

Policy Document

Voluntary Assisted Dying

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for Australia's medical students. AMSA believes that all communities have the right to the highest attainable standard of health and quality of life. Accordingly, AMSA advocates on issues that impact local, national and global health outcomes. Voluntary assisted dying (VAD), encompassing both euthanasia and physician-assisted dying (PAD), is becoming increasingly important and relevant within the health sphere. At the time of writing, both are illegal in all Australian jurisdictions, and so adopting a measured position on voluntary assisted dying is integral to progressing and improving how we care for people nearing the end of their lives. Although the Victorian Labour government passed legislation to legalise VAD in November 2017, it is yet to come into effect. While AMSA recognises its limited clinical expertise in this field, as future doctors we have a vested interest in any VAD legislation. Furthermore, VAD has the potential to impact many individuals, and as such discussions surrounding it require diverse perspectives from different members or groups in our community.

Definitions

Euthanasia:

The word euthanasia comes from the Greek words *eu* and *thanatos*, and translates roughly to English as 'good death'. It describes the practice of intentionally ending a life in order to relieve suffering [1]. This policy concerns voluntary euthanasia, which is performed with a patient's informed consent. Euthanasia may be active - a deliberate act undertaken to end a patient's life - or passive - omission of an action which would reasonably be expected to keep the patient alive [1]. It may also be voluntary - at the request of a competent patient - or non-voluntary - at the request of a surrogate decision-maker [1]. In the medical profession, passive euthanasia is commonly accepted as ethically permissible, in 'futile' circumstances [2]. Consequently, there is a perception of a strict moral delineation between passive and active euthanasia. Nonetheless, ethical questions can be asked regarding the difference between an action and an omission of an action. Such a discussion is outside the scope of this policy. This policy concerns voluntary active euthanasia, which is performed with a patient's informed consent.

It is important to note that other actions made by a medical practitioner may lead to a patient's death but are not considered euthanasia. Specifically, doctors may prescribe a dying patient morphine to relieve suffering, but at doses that are likely to accelerate their death [3]. This is known as the 'double effect', i.e. where an action causes both morally 'good' and 'bad' effects to occur and is neither strictly illegal nor considered unethical within the medical profession [3].

Assisted Dying:

Assisted suicide is any suicide committed by a person with aid from another person. Physician-assisted dying (PAD) is a subset of assisted suicide, whereby the patient's death is enabled via means (for example, a drug) or by information (for example, how to use a drug) by a medical practitioner [1]. This is distinct from euthanasia as it is the patient taking the final action that will end their life, rather than the clinician. PAD becomes more complicated when the individual is physically unable to take the steps to end their own life. This is the case in conditions such as locked-in syndrome and other neurological conditions (such as amyotrophic lateral sclerosis) where the patient is still cognitively competent yet cannot control their own movements.

Palliative Care:

The World Health Organization (WHO) defines palliative care as an 'approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness'. Palliative care, amongst other things, 'provides relief from pain', 'affirms life and regards dying as a natural process', and 'intends neither to hasten or postpone death' [4].

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Safeguards:

Safeguards in relation to VAD legislation refers to any conditions that are in place to ensure that the intention behind VAD legislation is properly implemented. Safeguards are designed with the express intention of protecting potentially vulnerable populations, which includes, but not limited to, people with disabilities, the elderly, those with mental health problems and patients from low socioeconomic backgrounds.

While in depth discussion of safeguards is beyond the scope of this policy, a few examples are given to demonstrate what an optimum VAD policy would consider. The following examples are taken from the Victorian *Voluntary Assisted Dying Bill 2017* (see appendix 1 for full bill):

1. The person must be diagnosed with a disease, or medical condition that is incurable, advanced and will cause death within the next 12 months.
2. No one can request VAD on someone else's behalf - the person in question must request access.
3. The person must be assessed by two separate independent medical practitioners.
4. A review process must be established, with a board that is responsible for monitoring the actions of VAD activity that is occurring under legislation.

Other countries that have legalised VAD have implemented safeguards with varying degrees of stringency - see Global Perspectives for more details.

Perspectives on VAD

VAD is a complex issue with great significance in moral philosophy and public debate. There are a wide range of important arguments both for and against. If VAD were to be legalised in Australia in the future, it is necessary to explore all arguments in order to ensure appropriate, well considered legislation is created.

Moral Perspectives

There are three main moral arguments in support of VAD. These involve the ethical principle of autonomy, compassion for those who are suffering, and the suggestion that it is already current practice. Concurrently, there are three main arguments against VAD. These include the sanctity of life principle, concern for vulnerable populations, and the argument that it contradicts the intrinsic role of a doctor.

Arguments for VAD:

Autonomy is the right of competent individuals to make informed and voluntary decisions about their own care and is a central argument for the legalisation of VAD [5]. VAD allows individuals with life-limiting illness to choose to die on their own terms, preserving their autonomy. Public support for terminally ill patients to be allowed to legally end their own lives with medical assistance has been increasing over the past four decades [6] and data from 2017 suggest that 85% of Australians support allowing a doctor to perform euthanasia [7]. By offering patients the opportunity to choose death, their autonomy is respected, and fears and uncertainty surrounding their death can be reduced [8]. This returns a measure of control to those who may feel they no longer have control over their life, illness or death.

Another primary argument in support of VAD is concern for quality of life and compassion for those enduring irremediable pain and suffering. Advocates for VAD believe that when a competent person makes a voluntary and enduring request for assistance in dying, it is wrong to ignore these requests. Studies have demonstrated that patients perceive a good death as quick, with minimal suffering and on their own terms [9,10]. It is inevitable that there will be both 'good natural deaths' and 'bad natural deaths' regardless of even the best palliative care provided. For example, the Parliamentary Committee inquiry into end of life choices, which prompted the Victorian *Voluntary Assisted Dying Bill 2017*, concluded that palliative care in Victoria was not adequate to deal with the pain and suffering of a small percentage of individuals at the end of their life [11]. Therefore, the argument holds that persons who have incurable illness that generates unrelenting, intolerable and profound suffering should have the right to choose to die in a manner acceptable to them.

Finally, while VAD is currently illegal in Australia, it is difficult to empirically quantify the extent to which it is being practiced. However, there is limited evidence to suggest that it is being

practiced surreptitiously in some clinical settings [12-14]. One such study conducted in 2007 found that despite the current illegality of the actions, more than one-third (35%) of Victorian doctors who had received a request from patients to hasten death had taken active steps to end a patient's life (via prescription or injection of lethal drugs) [14]. This was most commonly justified by persistent and untreatable pain, terminal illness, incurable conditions, or infirmities of old age [14]. These studies suggest that there is demand for VAD and it is being practiced in an unregulated, potentially dangerous manner [13,14]. Legalising VAD would theoretically provide regulations, guidelines and safeguards, therefore protecting patients from malpractice and doctors from prosecution.

Arguments against VAD:

An overarching moral objection to VAD is the ethical principle of 'sanctity of life', which affirms that the taking of human life is intrinsically wrong. Some proponents view this principle as an axiom that requires no further justification [15], holding primacy over other ethical principles that may support VAD (such as respect for patient autonomy). A variant of the sanctity of life principle is espoused by individuals from various religious faiths [16]. It is important to acknowledge, however, that religious beliefs are incredibly diverse and certain views will not be held by all individuals that ascribe to a particular religion.

Another predominant argument against VAD is a concern for potentially vulnerable populations who might experience internal and external pressure to end their lives [17]. Indeed, the central idea supporting VAD that some lives are worth living and others are not, is deeply divisive and may be regarded as stigmatising. It's suggested that fear of being a burden on family or society may drive individuals to end their lives prematurely, or conversely, the fear of being offered VAD prematurely may prevent potentially vulnerable people from seeking medical services that they require [18]. Individuals arguing against VAD on these grounds also consider it plausible that the family or carers of a potentially vulnerable person may coerce the individual to seek VAD against their will [19].

There are also widespread moral reservations regarding the role of the doctor in providing euthanasia and PAD. Opponents consider any involvement in actively ending a person's life as a violation of the Hippocratic Oath which states "I will not give a drug that is deadly to anyone if asked [for it], nor will I suggest the way to such a counsel" [20]. Many modern medical associations however, including the AMA, have adopted the World Medical Association's (WMA) *Declaration of Geneva* which does not make such specific reference to assisted dying. Instead, it states more broadly "I will maintain the utmost respect for human life" [21]. Whether the act of assisting in, or actively ending, a person's life when they are fully consenting and experiencing intolerable suffering is in fact a "harm" is a separate subject of debate.

Lastly, the 'slippery slope' argument relates to the perceived inevitability that voluntary euthanasia will inevitably lead to involuntary euthanasia, particularly in vulnerable populations [22,23] Proponents of this argument describe an absence of barriers to prevent a downward spiral once voluntary euthanasia is legalised, however this is not supported by evidence. A recent cross-party Victorian parliamentary inquiry supported that properly drafted legislation can draw a fixed barrier across the slippery slope in that they found "no evidence of institutional corrosion or the often cited 'slippery slope'" [11].

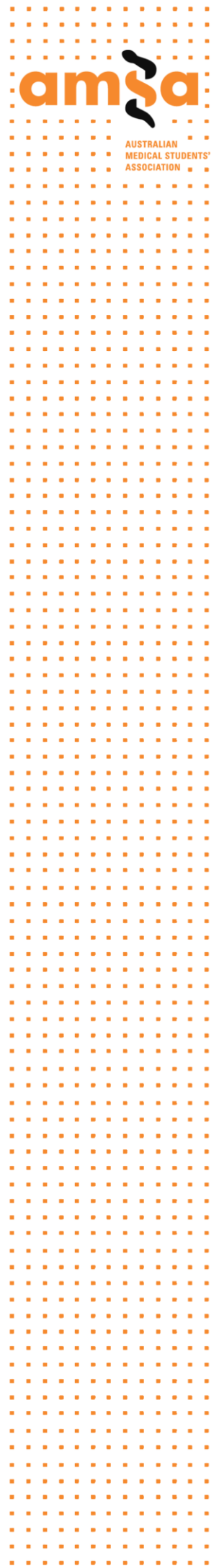
Pragmatic Implications

Pragmatic arguments against VAD are not concerned with the moral permissibility of the act (of actively ending a life), but rather with the complex factors that may limit the practicality of legalising any form of euthanasia or assisted dying.

The following table represents a number of salient pragmatic arguments against VAD along with possible solutions or safeguards for these arguments which are part of either the Victorian *Voluntary Assisted Dying Act 2017*, or from the implementation of such legislation by other foreign governments.

Pragmatic arguments against VAD	Possible solutions/safeguards
Difficulty ensuring adequate safeguards for potentially vulnerable populations, such as those with mental illness or disabilities that they may experience direct or indirect pressure to end their life [18,19].	A person is not eligible for access to VAD only because the person is diagnosed with a mental illness or has a disability [24]. It is an offence for a person by dishonesty or undue influence, to induce another person to make a request for access to VAD [24].

<p>Difficulty in predicting the course of serious illness, despite best medical expertise, thus the possibility of prematurely ending a life.</p>	<p>A person is eligible if they are diagnosed with a disease, illness or medical condition that is expected to cause death within weeks or months, not exceeding 6 months, and is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable [24]. Furthermore, this assessment requires significant medical expertise to complete. For example;</p> <ol style="list-style-type: none"> 1. Two coordinating and consulting medical practitioners are required to complete independent assessments regarding VAD eligibility. 2. They must hold a fellowship with a specialist medical college, be a vocationally registered general practitioner, have 5 years of experience as a consultant, have relevant expertise in the disease, illness or medical condition [24].
<p>Challenges of defining competency/capacity and intolerable/untreatable suffering in the eyes of the law, such that objective decisions can be made regarding who is eligible for VAD.</p>	<p>A person is eligible if they have decision-making capacity in relation to VAD. If either registered medical practitioner are not satisfied this eligibility is met, the request and assessment process ends [24].</p> <p>A person is eligible if the disease, illness or medical condition is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable [24]. This latter safeguard implies that the decision is a subjective one based on the patient's experience of suffering. If the patient states they are suffering in manner that cannot be relieved in a tolerable way, this is enough to satisfy an objective assessment by a medical practitioner.</p>
<p>The need to invest more in palliative care services [25], such that fewer people experience intolerable suffering at the end of life and the need for VAD is reduced.</p>	<p>As a condition of passing the Voluntary Assisted Dying bill in Victoria, the Labour government announced an additional \$62 million funding package for better end-of-life choices, including \$19 million for palliative care. This funding will be allocated over a five-year period and will be reviewed [26]. The current 2018-2019 Victorian State government budget commits \$500million to palliative care. This commitment recognises how essential palliative care is when discussing VAD legislation. [27]</p>
<p>The need to protect the values and beliefs of doctors and other health professionals who conscientiously object to any act of VAD.</p>	<p>A registered health practitioner has the right to refuse to provide information, participate in the request or assessment progress, or prescribe VAD substances and are protected from litigation where they are requested to assist with the process [24].</p>
<p>The difficulty in ensuring that any legal VAD services are accessible to all who seek them (for example, should services be provided as part of the public healthcare system).</p>	<p>Accessibility of healthcare is not an issue specific to VAD. Doctors must remain advocates for equitable and accessible healthcare, including investment in the areas that will deliver more sustainable healthcare spending, reduce health disparities, and improve health outcomes for all Australians [28].</p> <p>While there is currently no legislation regarding accessibility, it is important that the implementation of any VAD scheme be accessible from both a location and cost perspective. More information regarding this may become available when the Victorian VAD bill becomes enacted in July 2019.</p>
<p>The inclusion or exclusion of psychiatric conditions, severe</p>	<p>The disease, illness or medical condition must be incurable, advanced, progressive and will cause death.</p>



disabilities, and non-terminal (but untreatable) illnesses.	A person is not eligible for access to VAD only because the person is diagnosed with a mental illness or has a disability [24].
The doctor-patient relationship may be affected by legal VAD, as patients may not access services or disclose information to their doctor due a fear euthanasia will be recommended	A registered health practitioner must not in the course of providing services to a person initiate discussion with that person that is, in substance, about VAD or in substance, suggest VAD to that person [24].

VAD in the context of palliative care and end-of-life care

It is important to consider the place of VAD within existing palliative care services. As per the definitions stated in this policy, VAD and palliative care are often considered distinct treatment options of the end-of-life care continuum [29,30].

In this policy, and in many areas across the world, VAD is no substitute for, or replacement of, palliative care. Instead, VAD is to be a considered and well-thought-out option in the context of a patient's end-of-life care and in conjunction with palliative care. Palliative care aims to affirm life and intends to neither accelerate or delay death [31], however supports dying as a natural life process. In most countries, including Australia, palliative care remains the standard of care for all patients nearing the end of their lives. However, VAD has the potential to be applied in cases of terminal illness that cause profound and unchangeable systemic, psychological and physical suffering. Non-pain related reasons for patients who are seeking a hastened death are typically the result of a loss of control, loss of hope, and loss of meaning in life or sense of burden to others [32,33]. Therefore, much of the justification for VAD lies in circumstances where the suffering described by patients can only be relieved by death, as all other options have been exhausted or the patient refuses treatment [29,33].

In countries that have accepted VAD, there seems to be no detriment or impact on the effect on palliative care services [34]. Moreover, there is a general global trend that in jurisdictions where VAD is legal, palliative care specialists are in support of VAD [33]. Therefore, it is well regarded that palliative care services will be involved in all VAD cases and not discontinued until the moment of death.

On the other hand, palliative care specialists in jurisdictions where VAD is illegal tend not to be in support of VAD [33]. In Australia, Palliative Care Australia reinforced in their 2016 position statement (at the time of writing this policy, it was currently under review) that 'palliative care does not include euthanasia or physician assisted suicide' and they commented that there is not enough research surrounding the topic [35].

Perspective from the medical profession

Doctors have an important voice in debates around any legislation on VAD, especially as if legalised in all states Australia, doctors are likely to be deeply involved in the process.

Unfortunately, there is a large deficit of peer-reviewed research surrounding the attitudes of Australian medical professionals towards VAD. The most recent formally published data was a 2007 survey of Australian general practitioners and specialists from Victoria, which revealed that 53% of doctors believed VAD was appropriate in the right circumstances [14]. More recent indicators of Australian doctors' overall opinion towards the involvement of the medical profession in VAD has relied on informally published opinion polls. In 2016, an AMA member survey of 4000 Australian medical professionals (from a pool of 13,000 members) found that 38% of doctors believed doctors should be involved in VAD, while 50% thought they should not be involved, and 12% were undecided [36]. Furthermore, an Australian Doctor poll of approximately 370 medical practitioners in 2016 demonstrated that around 65% of doctors supported a change to the law on PAD if strict safeguards were enforced [37]. However, as data drawn from both of these surveys was not published in peer-reviewed journals, it should be noted that this is opinion poll data.

In countries where euthanasia and/or PAD are currently practised legally, medical professionals are generally supportive of it [38-40]. However, medical professionals in these countries still vary on their willingness to be involved in VAD, some still personally object to the practice due to fear of their own incompetence or opposing personal attitudes towards VAD [33,39]. Moreover, the opinion surrounding VAD has the potential for change; in Belgium for example, support for PAD increased from 78% in 2002 around the time of the legislation recently passing to 90% in 2009 [41].

Legality of VAD

VAD in Australia

At the time of writing, VAD is illegal within all Australian states and territories. However, prosecutions are rare [9]. VAD was briefly legalised in the Northern Territory in 1995-1996 (becoming the first jurisdiction in the world to do so), however the Bill was overruled by the Federal government soon after [2]. Victoria's state government passed the Victoria's *Voluntary Assisted Dying Bill 2017* in November 2017 (see Appendix 1). The bill is intended to come into effect from mid-2019, making VAD legal within Victoria under certain circumstances. It should be noted that Victoria's Liberal opposition may repeal the bill if elected in the late-2018 state election.

The passing of Victoria's Voluntary Assisted Dying Bill has been met with a variety of responses from various groups. In a statement on its website, the AMA expressed 'grave concerns' over the final bill, and reiterated their 2016 policy statement, which states that *'doctors should not be involved in interventions that have as their primary intention the ending of a person's life'* [42]. However, they clarified that they do not *'describe doctors who support or participate in Euthanasia or Physician Assisted Suicide as unethical'* [42]. Disability advocates have also expressed concerns about the bill, citing a lack of access to more fundamental healthcare services as a priority over the legalisation of VAD [43]. Similarly, some Victorian palliative care doctors have suggested that adequate resourcing of palliative care services takes primacy over the introduction of VAD, as well as expressing pragmatic concerns [44]. By contrast, the Royal Australian College of General Practitioners (RACGP) welcomed the bill and deemed its safeguards appropriate [45].

Outside of Victoria, there is a continued push for the legalisation of VAD. Notable introductions of VAD bills have recently occurred in Tasmania, New South Wales, and South Australian state parliaments, with the New South Wales and South Australian bills both being defeated by only one vote [46-48].

Global practices of voluntary assisted dying

In this section, we detail some of the global practices around VAD. Through understanding the practices of other jurisdictions, we gain insight into how they have navigated policy challenges, dealt with potentially unforeseen practical implications of the policy, responses to the policy and the deeper moral/ethical implications of voluntary assisted dying policy in practise.

As of 2017, few jurisdictions worldwide have legalised euthanasia and/or PAD. Both euthanasia and PAD can be legally practised in the Belgium, the Netherlands, Luxembourg, Colombia, and Canada. Further, PAD, but not euthanasia, is legal in seven US states and in Switzerland [24] (a more extensive list can be found in Appendix 2). It is important to acknowledge that, due to both an absence and an underreporting of statistics, there is a lack of clarity in discerning just how widespread such practices currently are. In 2008, while PAD was not legal it was nevertheless occurring in other European nations, including England, Wales, France, Italy, Spain, Norway, Denmark, and Sweden [41].

Cultural differences and norms are crucial in guiding discussion and legislation with respect to VAD. The framing of discussions around VAD differ considerably between countries, as different cultures have markedly different attitudes towards death and dying. In order to develop proper safeguards for VAD in Australia, it is important to take note of the trends occurring in other nations following the legalisation of euthanasia and/or PAD. For example, the legalisation of PAD in Switzerland has led to the creation of what has been viewed as 'suicide tourism,' where visitors travelled to that country for the sole purpose of suicide [49]. Most notably, 104 year old Australian scientist, David Goodall, travelled to Switzerland in May 2018 for PAD, believing he had no need to "continue life" [50]. The Victorian Voluntary Assisted Dying Act, however, states that VAD is only eligible for residents of Victoria for at least a year [51].

Below we have highlighted some of the key jurisdictions where VAD has been legalised and identify some of the obstacles encountered.

The Netherlands

The Netherland's 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act established grounds for assisted suicide with non-prosecution for physicians

[24]. Review committees in Netherlands found an increase in approved euthanasia on the basis of mental illness and dementia [52]. Although a case can be made for the use of assisted dying for severe mental illness, the status quo in the Netherlands has in the past been viewed as concerning due to the lack of transparency and legislation that regulate assisted dying for mental illness [53,54]. The quality of end-of-life decision making and due care has also been a concern, considering the increase of deaths as a result of euthanasia from 1.7% in 1990 to 4.5% in 2015 [52]. It is important to note, however, that the increasing trend is partially due to a greater awareness towards euthanasia from both patient and physician perspectives.

US

In the United States, PAD is legal in Vermont, California, Washington, Colorado, Oregon, Hawaii and Montana [24]. Practices differ in each state and are regulated by state governments. In Oregon, critics have raised concerns of patients diagnosed with Alzheimer's and dementia being able to choose to starve to death, allowing for an elected health care representative to act on behalf of the patient [55]. In contrast, Montana's judicial model has raised concerns for the lack of clear statute that outlines safeguards for the physician and the patient [24].

Belgium

The Belgium Act on Euthanasia (with its amendment in 2014) allows both adult patients and competent minors as assessed by a secondary psychiatric or specialist physician to access VAD, effectively abandoning the age criterion. This contrasts with other countries such as Canada, USA or even Victoria where it is restricted to adults only [56]. Controversy surrounding this legislation was the sign for many that Belgium had started down the slippery slope of assisted dying being extended and potentially abused [57]. The reason for the Belgium senate to rule in favour of extending assisted dying laws was to dispose of age-based discrimination, as minors may be psychologically mature to an equal degree [58]. Their suffering should therefore be recognised as just as real as any other competent individual [58]. Despite this controversy, public opinion in Belgium for the extension of the law still shows a majority for the support of the extension of the legislation [59].

Canada

The Parliament of Canada enacted Bill C-14, an amendment to the *Criminal Code* to permit medical assistance in dying, which became legal as of June 2016 [60]. This legislation bears great similarity to the *Voluntary Assisted Dying Act* 2017 in Victoria, in that it permits medically assisted dying for citizens with a grievous and irremediable medical condition causing enduring and intolerable suffering who consent to an assisted death [60]. It stipulates that minors and mentally ill patients are barred from accessing assisted dying and the futility of advanced directives in all cases [60]. Critics have raised concerns regarding the unconstitutional conditions required for accessing voluntary assisted death [61]. In stipulating that a patient's natural death must be "reasonably foreseeable" or condition "incurable", has said to challenge the constitutionality of current law as it excludes people with long-term disabilities, and those with "curable" medical conditions whose only treatment options patients may find unacceptable [61].

Position Statement

AMSA believes individuals with an incurable physical illness that creates unrelieved, unbearable and profound suffering should have the right to choose to die with dignity in a manner acceptable to them, and should not have to suffer beyond their wishes. AMSA, in principle, supports legalising VAD. Despite VAD being practiced in a global context, as VAD legislation is yet to come into effect in any Australian state it is possible that there are unforeseen practical consequences of legislation. AMSA therefore, in principle, supports a well-researched legal framework with appropriate safeguards which considers balanced input from all interested parties and best practices in other jurisdictions.

AMSA believes that any future Australian legislation on VAD should strongly consider:

1. Including eligibility criteria that is non-discriminatory towards, and has an appreciation of the subjective nature of incurable, unbearable and unrelenting suffering;
 - a. Consider, understand and learn from the potentially unforeseen practical and ethical implications of VAD policy in other jurisdictions, especially regarding legalisation of VAD for those with mental illness and minors;

- b. Ensure VAD services, if implemented, are accessible to all relevant patients and cannot be contradicted by other legislation or the constitution.
2. Enforcing adequate safeguards in order to protect vulnerable populations and ensure the limited and appropriate use of VAD;
 - a. Safeguards should include instituting a reporting regime to monitor the use of VAD;
 - b. Safeguards should strike the right balance between adequate protection of vulnerable populations and regulatory burden, as to not prolong the patient's suffering and hence defeat the intended purpose of regulated VAD.
3. Medical professionals should be able to enforce their right to conscientious objection in regards to VAD and should not be subject to judgement from within or outside of the health profession for any views they might hold;
 - a. By this token, legislation should ensure that no individual, group or organisation shall be discriminated against due to legal participation or non-participation in the assisted or supported death of a sufferer;
 - b. Any conscientious objection should not jeopardise patient autonomy, or limit patient access to legal and appropriate health care services that they are seeking;
 - i. To ensure equal access, all practitioners who refuse to provide a VAD service to a patient, need to provide an effective referral, including a verbal handover as well as a written referral, to a secondary doctor that is willing to facilitate the VAD service.
4. Actively involving medical professionals (including palliative care specialists) in the design and adoption of any VAD legislation.
5. Maintaining high quality, accessible palliative care services as an essential component of end of life care;
 - a. VAD should not replace or be a substitute for high quality palliative care;
 - b. Efforts should be made to ensure that any VAD legislation should not alienate people from palliative care service.
6. Based on issues faced in the US, ensure prevention of the abuse of de-facto judicial law with transparent regulation.

Policy

AMSA calls upon:

1. Australian federal and state governments to:
 - a. Ensure that appropriate safeguards are able to be implemented before any legislation on VAD is proposed;
 - b. Ensure any VAD legislation is evidence-based, taking into account data and perspectives from overseas jurisdictions where this is legal;
 - c. Protect potentially vulnerable people, through a series of rigorous safeguards, so that any access to VAD is strictly limited to the intended population only;
 - d. Consult and engage potentially vulnerable people (including, but not limited to, people with disabilities, elderly people, people with mental health problems and disadvantaged populations), so that policy adequately addresses the needs and concerns of those it impacts;
 - e. Measure and monitor any use of VAD programs, including providing statistics to the greater public while ensuring due process is adhered to;
 - f. Ensure funding to palliative care services is prioritised in conjunction with legislation for VAD;
 - g. Ensure that the views of the general public remain central to the VAD debate and any relevant legislation;
 - h. Actively involve medical professionals (including palliative care specialists) in the design and adoption of any VAD legislation;
 - i. Continue to obtain up-to-date information on the views of both medical professionals and the wider public on this issue;
 - j. Ensure medical professionals' right to conscientiously object to provide VAD to patients is upheld, as long as access is not unjustly compromised.
2. Medical professionals to:
 - a. First and foremost, abide completely and entirely by state or federal legislation, and the principles behind such legislation;

- b. Assist patients in their suffering or illness as part of appropriate palliative and/or end-of-life care;
 - c. Ensure patients are fully informed about all treatment options - curative and palliative - before being eligible for VAD;
 - d. In the event that VAD is legislated:
 - i. Reserve VAD for only cases where all other viable and acceptable treatment options have been exhausted;
 - ii. Ensure, to the best of their ability, that the true intention of patients seeking VAD are upheld in all circumstances;
 - iii. Not discriminate against patients seeking VAD, or against doctors who choose to perform (or not to perform) related services within the boundaries of the law;
 - e. Continue to engage in constructive debate both with individual patients and publicly on this topic, formally and informally.
3. Royal Australasian College of Physicians (RACP), Royal Australian College of General Practitioners (RACGP), and other bodies involved in the training of professionals involved in end-of-life care to:
- a. Continue to provide high quality training and support surrounding end of life care for training and member medical professionals;
 - b. Provide appropriate information on VAD legislation to physicians involved in these services;
 - c. Not discriminate against medical professionals based on their stance regarding VAD;
 - d. Provide expert opinion where appropriate to the national debate surrounding VAD and end-of-life care;
 - e. Ensure all medical students and junior doctors are exposed to all VAD legislation during their training and are made aware of their rights, obligations and choices regarding VAD.

Appendices

Appendix 1

Victoria's VAD bill and subsequent act are both quite substantial and have deliberately specific wording, and to summarise them effectively would risk miscommunicating their nuances.

Victoria's *Voluntary Assisted Dying Bill 2017* can be found here:

<https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13834-voluntary-assisted-dying-bill-2017>

Victoria's *Voluntary Assisted Dying Act 2017* can be found here:

[http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/\\$file/17-061aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$file/17-061aa%20authorised.pdf)

Appendix 2

Legislation permitting euthanasia and assisted suicide has existed in:

Netherlands since 2001 (Termination of Life on Request and Assisted Suicide Act)

- In The Netherlands, legislation mandates that assisted suicide may only be legally administered voluntarily by physicians for unbearable suffering for which there is no other reasonable solution. Under the Act, physicians require the written approval of another independent physician. Concerns of a 'slippery slope' have been raised with an increase in deaths over the last decade. Hence, safeguards must be implemented in proposed legislation to ensure that voluntary assisted dying is only permitted for terminally ill patients, similarly outlined in the Victoria's Voluntary Assisted Dying Act.

Belgium since 2002 (Belgian Act on Euthanasia; Act amending the Belgian Act on Euthanasia)

- In Belgium, we have a country which has one of the more progressive and liberal legislations enacted to legalise euthanasia in the world. The Belgium Act on Euthanasia was brought into 'power' in May 2002, where the legislation extended euthanasia to adults only, suffering from either psychiatric/physical disease of an incurable nature. In the ten years following legalisation in Belgium, the number of reported euthanasia cases increased from 0.2% to 1.7% of all deaths; and palliative

care teams were increasingly consulted about euthanasia requests. However, international debate became more prominent on Belgium euthanasia law with its controversial amendment in 2014 to extend the legislation to include euthanasia for competent minors, effectively abandoning the age criterion. As such, the current legislation extends euthanasia to include both adult patients and competent minors as assessed on a case by case basis and by a secondary psychiatric or specialist physician.

Canada since June 2016

- In Canada, it had been previously illegal for physicians to assist or carry out euthanasia under the federal *Criminal Code*. However, in 2014 Quebec was the first province to pass legislation to legalise voluntary assisted death for patients at the end of life. Closely following that, in February 2015, in the case of *Carter*, the Supreme Court of Canada struck down the criminal prohibition of assisted suicide found in the federal *Criminal Code* on the grounds that it infringes the rights of competent adults. In the following year, the Parliament of Canada enacted an amendment to permit medical assistance in dying, which became legal as of June 2016. This legislation bears great similarity to the Voluntary Assisted Dying Act 2017 in Victoria, in that it permits medically assisted dying for Canadian citizens with a grievous and irremediable medical condition causing enduring and intolerable suffering who consent to an assisted death. It stipulates that minors and mentally ill patients are barred from accessing assisted dying as well as advanced directives not being allowed. For the more nuanced issues pertaining the legislation, such as advanced directives and conscientious objection, each state has guidelines and court rulings that have set a precedence for future decisions/actions.

USA

- **Oregon in 1994** passed The Death with Dignity Act, becoming the first US state to do so. Since then, assisted dying practices have been founded on Oregon's legislation. Specifically, a 2010 review of standardised reporting allowed for the collection of information regarding the circumstances of death using prescribed drugs. In March 2018, Oregon's House Bill 4135 passed to establish a Advance Directive Adoption Committee to allow for an advanced directive form to be used in Oregon.
- **Vermont since 2013** (the Patient Choice and Control at the End of Life Act). Under this law, competent adults who have been diagnosed with a terminal illness, and who are reasonably expected to die within six months, may request a prescription for a lethal substance from a physician.
- The End of Life Option Act, which was passed in **California on October 2015** in an extraordinary session called by the Governor, is very closely modelled on Oregon's Death with Dignity Act, and would allow physician-assisted suicide for terminally ill California residents over the age of 18, who have the capacity to make medical decisions. The Act also creates a felony offence of pressuring someone to make a request, or forging a request. The Act is due to come into force on 1 January 2016 and will expire after ten years unless extended. It is subject, however, to potential legal challenge through an attempt to petition for a ballot referendum.
- **Washington since 2008** (also known as the Death with Dignity Act) PAD

Switzerland

The law in **Switzerland** is unique in that whilst there is no specific legislation on assisted dying, assisted suicide is legal in the absence of selfish motives under s.115 of the Swiss Criminal Code. Anyone who incites or assists another to commit suicide for selfish motives will still be liable for conviction for murder.

Luxembourg since 2009 (Law on the Right to Die with Dignity).

Colombia reaffirmed a 1997 court decision to legalise assisted dying in 2015, outlining strict safeguards to protect patient vulnerability and physicians against prosecution.

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