emotional support when receiving advice even if no medical requests is made (such as those referred to in the *Medical Treatment Planning and Decisions Act 2016*). It follows that such emotional support would be in the discretion of the patient and the treating doctor(s). However, this gives rise to a number of issues:

1. If a support person is present, they may be pressuring the patient into making the request, or possibly pressuring them into not making a request;
2. A patient may feel pressured to make a decision either way after making a request in front of a support person;
3. A patient may require (for emotional or other purposes) a support person to make such a request; or
4. A doctor may refuse consent for a support person to be present.

The Panel noted in their report that a support person should be permitted, but the legislation does not explicitly state this right.[2]

[1] *Medical Treatment Planning and Decisions Act 2016* (Vic), ss 8A, 31.
[2] Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying* Final Report (2017), 46.

The role of a support person is difficult as they may be a source of duress to a patient. However, the lack of mention of support person(s) may create issues or contests under the Victorian model since family members who did not agree with the patient's VAD decision can claim that the support person influenced the decision of the patient.

This issue of duress is unfortunately impossible to solve. Nonetheless, steps could be taken to allow support persons for patients, as well as balancing that with confirming the wishes of the patient without the support person present, as a means to ensure that the support person is not a person exercising undue influence or duress on the patient.

To avoid confusion, it is desirable that the right of a patient to have a support person present with them at all times throughout the process should be enshrined within the legislation or regulations. To minimise duress, it would also be useful if there were a policy which allowed the doctor to see the patient alone so that the doctor can confirm with the patient if they truly desire the support person's presence.

It may also be wise to require doctors to report instances where they feel there may be duress or undue influence for further investigation by the Board, or where necessary, law enforcement.

2 *No Psychological Assessment*

The Victorian model does not mandate a psychological assessment of the patient prior to accessing the VAD process. Sections 18 and 27 of the Act only require that in the case where the co-ordinating and consulting doctor respectively, are unable to determine decision-making capacity of the patient.[3]

In the Northern Territory, the ROTI Act required that a psychiatrist assesses the patient to determine whether the person is 'suffering from a treatable clinical depression in respect of the illness'.[4] As noted above, depression was a common factor among the patients in *Seven Deaths in Darwin*.

As noted above, Kissane, Street and Nitschke noted that a survey conducted of psychiatrists in Oregon found only 6% would consider themselves a competent gatekeeper after a single assessment of a patient. They stated that there is an important role of psychology in the VAD

[3] *Voluntary Assisted Dying Act* (Vic), ss 18, 27.
[4] *Rights of the Terminally Ill Act 1995* (NT), s 7.

process, but note that having a psychologist/psychiatrist in a 'gatekeeping' role would be seen as adversarial by patients, rather than being a part of proper multidisciplinary care:[5]

Ultimately the Victorian model fails to answer this difficult problem. There is no assessment necessary, nor any real psychological treatment considered at all. All a coordinating or consulting practitioner must do is refer the patient to a specialist if they believe the patient's decision-making capacity is impugned. While sections 19(c) and 28(c) note that a practitioner must inform the patient about palliative care options and 'the likely outcomes of that care',[6] there is no requirement to refer for psychological assessment/treatment in any way.

As noted above, only 6% of psychologists in Oregon thought they would be a competent gatekeeper after a single assessment of a patient. It is submitted that despite the delay that will be involved, to avoid abuse of the vulnerable including those suffering from mental illness there must be qualified and careful psychological assessment to ensure that a VAD request is a consequence of the suffering that flows from a terminal illness rather than any kind of treatable psychological illness. As noted by Holmes, Christelis and Arnold, chronic pain and depression are frequently comorbid, with major depression being the most common mental illness associated with chronic pain.[7] As such, it is unfortunate that a safeguard ensuring that the intolerable suffering which has led to a patient requesting VAD is not the result of a treatable though comorbid psychological illness.

The House of Lords took the view that the psychological assessment of a VAD patient was essential. They stated:

> [W]e have asked ourselves whether there is not, perhaps, an element of unwitting condescension in saying to someone who is suffering unbearably and has asked to have his or her life ended that he or she ought to be seen and assessed by a psychiatrist. Some might argue that depression is an occupational hazard of living for all of us and that we all take decisions at different stages of our life which may well be coloured, to a greater or lesser extent, by depression.[8]

[5] David W Kissane, Annette Street and Philip Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' (1998) 353 *The Lancet* 1097, 1101.
[6] *Voluntary Assisted Dying Act* (Vic), ss 19(c), 28(c).
[7] Alex Holmes, Nicholas Christelis and Carolyn Arnold, 'Depression and chronic pain' (2013) 199(6) *Med J Aust*, 17.
[8] Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005), [253]-[254].

The Lords noted that psychiatric involvement had not been suggested to them, despite, in the opinion of the Lords, it being a reasonable suggestion. They continue to acknowledge that society seeks to prevent people from committing suicide, often with the argument that a person's situation may well improve, and acknowledge that those who seek VAD often change their minds due to receiving better palliative care or having come to terms with their situation. The Lords go on to recommend that any VAD legislation should include a requirement for any patient seeking VAD to first be given a psychiatric assessment to determine whether the request is based upon a reasoned decision, is free from external pressure, and the patient is not suffering from a psychiatric or psychological disorder causing impaired judgement', in such cases they state:

> In cases where such disorder was apparent, we would expect an applicant to be offered treatment. If a way could be found of confidently limiting applications to strong-minded individuals who are clear about what they want, such a requirement would be of less importance. Otherwise it would be necessary to weigh the inconvenience which a psychiatric assessment might cause to determined applicants against the need to protect less resolute persons from decisions arising from psychiatric disorder or external pressure.[9]

The Panel believed that psychological assessments could potentially be burdensome and cause unnecessary delays for a patient, because to limited access of suitably qualified psychologists/psychiatrists. While that is a reasonable position to hold, particularly given the vastness of Australia and the sprawl of its population, the balance of policy against treatment causes some difficulty, and does not respond to the House of Lord's expression of concern.

This issue could be alleviated to some extent by requiring that all first requests be provided to the Board. By registering all first requests, whether denied or accepted with the Voluntary Assisted Dying Review Board would enable the Board to monitor such activity. Further, requiring a 'cool down' period between 'first' requests would be a useful way of monitoring whether a patient is making numerous requests. In addition, or alternatively, where numerous first requests are denied the Board may intervene in the matter. When the Board intervenes it should have the power to request (or require) the patient seek psychological assessment and/or treatment to ascertain why they are making numerous first requests. This would allow for better treatment options for the patient, where the patient is suffering from a comorbid but treatable psychological illness. A multifaceted approach such as this would also somewhat

[9] Ibid, [253]-[254].

alleviate the issue of the risk of doctors feeling as if they are gatekeepers, as identified by the House of Lords.[10]

In addition, a psychological assessment may be a useful tool in combatting the risk of undue influence (including duress and coercion) on a patient, and investigating the patient's feelings as to whether their decision is based on outside influences or pressures (whether real or perceived), and empowering the assessor to refer the matter to police for further investigation if they form the view that the patient is being unduly influenced by another person into accessing VAD.

As noted by the House of Lords (above) a psychiatric/psychological assessment of a patient may be a particularly useful tool in treating a patient, as well as determining if that patient has capacity, or is a victim of some form of undue influence.

3 *Doctor Shopping*

The Victorian model does not address the issue of 'doctor shopping', which, as noted above in Chapter III, is a common argument against VAD because it potentially allows the system to be abused.

The 2021 Tasmanian model has its own (partial) solution to this problem, which is found within s 38 of the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021*. While there is no prohibition on first requests, the Tasmanian model notes that the 'primary medical practitioner' (equivalent to the Victorian co-ordinating medical practitioner) cannot refer a patient to a medical practitioner if 2 consulting medical practitioners (equivalent to the Victorian consulting medical practitioner) have determined that the patient is not eligible for VAD.[11] While this solution is not perfect, as it allows a patient to make infinite first requests, it does recognise the potential issue. As noted in the second reading speech:

> In order to prevent undue pressure on doctors and misplaced optimism on the part of the person, if 2 [coordinating medical practitioners] determine the person is not eligible, the process ends - although this does not preclude the person from commencing the VAD process

[10] Ibid, [126].
[11] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 38.

> again by making a new request, the former [primary medical practitioner] may not accept a first request for 12 months. (Except for certain unique circumstances explained in the Bill).[12]

While the Victorian model did not have the benefit of referring to this model at the time of its creation, the Tasmanian model recognises that such issues can occur and has taken steps to prevent doctor shopping.

Section 11 of the *Voluntary Assisted Dying Act* (Vic) deals with the 'first request'. However it does not state whether a first request must be recorded (if denied), nor does it proscribe a method for a first request. This means doctor shopping is a real possibility in Victoria for a determined patient. By implementing a cool-off period and/or review of a patient in cases where numerous first requests are made, 'doctor shopping' would become significantly more difficult and could enable treatment options to those suffering from psychological illness.

4 *Enforcement: Self Reporting & Investigations*

According to Dr John Keown, the Remmelink Report revealed that the Dutch regulations 'had failed to prevent major non-compliance with the guidelines',[13] and consequently demonstrates the issues faced when reporting (and defining) euthanasia, as Dr Keown noted a doctor may end a patient's life by double-effect and not by VAD.

Consequently, there is an argument that it may be impossible to get true and accurate statistics on assisted dying, as the actual number of assisted deaths may be much higher than that being reported.

Similarly, in a later 1995 survey Van der Maas and Van der Wal noted a considerable failure to report. The previous Remmelink report showed that only 18% of cases were reported, whereas this later report showed an improved 41% of cases reported. While this is an improvement it suggests that a majority of cases of assisted dying go unreported, thus meaning that most cases were not scrutinised as the Dutch regulations intended.[14]

In addition, Dr Keown has shown that the questionable reporting procedures in the Dutch reports are merely the tip of the non-compliance iceberg. According to the Dutch model,

[12] Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 65 (Hon Mike Gaffney MLC)
[13] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd Edition, 2018), 115 ("*Euthanasia, Ethics and Public Policy"*).
[14] Ibid, 134-135.

assisted dying should be a 'last resort'. However Dr Keown has noted that the studies show that in 21% of cases there were other options available to patients which they refused. He added that one third of general practitioners who decided that there were no alternatives failed to seek advice from a colleague despite that being a regulatory requirement.[15]

The Victorian model by being so proscriptive has largely prevented much of this issue, through its requirement to report all steps to the Board, which then permits the dispensing of the VAD drug, it is not a complete solution.

Dr Keown summarises the enforcement model in the Victorian context, stating

> It is evident that the Victorian law shares a key failing of all other permissive laws: its reliance on the intrinsically ineffective mechanism of self-reporting by physicians. It is incapable of effectively controlling VAD, either by ensuring that cases are reported or by ensuring that each reported case complies with the requirements of the Act. Far from being designed to detect a mistake or abuse it could not unreasonably be described, rather like the Oregon law, as being designed not to.[16]'

This issue of reporting was also noted in the first year of operation in Oregon, with the Oregon Health Division reporting that as best as they could determine, all participating doctors complied with the legal obligations. However the Oregon Health Division noted that under-reporting and non-compliance are difficult to assess as doctors were unlikely to report non-compliance due to possible repercussions.[17]

Ultimately this model does require self-reporting which other jurisdictions shows suggest is not effective. While the Victorian model does require a number of documents to be lodged with the Board, the enforcement of this section has been criticised as merely 'rubber stamping' an application if the paperwork is in order. Again Dr Keown has asked:

> What checks, if any will the Secretary carry out to ensure that the requirements have been met before issuing a permit? If the required forms have been submitted and the appropriate boxes ticked, will they not automatically attract a rubber stamp? [18]

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[15] Ibid, 110.
[16] *Euthanasia, Ethics and Public Policy* (n 13) 485.
[17] Oregon Health Division, '*Oregon's Death with Dignity Act: The Second Year's Experience'* (February 23, 200) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year2.pdf>, 12.
[18] *Euthanasia, Ethics and Public Policy* (n 13) 484.

It appears that while this application process may be a unique part of the Victorian model, these 'safeguards' serve more as a bureaucratic function than as a final check on abuse or misconduct. As Dr Keown explains:

> The Board is to 'promote compliance with the requirements' of the Act 'by the provision of information' to doctors and members of the community, but what other powers and duties does it have in order to ensure compliance? It is to refer any issue identified by the Board that is relevant to specified authorities including the police and the coroner, but how is the Board to identify issues? Section 103 provides that the Board may request information to assist it in discharging its functions, but what if a request is refused? In short, the Board seems designed to serve largely as a depository for completed forms, a publisher of statistics and indeed a promoter for VAD.[19]

Keown's critique suggests that the Board is a referral rather than an enforcement agency. As long as the paperwork is compliant, it is difficult to see how a prosecution could occur, unless gross negligence was reported by a third party after the patient is dead. The WA Joint Select Committee on End of Life Choices noted this challenge with the Victorian legislation and stated:

> [The] evidence from the Director of Public Prosecutions clearly highlights that the self-reporting of the doctor, and the fact that the best witness is deceased, will mean that the investigation and prosecution of assisted suicide cases outside of the law will be effectively impossible.[20]

It is difficult however to see how this issue may be solved with a retroactive approach to investigations. As noted in the Age, '[t]he board's role is not to grant or refuse applications for voluntary assisted dying. Its purpose is to review each case retrospectively to ensure that laws haven't been breached.[21]

[19] Ibid, 484-485.
[20] Hon Nick Goiran MLC, *The safe approach to End of Life Choices: License to Care not License to Kill,* (Joint Select Committee on End of Life Choices, Minority Report, August 2018), 156 ('*WA Minority Report*').
[21] Melissa Cunningham, 'How Victoria's assisted dying laws work', *The Age (Online)*, 18 June 2019 <https://www.theage.com.au/national/victoria/how-victoria-s-assisted-dying-laws-work-20190523-p51qeb.html>.

As noted above by White and Willmott, the issue with both prospective and retrospective review processes is balancing safeguards against alleviating the suffering of terminal patients.[22]

In the WA Parliamentary minority report this method was criticised for its inability to detect undue influence until after the fact. As the report noted that in the compared jurisdictions there have been cases of doctors breaching the framework of that jurisdiction. The Victorian review process would only be triggered where an aggrieved family member of the deceased makes an application to the Board for an investigation.[23]

This process obviously requires that a patient must first die, and another person must seek a review, which would be unlikely in the case of friends/family who supported the patient's decision. That leaves little evidence outside of the proscribed forms for the Board to review.

As noted above, the WA minority report observed the evidentiary burden involved in the VAD process, given that the best witness is deceased, and the only party left to give evidence is the accused, makes proving misconduct near impossible.[24]

The Victorian model does not provide for effective enforcement. As noted above in Chapter IV there have been no prosecutions under the Oregon model, and Belgium and the Netherlands have only had a handful of prosecutions. While this may suggest that the system is working as intended, it may also indicate that a retrospective reporting approach does not facilitate effective law enforcement – which the Remmelink report and Van der Maas survey appear to suggest.

Under such an approach there is no way to prevent disaster before it occurs. It is unlikely that a prospective reporting approach is well suited to enforcement either, particularly in cases of duress. However, the Board should welcome reports from third parties where they suspect abuse or misconduct as, for example, where a doctor forms the view that a patient is being coerced into making a VAD request. While the evidentiary burden to prove such a case will always be significant, additional evidence would make proof and prosecution of misconduct much easier.

[22] Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-based Model for Reform' in Ian Freckelton and Kerry Petersen (eds), *Tensions and Traumas in Health Law* (2017, Federation Press), 508.
[23] *WA Minority Report* (n 20) 208.
[24] Ibid, 211-212.

6 *Issues with the VAD Drug*

There are a number of issues with the Victorian model's approach to the VAD drug. First, the obligation to return the drug only applies to that which is 'unused or remaining'. Secondly, there is no mechanism to check in with patients to see if they retain decision-making capacity if they not yet ingested the drug after some time has passed. And finally, there are difficulties with the delivery method of VAD drugs particularly in remote areas since some methods of delivery may offend Commonwealth law.

(i) *Return of the Drug*

The Victorian model requires the contact person to return any 'unused or remaining' amount of the VAD drug. This requirement is found in s 89 of the Act. It states:

> The contact person for a person who is the subject of a self-administration permit must not fail to return to a pharmacist at the dispensing pharmacy, within 15 days after the date of death of the person, any voluntary assisted dying substance specified in the permit, and dispensed to the person, that the contact person knows is unused or remaining after the death.[25]

The clear intent of this provision is to deter contact persons from repurposing the remaining drugs. Section 89 is thus focused on medication management. However, the risk of liability may deter genuine contact persons who fear that a mistake may result in criminal prosecution.

This requirement also raises issues about how regularly a contact person should be in direct contact with the patient. Typically, a contact person will be a family member who the patient regularly sees, aged 18 years or over.[26] Simply put, if the patient takes the drug, perhaps in a time of emotional downturn, without informing the contact person, the contact person would be disadvantaged by the countdown beginning from the date of death, therefore creating issues of liability on the part of the contact person by not returning the drug within the 15 days required under the Act.[27]

This provision also gives light to a significant flaw in this safeguard. A contact person must return the assisted dying drug (if any remains) following the death of the patient. However

[25] Ibid.
[26] Ibid, s 39.
[27] *Voluntary Assisted Dying Act 2017* (Vic), s 89.

there is no method of checking when a patient would take the drug. As has been noted above, in Oregon there have been numerous recorded cases of a person ingesting a VAD drug well past their expected death date. Therefore the Victorian model creates a similar issue, the VAD drug will remain out in the community for an unknown amount of time with no way to check if or when it has been taken, unless otherwise somehow informed, of which there is no obligation on any person involved in the process following the provision of the VAD drug.

This failure to always identify the whereabouts of VAD drugs also begs the question as to what a contact person does if all the drug is consumed. Do they return an empty container? The legislation is silent. If they are only required to return 'any voluntary assisted dying substance specified in the permit, and dispensed to the person, that the contact person knows is unused or remaining after the death',[28] then the contact person could merely state they believed the drug to be consumed entirely and not return the container. Or if they are required to return an empty container, a contact person (or knowledgeable malicious third party) could merely empty the contents of the drug into another container and return an empty container. Since the Victorian law does not require the performance of an autopsy which might identify whether all the VAD drug provided was used, it is unlikely that any inconsistency regarding the dosage would be noticed.[29]

While such a turn of events is highly unlikely, there is of course the possibility of malicious use. However, short of having doctors present at all VAD deaths to certify the complete consumption of the drug there is no realistic way to prevent the possibility of unintended circulation or repurposing.

Further, the Act only requires that any unused drug be returned. In the event there is an amount of the VAD drug unused, it is less effort for the contact person to lie and say that none remains than to go through the process of returning any unused drug. It is highly unlikely the Board would investigate such a thing, or be able to prove that the contact person lied about whether any remained, particularly where no autopsy of the deceased occurs.

(ii) *Consumption and Decision-Making Capacity*

As the model does not require the VAD drug to be consumed within a certain amount of time (as such a requirement would be in opposition to the voluntary aims of the legislation), any

[28] *Voluntary Assisted Dying Act 2017* (Vic), s 39.
[29] Ibid, s 67(1)-(2).

amount of time can pass before the patient consumes the drug. As noted above, in Oregon there are a number of recorded cases where a patient has taken the drug up to 2 years after receiving it – despite the Oregon model requiring diagnosis of death within 6 months before a VAD drug can be provided. There is no requirement in any legislative model that requires a check with the patient following delivery of the drug. As noted by John Keown:

> How is anyone to know that when the patient takes the poison, perhaps up to a year (or more) later, that the patient's decision is still voluntary and informed, or that an heir has not crossed the (blurry) line between assisting the patient to self-administer the lethal drug and administering the lethal drug?[30]

John Keown has noted other safety issues that arise when the ingestion of VAD drugs is delayed. If a patient has a neurodegenerative disease and takes the VAD drug more than 12 months after obtaining it, there is a question whether their VAD decision is still voluntarily and whether their decision making capacity has been compromised by their illness. The likely answer to that question is no. However the Board does not appear to have the power to check these matters with patients under the existing Victorian law. Consequently the Victorian model suffers from the same problem as the Oregon model. That is, when patients take a VAD drug well after the intended period, they may have lost decision making capacity and they may have been coerced.

Patients taking the VAD drug well after their expected prognosis is not necessarily a bad thing. However, questions must be raised in situations involving patients who have obtained the drug with a neurodegenerative disease or any illness which may affect cognitive function over time. Due to the nature of the Victorian model preventing coronial inquiries and only being able to do any investigation upon the death of the patient, it is difficult to see how any wrongdoing in respect of the drug would be managed. In the absence of coronial inquiries in VAD cases, the Victorian legislation should require sufficient witnesses and recording to enable prosecution in the case of any wrongdoing.

A possible solution for this would be requiring the patient or contact person to notify the board at intervals (such as once per month) while the VAD drug is in the possession of the patient. Similarly, once a patient receives the VAD drug, they should continue to have regular visits with their doctor if they choose to not take the drug immediately. That doctor could

[30] *Euthanasia, Ethics and Public Policy* (n 13) 486.

then report to the Board that the patient maintains decision-making capacity, particularly in the case of neurodegenerative disorders. While these solutions would add further obligations on doctors and patients/contact persons, it would do more to ensure the patient has retained decision-making capabilities throughout the process.

8 *Conclusion*

The Victorian model has taken steps to rectify issues it has identified in other jurisdictions. However while steps have been taken, some issues remain. The Victorian model has had the benefit of observing the lived experiences of other jurisdictions and over two decades of debate on these models. Despite its best efforts it has failed to adequately answer to some common issues or arguments against other jurisdictions' models.

The presence of a support person is not enshrined within the legislation. While this is not a safeguard issue per se, it is an area where patient support could be improved.

The Panel made the conscious decision to not require a patient to undergo psychological assessment to access VAD. While there are valid criticisms against turning psychologist and/or psychiatrists into gatekeepers, other jurisdictions have suggested that the mental health of the patient should be considered and treated before a VAD decision is made. The frequency of depression and mental illness in Australian society (45% of adult Australians at some point in their lives)[31] suggests that the assessment of the mental health of VAD patients' needs to form a more prominent part in the VAD decision-making process.

Further the Victorian Panel assessing an appropriate VAD law for Victoria did not recommend steps to prevent doctor shopping. While the dangerousness of doctor shopping is debatable, when coupled with the frequency of mental health disorders in all Australian citizens, there is reason to suggest that there should be legislative provisions in place to prevent potential VAD patients seeking advice from medical practitioners until they find one who will 'cooperate' with their VAD wishes. As noted above, a more robust first request report notification process coupled with either cool-off periods or psychological assessment for those who make multiple requests in a short time could prevent this abuse and enable

[31] Department of Health and Human Services (Victoria), *Mental Illness Statistics* (undated). <https://www.betterhealth.vic.gov.au/health/servicesandsupport/mental-illness-statistics>.

further treatment options for patients whose VAD decisions may be adversely affected by poor mental health.

The enforcement provisions of the Victorian model are enlivened in its retrospective approach, which as discussed above, is insufficient for catching abuses before it is too late. To review paperwork in greater detail as it arrives is perhaps a method where compliance issues could be detected before the process progresses. Because of the retrospective reporting required in the legislation, the Board will always be at a significant disadvantage when investigating abuses. While a prospective approval approach might be a better deterrent because it would make oversight more obvious, it would not prevent all possibility of abuse, and may make the process for patients significantly more burdensome and encourage the 'covert euthanasia' discussed by the House of Lords.

Finally, the VAD drug administration is particularly difficult. The ability of the Board to keep track of VAD drugs once dispensed relies on contact persons to return any unused drug. But contact people have no incentive to comply with the return law since doing nothing and claiming there was no drug left is unlikely to lead to prosecution even if it is untrue. There is thus a risk of unused drug remaining in the community. Further, while the policy behind the law intends that the administration of the drug be entirely voluntary, that is wishful thinking particularly in the case of patients with neurological disorders or other ailments which may affect their decision-making capacity.

No system is perfect. The Victorian model makes a genuine effort to improve on international models. However the Victorian model has missed opportunities to perfect the Government's policy intentions though it does answer some of the concerns that arise from overseas experience.

VIII CONCLUSION

Assisted dying is a multi-layered complex issue. Victoria (and now other Australian states) have joined the small number of international jurisdictions which permit a patient to choose to end their life. When the Northern Territory legalised assisted dying in 1995 it did not have the benefit of drawing from the experiences of other jurisdictions. By the time the Victorian model was submitted to the Victorian Parliament, 22 years had passed and a handful of international jurisdictions had VAD models operating in some form on which the Victorian government could draw.

Since 1995 VAD has been legalised in some form in Europe and North America. In the United States of America Oregon passed its VAD law in 1994, which finally came into effect in 1997. Over the next three decades other US jurisdictions followed with Washington, Vermont, California and Colorado passing their own VAD models based upon the Oregon framework. In Canada the Province of Quebec passed its own VAD legislation in 2013 with a national model being implemented two years later in 2015. In Europe the Netherlands and Belgium passed their VAD laws in 2001 and 2002 respectively, with Luxembourg following in 2008.

An examination of international models reveals a significant amount of criticism of those models, particularly by those who oppose VAD. In particular, it becomes clear that there are common criticisms of the various models implemented throughout Europe and North America. These common themes include, the expansion of eligibility criteria ('slippery slope'), 'doctor shopping', psychological assessment and treatment, vulnerable groups, and the difficulty of accurate diagnoses and prognoses.

Of these criticisms, there is varying degrees of validity. The 'slippery slope' argument is hotly debated with one side arguing there is such a slope, while the other side says no such slope exists. In truth, it is more a question of semantics and ties into the expansion of eligibility. Indeed, many of these issues tie in together. The 'slippery slope' ties into eligibility based on psychological suffering (as has been done in Canada and Belgium), and the expansion into vulnerable groups, such as children and those suffering from dementia as has occurred in Belgium and the Netherlands respectively. Similarly, doctor shopping is, to some extent, tied to the difficulty in diagnosis and prognosis, and the experience of the ROTI Act and Oregon data shows doctor shopping occurs, and the systems are powerless to stop it.

It is with these experiences and criticisms made, the Victorian Panel had the benefit of drawing from these, and designing an improved system.

The Panel, tasked to advise on the form a VAD law in Victoria looked to other jurisdictions to determine what would work for Victoria. Even when one reviews the Panel's report by itself, it is clear that the panellists had a thorough understanding of the international experience and appear to have made a genuine attempt to recommend a Victorian model that responded to concerns that had arisen under other VAD laws.

However, the Panel's Report ignores some of the common criticisms of those other laws. The model it proposed has clearly addressed issues like compliance, but the lack of discussion on other matters suggests an intentional avoidance of uncomfortable topics that might reflect poorly on the policy of the Victorian government in implementing its particular VAD law.

Consequently, the Victorian model has not answered all the problems that have arisen in the international jurisdictions which have been considered in this thesis.

As outlined above in Chapter VII the Victorian model has neglected to enshrine in law the right of a patient to have a support person with them when they make a potentially life-ending decision. The Victorian law also decided against a requirement of compulsory mental health assessments as a part of the process of determining eligibility for VAD. This, despite the fact that major illness and severe depression are often comorbid. The Victorian VAD law has also neglected to address the possibility that mentally ill patients might engage in doctor shopping to manipulate the system. The implementation of a retrospective approach to reporting VAD deaths makes the investigation and prosecution of misconduct difficult if not practically impossible. There is also little incentive for contact persons tasked with custody of left over VAD drugs to return them and avoid future misuse.

While these shortcomings have been discussed in the thesis and some alternatives proposed, because of the short lifespan of the VAD legislation to date, it is impossible to ascertain the extent to which risks are significant.

In its effort to establish a safe system the Victorian model has established a highly bureaucratic system where many of its 'safeguards' are merely checklist items of dubious quality. Indeed, as Hon Nick Goiran MLC postulated in WA, most of the so-called Victorian safeguards present as merely bureaucratic requirements that will do little to protect a patient in reality.

Despite these criticisms, the Victorian model has indeed answered to some of the experiences of other jurisdictions. It has, for example, forced procedural compliance (ie, paperwork being submitted in the correct form) before the VAD drugs becomes accessible, and has created a system with far more accurate recordkeeping than in comparative jurisdictions.

Further, though there is only limited data available, it appears that the Victorian model is operating as intended. But the lack of data makes confidence in that conclusion difficult. That lack of data is also a reason why the Victorian model's retrospective approach to review and investigation of wrongful VAD deaths will largely be confined to the review of paperwork, and is unlikely to catch any wrongdoers.

The Panel had the unenviable task of balancing accessibility with minimising the risk to patients; neither objective could be achieved without concessions. As such the Victorian model is imperfect. No system is perfect. Even the best laws will be broken from time to time. Such a fact needs to be acknowledged in the VAD debate. Similarly, VAD will happen in some form whether it is legal or not. Perhaps the best that VAD legislators can do is create a system which proactively reviews and investigates cases and seeks to provide patients access to all treatment options – physical, mental, palliative, before they make the ultimate decision. The Victorian model has indeed responded to the experience of other jurisdictions but leaves room to improve the system to solve the issues which remain abroad and persist in the Victorian model.

BIBLIOGRPAHY

A *Articles/Books/Reports*

Alcorn, Gay, 'Victoria's proposal on assisted dying is careful and rigorous. Let the debate begin', *The Guardian (Online)*, 21 July 2017 <https://www.theguardian.com/society/2017/jul/21/victorias-proposal-on-assisted-dying-is-careful-and-rigorous-let-the-debate-begin>

Amarasekara, Kumar '*Euthanasia and the Quality of Legislative Safeguards*' (1997) 23(1) Monash University law Review

Amarasekara, Kumar, and Bagaric, Mirko, '*The Legalisation of Euthanasia in the Nertherlands: Lessons to be Learnt*' (2001) 27(2) Monash University Law Review 179

Amarasekera, Kumar and Mirko Bagaric, *Euthanasia Morality and the Law*, (Peter Lang Publishing, 2000)

Andorno, Roberto, 'Nonphysician-Assisted Suicide in Switzerland' (2013) 22(3) *Cambridge Quarterly of Healthcare Ethics* 246

Asscher, Eva Constance Alida, 'First prosecution of a Dutch doctor since the Euthanasia Act of 2002: what does the verdict mean' (2020) 46 *Journal of Medical Ethics* 71

Atwill, Nicole, 'Luxembourg: Right to Die with Dignity' *United States Library of Congress*, 02 March 2008 <https://www.loc.gov/item/global-legal-monitor/2008-03-02/luxembourg-right-to-die-with-dignity/>

Australian Human Rights Commission, Euthanasia, Human Rights and the Law (Web Page, May 2016) <https://humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law>

Banović, Božidar and Veljko Turanjanin, 'Euthanasia: Murder or Not: A Comparative Approach' (2014) 43(10) *Iranian J Publ Health* 1216

Baxendale, Rachel, 'First Victorian euthanasia figures released', *The Australian* (Online), 20 February 2020 <https://www.theaustralian.com.au/nation/victorian-euthanasia-figures-released-for-first-time/news-story/7b2ae73ae595f7b3b719e8af77b83255>

BBC, ‘A decade on: more than 70 people choose euthanasia in Luxembourg’, *Luxembourg Times (Online)*, 21 May 2019.<https://www.luxtimes.lu/en/luxembourg/a-decade-on-more-than-70-people-choose-euthanasia-in-luxembourg-602d6949de135b9236ab2834>

BBC, ‘Belgium euthanasia: Three doctors cleared in landmark trial’. *BBC News* (online, 31 January 2021) <https://www.bbc.com/news/world-europe-51322781>

BBC, ‘Netherlands backs euthanasia for terminally ill children under-12’ *BBC* (Online), 14 October 2020 <https://www.bbc.com/news/world-europe-54538288>.

Ben White and Lindy Willmot, ‘Future of Assisted Dying Reform in Australia’ (2018) 42 *Australian Health Review* 616, 618

Benatar, D, ‘A legal right to die: responding to slippery slope and abuse arguments’ (2011), 18(5) *Current Oncology* 206

Berard, Gabrielle and Joelle Walker, ‘CPhA surveys pharmacists on physician-assisted dying’ (2016), 149(1) *Canadian Pharmacists Journal* 54.

Boer, Theo A, ‘After the Slippery Slope: Dutch Experiences on Regulating Active Euthanasia’ (2003) 23(2) *Journal of the Society of Christian Ethics* 225.

Boffey, Daniel, ‘Doctor to face Dutch prosecution for breach of euthanasia law’, *The Guardian* (online), 10 November 2018 <https://www.theguardian.com/world/2018/nov/09/doctor-to-face-dutch-prosecution-for-breach-of-euthanasia-law>

Bonython, Wendy, ‘From Oregon to Belgium to Victoria – the different ways suffering patients are allowed to die’, *The Conversation* (Online, December 2017), < https://theconversation.com/from-oregon-to-belgium-to-victoria-the-different-ways-suffering-patients-are-allowed-to-die-88324>

Bourgeois, James A, et al, ‘Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act’ (2018) 59 *Psychosomatics* 441

Caldwell, Felicity, ‘Premier launches inquiry into the legalisation of voluntary euthanasia’, *The Canberra Times* (online), 14 November 2018 <https://www.canberratimes.com.au/politics/queensland/premier-launches-inquiry-into-the-legalisation-of-voluntary-euthanasia-20181114-p50fwq.html>

Caldwell, Simon, ‘Doctors who certified a woman as autistic so she could get a lethal injection face jail under euthanasia laws as family insist she was just broken hearted’, *The Daily Mail* (online), 25 November 2018 <https://www.dailymail.co.uk/news/article-6425417/Doctors-allowed-woman-lethal-injection-face-jail-euthanasia-laws.html>.

Cecco, Leyland, ‘Canada debates assisted death laws after woman is forced to end life early’, *The Guardian (Online)*, 06 November 2018 <https://www.theguardian.com/world/2018/nov/06/canada-debates-assisted-death-laws>

Cica, Natasha, ‘Euthanasia - the Australian Law in an International Context’ (Research Paper No 4, Parliamentary Library, Parliament of Australia, 1996-1997) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/RP9697/97rp4 >

College of Physicians & Surgeons of Nova Scotia, *Professional Standard Regarding Medical Assistance in Dying* (December 14, 2018) <https://cpsns.ns.ca/wp-content/uploads/2016/06/Medical-Assistance-in-Dying-Standard.pdf>

Colorado Department of Public Health & Environment, ‘Medical Aid in Dying’, Colorado Department of Public Health & Environment, undated <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying >

Copolov, David and Julian Savulescu, ‘Victoria's voluntary assisted dying law isn't on a slippery slope’ (2018) *Monash Lens (Online)* <https://lens.monash.edu/2018/08/14/1357466/victorias-voluntary-assisted-dying-law-isnt-on-a-slippery-slope>

Cosic, Miriam, *The Right to Die? An examination of the euthanasia debate* (New Holland Publishers, 2003)

Cunningham, Melissa, ‘How Victoria's assisted dying laws work’, *The Age (Online)*, 18 June 2019 <https://www.theage.com.au/national/victoria/how-victoria-s-assisted-dying-laws-work-20190523-p51qeb.html>

De Vleminck, Aline, et al, ‘The prevalence in the general population of advance directives on euthanasia and discussion of end-of-life wishes: a nationwide survey’ (2015) 14(71) *BMC Palliative Care* 1

Deliens, Luc, et al, ‘End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey’ (2000) 356 *The Lancet* 9244

Department of Health and Human Services (Victoria), *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report* (2017) <https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report>

Dickinson, Emma, ‘No evidence physician-assisted death leads to 'slippery slope'’, *Eureka Alert! (Online)*, 26 September 2007 < https://www.eurekalert.org/news-releases/820734>

Dobuzinskis, Alex, 'California Lawmakers Introduce Oregon-Style Assisted Suicide Bill', *Scientific American (online)*, 22 January 2015 <https://www.scientificamerican.com/article/california-lawmakers-introduce-oregon-style-assisted-suicide-bill/>

Dow, Aisha ‘Lethal medication sourced for Victoria’s voluntary euthanasia scheme’, The Age (online), (January 14 2019) <https://www.theage.com.au/national/victoria/lethal-medication-sourced-for-victoria-s-voluntary-euthanasia-scheme-20190104-p50pnl.html>

Dowbiggin, Ian, A Concise History of Euthanasia (Rowman & Littlefield Publishers Inc, 2007)

Downie, Jocelyn, ‘*Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions*’ (2016) 16(1) Queensland University of Technology Law Review 84

Dyer, Owen, Caroline White and Aser García Rada, ‘Assisted dying: law and practice around the world’ (2015) *The BMJ* 351

Emmanuel, Ezekiel ‘Euthanasia and physician-assisted suicide: focus on the data’ (2017), 206(8) *Medical Journal of Australia* 339

Erratum, Pereira J. ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls’ 2012 19(3) *Current Oncology* 38

European Institute of Bioethics, *Analysis of the 9th Report of the Federal Monitoring and Evaluation Commission on Euthanasia (2018-2019)* (11 November 2020) < https://www.ieb-eib.org/nl/nieuws/einde-van-het-leven/euthanasie-en-geassisteerde-

zelfmoord/analyse-van-het-9de-verslag-van-de-federale-controle-en-evaluatiecommissie-euthanasie-2018-2019-1918.html>

European Institute of Bioethics, *Euthanasia in Belgium: Analysis of the 2020 Commission Report* (16 November 2020) <https://www.ieb-eib.org/en/news/end-of-life/euthanasia-and-assisted-suicide/euthanasia-in-belgium-analysis-of-the-2020-commission-report-1921.html>

Fleming, John L, '*Euthenasia, The Netherlands, and Slippery Slopes*' (1992) 1 Bioethics Research Notes Occasional Paper

Gentleman, Amelia 'Inside the Dignitas House', *the Guardian (Online)*, 18 November 2009 <https://www.theguardian.com/society/2009/nov/18/assisted-suicide-dignitas-house>.

Givens, Jane L. and Susan L. Mitchell, '*Concerns About End-of-Life Care and Support for Euthanasia'* (2009) 38(2) Journal of Pain and Symptom Management, 170-171

Golden, Marilyn and Tyler Zoanni, '*Killing us softly: the dangers of legalizing assisted suicide'* (2010) 3(1) Disability Health Journal, 21

Green, Paul D, '*Suicide, Matyrdom and Thomas More'* (1972) 19 Studies in the Renaissance, 137-138

Hamlyn, Charlotte and Briana Shepherd, 'David Goodall ends his life at 104 with a final powerful statement on euthanasia', *ABC News (online)*, 11 May 2018 <https://www.abc.net.au/news/2018-05-10/david-goodall-ends-life-in-a-powerful-statement-on-euthanasia/9742528>

Hennessy, Jill, 'Supporting Families of Terminally Ill Victorians' (Media Release, 11 April 2018), 1. <https://www.premier.vic.gov.au/supporting-families-of-terminally-ill-victorians/>

Hennessy, Jill, 'Voluntary Assisted Dying Bill 2017' (Research Note No 1, Parliamentary Library, Parliament of Victoria, 2017)

Herx, Leonie, Margaret Cottle and John Scott, 'The "Normalization" of Euthanasia in Canada: the Cautionary Tale Continues' (2020) 66(2) *World Medical Journal* 31

Holmes, Alex, Nicholas Christelis and Carolyn Arnold, 'Depression and chronic pain' (2013) 199(6) *Med J Aust*, 17

Hurst, Samia A, and Alex Mauron, 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians' (2003), 326 (7383) BMJ 271

Inghelbrecht, Els, Johan Bilsen, Freddy Mortier and Luc Deliens, 'The role of nurses in physician-assisted deaths in Belgium' (2010), 182(9) *Canadian Medical Association Journal* 905

Joint Select Committee on End of Life Choices, 'My Life, My Choice' (Report No 1, Parliamentary Library, Parliament of Western Australia, 2018)

Journal Article, 'https://www.smh.com.au/world/dealing-in-the-desire-for-death-20070203-gdpe4s.html', *Sydney Morning Herald (Online)*, 03 February 2007 < https://www.smh.com.au/world/dealing-in-the-desire-for-death-20070203-gdpe4s.html>

Kelsey-Sugg, Anna, 'It's been two years since Victoria introduced assisted dying laws, so how well are they working?' *ABC News (online)*, 07 May 2021 <https://www.abc.net.au/news/2021-05-07/voluntary-euthanasia-laws-how-well-are-they-working/100117058 >

Keown, John '*Euthanasia in the Netherlands: Sliding down the Slippery Slope*' (1995) 9 Notre Dame Journal of Ethics and Public Policy 407

Keown, John, 'Voluntary Assisted Dying" in Victoria: the Parliamentary Committee's Tenuous Case for Legalization' (2018) 33 (1) *Issues in Law and Medicine* 55

Keown, John, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge University Press, 1995).

Keown, John, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd Edition, 2018)

Keown, John, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisatio*n (Cambridge University Press, 2002)

Kim, Scott Y.H, and Trudo Lemmens, 'Should assisted dying for psychiatric disorders be legalized in Canada?' (2016) 188(14) CMAJ 337.

Kissane, David W, Annette Street and Philip Nitschke, '*Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia*' (1998) The Lancet 353, 1097

Kurti, Peter, Euthanasia: *Putting the Culture to Death* (Connor Court Publishing, 2018)

Legal and Social Issues Committee, Parliament of Victoria, ‘Inquiry into end of life choices final report’ (June 2016)

Lewis, Penney ‘Euthanasia in Belgium five years after legalisation’ (2009) 16(2) *European Journal of Health Law,* 126

Library of Parliament (Canada), *Euthanasia and Assisted Suicide in Canada*, Background Paper (2015) 10

Macauley, Robert C. , Ethics in Palliative Care: A Complete Guide (Oxford University Press, 2018), 226

Manch, Thomas, ‘Euthanasia pioneer warns of 'beg and grovel' legislation’, Stuff.co.nz (online, November 8 2018) <https://www.stuff.co.nz/national/health/euthanasia-debate/108441737/euthanasia-pioneer--warns-of-beg-and-grovel-legislation>

McDougall, Rosalind and Bridget Pratt, ‘Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation’ (2020) 21 (38) *BMC Med Ethics* 1

Melley, Brian, ‘California court reverses ruling against assisted suicide’, AP News (online), 29 November 2018 <https://www.apnews.com/6705d8ae21154674a24acffa1f42ba47>

Muehlenberg, Bill, *The Challenge of Euthanasia* (Createspace Independent Publishing Platform, 2016)

Murphy, Sean, ‘Canadian Medical Association and Euthanasia and Assisted Suicide in Canada: Critical Review of CMA Approach to Changes in Policy and Law’ *SSRN Electronic Journal* (September 2018)

New York Times, ‘Netherlands to Allow Doctors to Help End Lives of Terminally Ill’ New York Times (Online) 16 October 2020

O’Connor, Margaret M, et al, ‘Documenting the process of developing the Victorian voluntary assisted dying legislation’ (2018) 42 Australian Health Review 621

Ogden, Russel, *Euthanasia, Assisted Suicide and AIDS* (Peroglyphics Publishing, 1994)

Oregon Health Division, ‘Death with Dignity Act Requirements’ (undated) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/requirements.pdf>.

Oregon Health Division, *Oregon Death with Dignity Act 2018 Data Summary* (2019) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf >

Oregon Health Division, *Oregon's Death with Dignity Act: 2019 Data Summary* (February 25, 2020) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

Oregon Health Division, *Oregon's Death with Dignity Act: The First Year's Experience* (February 18, 1999) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year1.pdf>

Oregon Secretary of State, *Oregon Blue Book* (2019) <https://sos.oregon.gov/blue-book/Documents/elections/initiative.pdf>

Ost, Suzanne *An Analytical Study of the Legal, Moral, and Ethical Aspects of the Living Phenomenon of Euthanasia* (Edwin Mellen Press, 2003)

Otlowski, Margaret, *Voluntary Euthanasia and the Common Law* (Oxford University Press, 2000)

Papadimitriou, John D, et al, 'Euthanasia and suicide in antiquity: viewpoint of the dramatists and philosophers' 100(1*) J R Soc med*, 35

Pereira, J. ,'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls' (2011), 18(2) *Current Oncology* 38

Petrillo, Laura A, et al, 'How California Prepared for Implementation of Physician-Assisted Death: A Primer' (2017) 107(6) *American Journal of Public Health*, 883–888

Reuters, 'Netherlands may extend assisted dying to those who feel life is complete' *The Guardian* (Online), 13 October 2016 <https://www.theguardian.com/world/2016/oct/13/netherlands-may-allow-assisted-dying-for-those-who-feel-life-is-complete>

Ritjens, Judith A.C. et al, 'Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?' (2009) 6(3) *J Bioeth Inq* 273

Roy, Kamalika, ‘Role of Psychiatrists in Assisted Dying: A Changing Trend’ (2016) 11(9) *American Journal of Psychiatry* 5.

Schadenberg, Alex, *Exposing Vulnerable People to Euthanasia and Assisted Suicide* (Connor Court Publishing, 2013)

Select Committee on Assisted Dying for the Terminally Ill Bill, First Report, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005)

Sheldon, Tony, ‘Being “tired of life” is not grounds for euthanasia’ (2003) 326(73) *BMJ* 71.

Siegel, Mark C, ‘Lethal Pity: The Oregon Death with Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World’ (1998) 16(1) *Law & Inequality: A Journal of Theory and Practice*, 270

Somerville, Margaret ‘Euthanasia and assisted suicide: a physician’s and ethicist’s perspectives’ (2014) 4 *DovePress Medicolegal and Bioethics*, 1

Somerville, Margaret, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide* (McGill-Queen’s University Press, 2001)

Stolberg, Michael, ‘Active Euthanasia in Pre-Modern Society, 1500–1800: Learned Debates and Popular Practices’ (2007) 20(2) *Social History of Medicine*

Tran, Peter Hung Manh, *Advancing the Culture of Death: Euthanasia and Physician Assisted Suicide* (Freedom Publishing Australia, 2006)

Tulloch, Gail, *Euthanasia – Choice and Death* (Edinburgh University Press ltd, 2005)

UCHealth, ‘Colorado End of Life Options Act’, University of Colorado Hospital, undated <https://www.uchealth.org/colorado-end-life-options-act/>

Uhlmann, Michael M., *Last Rights: Assisted Suicide and Euthanasia Debated* (Wm. B. Eerdmans Publishing Co., 1998)

Unknown, ‘Bendigo woman Kerry Robertson becomes first Victorian to use Voluntary Assisted Dying Act’, *ABC News* (online 05 August 2019) <https://www.abc.net.au/news/2019-08-04/bendigo-woman-first-victorian-use-voluntary-assisted-dying-law/11382332>

Unknown, ‘Public prosecutor investigates euthanasia of woman with dementia’ (2017) *Dutch News* (Online) <https://www.dutchnews.nl/news/2017/09/public-prosecutor-investigates-euthanasia-of-woman-with-dementia/>

Unknown, ‘Spain passes law allowing euthanasia’, *BBC News (online)*, 18 March 2021 <https://www.bbc.com/news/world-europe-56446631>.

Urofsky, Melvin and Phillip Urofsky (eds), *The Right to Die: A Two-Volume Anthology of Scholarly Articles Volume 1* (Garland Publishing, 1996)

Urofsky, Melvin and Phillip Urofsky (eds), *The Right to Die: A Two-Volume Anthology of Scholarly Articles Volume 2* (Garland Publishing, 1996)

van Delden, JJM ‘The unfeasibility of requests for euthanasia in advance directives’ (2004), 30 BMJ 447

Verhostadt, Monica, et al, ‘Belgian psychiatrists’ attitudes towards, and readiness to engage in, euthanasia assessment procedures with adults with psychiatric conditions: a survey’ (2020) 20 *BMJ Psychiatry* 374

Verweel, Lee, et al, ‘Medical assistance in dying: Examining Canadian pharmacy perspectives using a mixed-methods approach’ (2018), 151(2) *Canadian Pharmacists Journal* 121

Voztas, Senay, ‘Dutch MP backs euthanasia for over-75s who are tired of life’, *The Times* (Online), 19 July 2020 <https://www.thetimes.co.uk/article/dutch-mp-backs-euthanasia-for-over-75s-who-are-tired-of-life-z8bdp6685>.

Werth JR, James L & Howard Wineberg, ‘A Critical Analysis of Criticism of the Oregon Death with Dignity Act’ 29(1) *Death Studies*, 1

White, Ben P and Lindy Willmott and Eliana Close, ‘Victoria’s voluntary assisted dying law: clinical implementation as the next challenge’ (2019) 210(5) *Medical Journal of Australia* 1

Williams, George and Matthew Darke, ‘Euthanasia Laws and the Australian Constitution’ (1997) 20(3) *University of New South Wales Law Journal* 647

Willmott, Lindy and Ben White, ‘Assisted Dying in Australia: A Values-based Model for Reform’ in Freckelton, Ian and Kerry Petersen (eds), *Tensions and Traumas in Health Law* (2017, Federation Press)

Willmott, Lindy, et al, '(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics' (2016) 39(1) *UNSW Law Journal* 1

Zdenkowski, George, 'The International Covenant on Civil and Political Rights and Euthanasia (1997) 20(1) *University of New South Wales Law Journal* 170

B *Cases*

Airedale N.H.S. Trust v Bland [1993] 1 All ER 821

Alberto R. Gonzales, Attorney General, et al. 546 US 243 (2006)

Baxter v Montana 2009 MT 449

Carter v Canada (Attorney General) 2015 SCC 5

Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario [2019] ONCA 393

Criminal Code Amendment (Suicide Related Material Offences) Act 2005 (Cth)

Criminal Code, RSC 1985 c C46 (Canada)

Euthanasia Laws Act 1997 (Cth)

Justins v Regina [2010] NSWCCA 242

Lee v. State of Oregon 107 F. 3d 1382

Lee v. State of Oregon 891 F. Supp. 1439 (D. Or. 1995)

Northern Territory (Self Government) Act 1978 (Cth)

R v Adams [1957] Crim LR 365

R v Brown [1994] 1 AC 212

R v Cox [1992] 12 BMLR 38

R v Shirley Justins [2011] NSWSC 568

Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 (Cth).

Rights of the Terminally Ill Act 1995 (NT)

The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario [2018] ONSC 579

Wake & Anor v Northern Territory of Australia & Anor [1996] NTSC 56

Wake & Anor v The Northern Territory & Anor [1996] HCATrans 352

C *Legislation*

Act amending the Act of 28 May 2002 on euthanasia, sanctioning euthanasia for minors (Belgium)

An Act Respecting End-of-life Care, RSQ, 2014 (Canada)

An Act to amend the Criminal Code (medical assistance in dying), C 2021, C-7 (Canada)

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), RSC 2015 (Canada)

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), C 2016, C-14 (Canada)

Assisted Dying Bill 2017 (UK) HL 42 (UK)

Australian Constitution 1901 (Cth)

California End of Life Option Act 443 HSC §§ 443-443.22 (2016) (California)

Colorado End of Life Options Act 48 CRS §§ 25-48-101 - 25-48-123 (2016) (Colorado)

Crimes Act 1958 (Vic)

Criminal Code Amendment (Suicide Related Material Offences) Act 2005 (Cth)

Criminal Code Compilation Act 1913 (WA)

Criminal Code, RSC 1985 c C46 (Canada)

Death with Dignity Act 1993, §3.06, ORS, 127.840, Oregon Health Authority (2017). (Oregon)

Disability Act 2006 (Vic)

End-of-Life Choices (Voluntary Assisted Dying) Act 2021 (Tas)

Euthanasia Laws Act 1997 (Cth)

Legislation Reglementant Les Soins Palliatifs Ainsi Que L'euthanasie Et L'assistance Au Suicide (2009) [Legislation Regulating Palliative Care as Well as Euthanasia And Assistance to Suicide] (Luxembourg)

Medical Treatment Planning and Decisions Act 2016 (Vic)

Mental Health Act 2014 (Vic)

Northern Territory (Self Government) Act 1978 (Cth)

Patient Choice and Control at End of Life Act 18 VSA §§ 113(2013) (Vermont)

Pharmacy Regulation Act 2010 (Vic)

Proposition de loi No. 4909 sur le droit de mourir en dignité (2008) [Bill No. 4904 on the right to die with dignity] (Luxembourg)

Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 (Cth)

Rights of the Terminally Ill Act 1995 (NT)

Rights of the Terminally Ill Amendments Act 1996 (NT)

Swiss Criminal Code (1937) (Switzerland)

Telecommunications Act 1997 (Cth)

Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

The Belgian Act on Euthanasia of May, 28th 2002 (Belgium)

Voluntary Assisted Dying Act 2017 (Vic)

Voluntary Assisted Dying Bill 2017 (Vic)

Voluntary Assisted Dying Regulations 2018 (Vic)

The Washington Death with Dignity Act 70.245 RCW §§ 70.245.010 - 70.245.903 (2008) (Washington)

Wetboek van Strafrecht 1881 [Criminal Law 1881] (Netherlands)

D *Other*

Australian Health Practitioner Regulation Agency, 'Mandatory notifications about registered health practitioners' (March 2020), <https://www.ahpra.gov.au/documents/default.aspx?record=WD20/29515&dbid=AP&chksum=YMVsT2Py%2bC0erSWK0OqAhg%3d%3d>

Death with Dignity, 'Colorado', *Death with Dignity*, undated <https://deathwithdignity.org/states/colorado/>

Department of Health (Victoria), *Voluntary assisted dying Guidance for health practitioners* (2019) <https://www2.health.vic.gov.au/Api/downloadmedia/%7B556A1C84-DC8B-4FC8-94BA-FFEF825D0373%7D>

Department of Health and Human Services (Victoria), *Mental Illness Statistics* (undated). <https://www.betterhealth.vic.gov.au/health/servicesandsupport/mental-illness-statistics>.

Department of Health (Victoria), *What process do my doctor and I need to follow?* (undated) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/process-to-follow>

End of Life Law for Clinicians, 'Palliative Care Education and Training Collaborative: End of Life Law for Clinician', *Queensland University of Technology* <https://palliativecareeducation.com.au/course/index.php?categoryid=5 >. (accessed 16/07/2019)

End of Life Washington, *The Washington Death with Dignity Act: An overview for patients and families* (2015), 1 <https://endoflifewa.org/wp-content/uploads/2012/09/WA.DWDA_.An_.Overview.for_.Patients.and_.Families.10.2015.pdf>

Government of Canada, *Guidelines for death certificates*, (2017) <https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidelines-death-certificates.html>

Government of Canada, *Monitoring System for Medical Assistance in Dying in Canada* (undated) <https://www.canada.ca/en/health-canada/services/publications/health-system-services/monitoring-system-medical-assistance-dying.html>

Government of Canada, *Monitoring System for Medical Assistance in Dying in Canada* (undated) <https://www.canada.ca/en/health-canada/services/publications/health-system-services/monitoring-system-medical-assistance-dying.html>.

Government of Canada, *Regulations for the Monitoring of Medical Assistance in Dying: SOR/2018-166* (2018) <http://www.gazette.gc.ca/rp-pr/p2/2018/2018-08-08/html/sor-dors166-eng.html>

Government of Luxembourg, *Information on requesting euthanasia or assisted suicide* (undated) <https://guichet.public.lu/en/citoyens/famille/euthanasie-soins-palliatifs/fin-de-vie/euthanasie-assistance-suicide.html>

Government of the Netherlands, *Euthanasia, assisted suicide and non-resuscitation on request* (undated) <https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>. See also, Regional Euthanasia Review Committees, *Due Care Criteria* (undated) <https://english.euthanasiecommissie.nl/due-care-criteria>.

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, 'Voluntary assisted dying' (Report No 34, Parliamentary Library, Parliament of Queensland, 2020), 35.

Hon Daniel Andrews MP, 'Historic Voluntary Assisted Dying Bill Now in Parliament' (Media Release, 20 September 2017) <https://www.premier.vic.gov.au/wp-content/uploads/2017/09/170920-Historic-Voluntary-Assisted-Dying-Bill-Now-In-Parliament-1.pdf>

Hon Nick Goiran MLC, *The safe approach to End of Life Choices: License to Care not License to Kill,* Joint Select Committee on End of Life Choices (Minority Report) (August 2018)

Memorandum from the Attorney General, Select Committee on Assisted Dying for the Terminally Ill Bill Minutes of Evidence (2005) <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/5012004.htm>.

Memorandum from the Attorney General, Select Committee on Assisted Dying for the Terminally Ill Bill Minutes of Evidence (2005) <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/5012004.htm>

Northern Territory, *Parliamentary Debates*, Legislative Assembly, 22 February 1995 (Marshall Perron)

Oregon Health Division, '*Oregon's Death with Dignity Act: The Second Year's Experience'* (February 23, 200) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year2.pdf>,

Parliament of Australia, ‘history of criminal law’ (undated) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Browse_by_Topic/Crimlaw/Historycriminallaw>

Parliamentary Library, *Euthanasia - the Australian Law in an International Context*, Research Paper 4 (1996-1997)

Patient Choices Vermont, *About PCV - History* (undated) <https://www.patientchoices.org/history.html>

Pharmacy Board of Australia, ‘*Guidelines for dispensing of medicine*’ (2018), <https://ahpra-search.clients.funnelback.com/s/redirect?collection=ahpra-websites-web&url=https%3A%2F%2Fwww.pharmacyboard.gov.au%2Fdocuments%2Fdefault.aspx%3Frecord%3DWD15%252f17695%26dbid%3DAP%26chksum%3DcZm3mO8R6fTMdPPl3scPUw%253d%253d&auth=401VsTxX%2FDBuFALH%2FcCiuQ&profile=pharmacy&rank=3&query=Guidelines+for+dispensing+of+medicines>

Queensland University of Technology, *End of Life Choices: Euthanasia and Assisted Dying* <https://end-of-life.qut.edu.au/euthanasia>. (Accessed 04 March 2020)

Queensland University of Technology, *End of Life Law in Australia: Advance Directives* (undated) <https://end-of-life.qut.edu.au/advance-directives >

Rachel Baxendale, ‘First Victorian euthanasia figures released’, *The Australian* (Online), 20 February 2020 <https://www.theaustralian.com.au/nation/victorian-euthanasia-figures-released-for-first-time/news-story/7b2ae73ae595f7b3b719e8af77b83255>

Regional Euthanasia Review Committees, *Due Care Criteria* (undated) <https://english.euthanasiecommissie.nl/due-care-criteria>

Regionale Toetsingscommissies Euthanasie, *Annual Report 2020 Regional Euthanasia Review Committees (RTE)*, (20 April 2021) <https://www.euthanasiecommissie.nl/actueel/nieuws/2021/04/15/jaarverslag-2020-aangeboden-op-15-april-2021>

Saskia Gauthier et al, 'Suicide tourism: a pilot study on the Swiss phenomenon' (2015) 41 *Journal of Medical Ethics*, 611

Scott Neuman, ‘Judge Overturns Assisted Suicide Law In California’, *NPR News* (online), 16 May 2018 <https://www.npr.org/sections/thetwo-way/2018/05/16/611527757/judge-overturns-assisted-suicide-law-in-california>.

See: *Voluntary Assisted Dying Act 2017* (Vic)

Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005)

Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report*, House of Lords, House of Lords Paper 86, Session 2005-2006 (2005)

Select Committee on Euthanasia, Northern Territory, *The Right of the Individual or the Common Good* (1995)

Simon Caldwell, 'Doctors who certified a woman as autistic so she could get a lethal injection face jail under euthanasia laws as family insist she was just broken hearted', *The Daily Mail* (online), 25 November 2018 <https://www.dailymail.co.uk/news/article-6425417/Doctors-allowed-woman-lethal-injection-face-jail-euthanasia-laws.html>

Special Senate Committee on Euthanasia and Assisted Suicide (Canada), *Of Life and Death – Final Report* (1995). < https://sencanada.ca/content/sen/committee/351/euth/rep/lad-e.htm>.

Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* (2008)

Tasmania, *Parliamentary Debates*, Legislative Council, 15 September 2020, 65 (Hon Mike Gaffney MLC)

Vermont Department of Health, *Act 39 Frequently Asked Questions* (undated) <http://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf>

Victoria, *Gazette*, No G 12, 21 March 2019

Victoria, *Special Gazette*, No S259, 26 June 2019

Victorian Legislation, *Voluntary Assisted Dying Act 2017* <https://www.legislation.vic.gov.au/in-force/acts/voluntary-assisted-dying-act-2017/005>.J. Pereira, 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls' (2011), 18(2) *Current Oncology* 38

Vikas Wadhwa, 'More than 1% of deaths in Canada last year were medically assisted' (2019), 365 *The BMJ* (Online) <https://www.bmj.com/content/365/bmj.l1989/rr>.

Voluntary Assisted Dying Review Board, *Report of Operations January to June 2019*, (2020)

Voluntary Assisted Dying Review Board, *Report of Operations January to June 2020*, (2020)

Voluntary Assisted Dying Review Board, *Report of Operations June to December 2020*, (2021)

Western Australia, *Parliamentary Debates*, Legislative Council, 15 October 2019, p7533c-7550a [3] (Hon Nick Goiran MLC) <https://parliament.wa.gov.au/Hansard/hansard.nsf/0/01d6fbb00098e4e9482584d5002081e3/$FILE/C40+S1+20191015+p7533c-7550a.pdf>.

World Health Organisation, *WHO Definition of Palliative Care* <http://www.who.int/cancer/palliative/definition/en/>

World Health Organisation, WHO Definition of Palliative Care <http://www.who.int/cancer/palliative/definition/en/>