

## Victoria (2019- )

Assisted suicide and euthanasia become legal in Victoria on 19 June 2019 when the [Voluntary Assisted Dying Act 2017](#),<sup>1</sup> which [passed the Legislative Council on 22 November 2017](#) by just two votes (22-18) came into full operation.<sup>2</sup>

[Regulations](#) were gazetted in September 2018.<sup>3</sup>

### *Eligibility criteria*

The core eligibility criterion is set out in Section 9 (1) (d) of the Act:

*the person must be diagnosed with a disease, illness or medical condition that—*

- (i) is incurable; and*
- (ii) is advanced, progressive and will cause death; and*
- (iii) is expected to cause death within weeks or months, not exceeding 6 months; and*
- (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.*

The first three elements of this criterion are to be assessed by two doctors, one of whom is required to “*relevant expertise and experience in the person's disease, illness or medical condition*”, the nature of such expertise and experience to be stated on Form 1 or Form 2 as set out in Schedule 1 of the Act.

None of the terms used in this provision are further defined in the Act nor is any guidance given in the Regulations as to how they are to be assessed.

During debate on the Bill it became clear that there are uncertainties around the meaning of “*incurable*” and “*will cause death*” so that, for instance an insulin dependent diabetic who declines to take insulin may qualify under this criterion.

It was also accepted that there are [misdiagnoses](#)<sup>4</sup> and [errors in prognosis](#)<sup>5</sup> so that there will inevitably

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[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)

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[https://www.parliament.vic.gov.au/images/stories/daily-hansard/Council\\_2017/Council\\_Daily\\_Extract\\_Tuesday\\_21\\_November\\_2017\\_from\\_Book\\_20.pdf](https://www.parliament.vic.gov.au/images/stories/daily-hansard/Council_2017/Council_Daily_Extract_Tuesday_21_November_2017_from_Book_20.pdf)

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[http://www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf)

<sup>4</sup> [https://www.australiancarealliance.org.au/a\\_wrong\\_diagnosis](https://www.australiancarealliance.org.au/a_wrong_diagnosis)

<sup>5</sup> [https://www.australiancarealliance.org.au/a\\_wrong\\_prognosis\\_part\\_1](https://www.australiancarealliance.org.au/a_wrong_prognosis_part_1)

be some wrongful deaths.

It is important to note that the fourth element in the criterion relating to “suffering” is specifically NOT to be assessed by the two doctors. It is entirely subjective and therefore entirely meaningless. A person is suffering in the required sense simply if the person asserts that this is the case.

This approach applies in Canada but notable not in the Netherlands or Belgium where the objective nature of the suffering – and the incapacity to relieve it – is a matter for professional assessment by the physician, including a relevant specialist.

There is no definition of suffering and therefore nothing to exclude forms of existential suffering such as loss of autonomy, lack of capacity to enjoy former hobbies, feeling a burden on family or financial concerns to be the only suffering experienced. [There is absolutely no requirement for the person to be experiencing pain or other physical symptoms.](#)<sup>6</sup>

### **Mental illness**

Section 9 (2) of the Act provides that:

*A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the **Mental Health Act 2014**.*

The force of the word “only” is the key to understanding the limited usefulness of this provision in protecting persons with mental illness.

It does not preclude a person with a profound mental illness but who also has another “*a disease, illness or medical condition*” that meets the criterion set out in section 9 (1) (d) of the Act from accessing assisted suicide or euthanasia.

Nor does it explicitly preclude a mental illness from itself being considered to be “*a disease, illness or medical condition*” that meets the criterion set out in section 9 (1) (d) of the Act. For example, a person with anorexia who is expected to die within 6 months as a result of refusing treatment could qualify or even a person with treatment resistant suicidal ideation. It remains to be seen whether the Act will be applied in this way.

Sections 18 (1) and 27 (1) provide respectively that if the co-ordinating medical practitioner or the consulting medical practitioner:

*is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, [he or she] must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.*

It is entirely up to the assessing doctors to form their own view as to their expertise in assessing decision-making capacity. This provision is weaker than the [corresponding provision in Oregon](#) which refers to “*impaired judgement*”<sup>7</sup> rather than a lack of “*decision-making capacity*” which is defined in section 4 in purely cognitive terms, taking no account of the effects, say, of depression or demoralisation on a person judging what is truly in his or her best interests.

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<sup>6</sup> [https://www.australiancarealliance.org.au/access\\_to\\_palliative\\_care](https://www.australiancarealliance.org.au/access_to_palliative_care)

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<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf>

The evidence from Oregon shows that even with this stricter approach “[as many as 150 people with depression may have been helped to commit suicide without any such referral](#)”.<sup>8</sup>

Under section 36 of the Act the two people witnessing the signature on the written declaration must certify in writing “*that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying*”. This hardly adds any extra assurance to the process as the witnesses do not need to have any expertise or prior knowledge of the person.

There is a provision in section 68 of the Act for a person who is considered by VCAT (Victorian Civil and administrative Tribunal) to have “*a special interest in the medical treatment and care of the person*” assessed as eligible for assisted suicide or euthanasia to apply to VCAT for a review of the decision that the person has decision-making capacity.

### **Disability**

Section 9 (3) of the Act provides that “A person is not eligible for access to voluntary assisted dying only because the person has a disability, within the meaning of section 3(1) of the **Disability Act 2006**.”

Once again the key word is “*only*”.

Nothing precludes a person with a disability – physical or intellectual – from accessing assisted suicide or euthanasia provided the person meets the other eligibility criteria.

Nothing precludes the person’s disability from being considered as “*a disease, illness or medical condition*” expected to cause death within 6 months.

There are no explicit provisions to protect people with disability from discriminatory assessment under the required processes by doctors who would consider a person with a particular disability as “*better off dead*”.

People with disability [are more likely to experience undiagnosed depression](#) especially following initial acquisition of a disability or adverse developments in their physical, psychological or social condition.<sup>9</sup>

The Act explicitly provides for requests for assisted suicide or euthanasia to be made by gestures. It is not made explicit in the Act whether or not an accredited interpreter is required in this case. A [recent court case in the Netherlands](#) determined that “*hand squeezes, nods, eye blinking and crying were all sufficient signs of*” a request for euthanasia.<sup>10</sup>

### **Coercion**

The Act requires the two assessing doctors, as well as the witness to an administration request in the case of euthanasia, to certify that the person requesting assisted suicide or euthanasia is “*acting voluntarily and without coercion*”.

Assessing doctors will be required to complete training approved by the Secretary of the Department of Health on “*identifying and assessing risk factors for abuse or coercion*”.

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<sup>8</sup> [https://www.australiancarealliance.org.au/mentally\\_ill\\_at\\_risk](https://www.australiancarealliance.org.au/mentally_ill_at_risk)

<sup>9</sup> [https://www.australiancarealliance.org.au/better\\_off\\_dead](https://www.australiancarealliance.org.au/better_off_dead)

<sup>10</sup> [https://www.australiancarealliance.org.au/euthanasia\\_consent\\_by\\_gestures](https://www.australiancarealliance.org.au/euthanasia_consent_by_gestures)

This training is likely to be a simple online module and cannot guarantee that assessing doctors never miss the signs of coercion or abuse [given the well-documented evidence of failure by professionals in Australia to identify elder abuse](#).<sup>11</sup>

There is no provision for anyone to seek a review at VCAT of an assessment by the two doctors that a person is acting “*voluntarily and without coercion*” in requesting assisted suicide or euthanasia. A family member or friend who becomes aware that a person is being coerced has no formal recourse under the Act at all.

### *State issued permits*

Form 3 in the [Regulations](#) sets out what a VADSAP or “voluntary assisted dying self-administration permit” will look like.<sup>12</sup>

*“This self-administration permit in respect of Mary Brown authorises Dr John Smith for the purpose of causing Mary Brown death, to prescribe and supply the substance specified in this permit to Mary Brown that is able to be self-administered; and is of a sufficient dose to cause death”.*

The permit will be signed by the Secretary of the Department of Health and Human Services or his or her delegate.

The permit will also directly authorise Mary Brown to “*use and self-administer the substance*” specified in the permit in order to cause her death.

This is clearly not just State sanctioned suicide but – in a world first since ancient times – **State authorised suicide of a particular, named person using a specified lethal substance**.

Form 4 in the [Regulations](#) sets out what a VADPAP or “voluntary assisted dying practitioner administration permit” will look like.

*“This practitioner administration permit is issued to Dr John Smith ... this practitioner administration permit in respect of Jim Brown for the purpose of causing Jim Brown death, authorises Dr John Smith to administer the substance to Jim Brown.”*

This is **State authorised euthanasia of a named individual by a named doctor using a specified lethal substance**. It was last done in Germany in the 1940s.

The [Regulations](#) specify that the Secretary of the Department of Health and Human Services or his or her delegate will have 3 business days from receiving a VADSAP or VADPAP application form (accompanied by five other forms) to either issue the permit or refuse to do so.

All that the Secretary or his or her delegate will do is to check that two doctors have ticked the right boxes and filled in the blanks on the six forms.

None of this checking of ticked boxes can possibly guarantee that the person who the Secretary or delegate will authorise to commit suicide or to be killed by euthanasia really:

- has the [alleged condition](#);<sup>13</sup>

<sup>11</sup> [https://www.australiancarealliance.org.au/bullying\\_or\\_coercion](https://www.australiancarealliance.org.au/bullying_or_coercion)

<sup>12</sup>

[http://www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf)

<sup>13</sup> [https://www.australiancarealliance.org.au/a\\_wrong\\_diagnosis](https://www.australiancarealliance.org.au/a_wrong_diagnosis)

- actually has only six months to live;<sup>14</sup>
- is not being coerced overtly or subtly by impatient heirs or weary caregivers;<sup>15</sup>
- is not depressed; <sup>16</sup>
- is not missing out on effective treatment; <sup>17</sup>
- is not being discriminated against due to disability;<sup>18</sup> and
- could not have had their suffering relieved with appropriate palliative care<sup>19</sup>.

### ***Assisted suicide***

The processes for assisted suicide are deeply flawed.

The “*poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person's death*” approved by the Secretary, prescribed by the doctor and issued by a pharmacist to the person will be 20 g of sodium pentobarbital.

On 5 January 2019 the Minister for Health, Martin Foley, announced that The Alfred Hospital pharmacy would be “the sole service for dispensing” the lethal poison across Victoria. “*For people too sick to travel, the pharmacy service will deliver them their medication and provide information on administration*”.<sup>20</sup>

It is not evident how this administrative announcement can prevent other pharmacists from participating in providing lethal substances under the Act.

The notion of a kind of “uber-poison” service to country Victoria - where there is a chronic shortage in ready access to palliative care medicines as needed - is particularly disturbing.

There is no requirement for any doctor or other health practitioner to be present when the poison is ingested.

In Oregon, under a similar scheme, in 2017 for two out of three (66.43%) people there was no physician or other healthcare provider known to be present at the time of ingestion. More than one in nine (11.63%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose, had seizures or other complications or regained consciousness and died subsequently from the underlying illness.<sup>21</sup>

The interval from ingestion of lethal drugs to unconsciousness was as long as four hours while the time from ingestion to death was as long as 21 hours.

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<sup>14</sup> [https://www.australiancarealliance.org.au/a\\_wrong\\_prognosis\\_part\\_2](https://www.australiancarealliance.org.au/a_wrong_prognosis_part_2)

<sup>15</sup> [https://www.australiancarealliance.org.au/bullying\\_or\\_coercion](https://www.australiancarealliance.org.au/bullying_or_coercion)

<sup>16</sup> [https://www.australiancarealliance.org.au/mentally\\_ill\\_at\\_risk](https://www.australiancarealliance.org.au/mentally_ill_at_risk)

<sup>17</sup> [https://www.australiancarealliance.org.au/unaware\\_of\\_available\\_treatment](https://www.australiancarealliance.org.au/unaware_of_available_treatment)

<sup>18</sup> [https://www.australiancarealliance.org.au/better\\_off\\_dead](https://www.australiancarealliance.org.au/better_off_dead)

<sup>19</sup> [https://www.australiancarealliance.org.au/access\\_to\\_palliative\\_care](https://www.australiancarealliance.org.au/access_to_palliative_care)

<sup>20</sup> <https://www.premier.vic.gov.au/voluntary-assisted-dying-a-step-closer/>

<sup>21</sup> [https://www.australiancarealliance.org.au/happy\\_21st\\_oregon](https://www.australiancarealliance.org.au/happy_21st_oregon)

Imagine these complications occurring for a person who is home alone when they ingest the poison.

The Act does not require any assessment of decision-making competence or absence of coercion at the time of ingestion nor does it set any time limit on the length of time between the poison being prescribed under a VADSAP and it being ingested. In [Oregon](#) the longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).

The [Regulations](#) provide the specifications for the locked box in which the Act requires the lethal poison issued under a VADSAP to be stored. It must be made of steel. It must be “*not easily penetrable*”. It must be “*lockable with a lock of sturdy construction*”.

The last two requirements are entirely subjective. What counts as “*not easily penetrable*” or as a “*lock of sturdy construction*”? Who knows? Almost any steel petty cash box could be thought to qualify.

There are no requirements for where the box containing the lethal poison is to be kept. However, section 126 of the Act does specifically exclude it from the usual protective requirements for dangerous medication in aged care services - so it may have to **be kept under grannie’s bed in her aged care room**.

Nor are there any limits on how many keys there can be to the box or on who can have a key (or the code in case of a combination lock).

And of course if there is no witness we will never know if the person really self-administered the poison or if it was administered to them by a family member or other person under duress, surreptitiously or violently.

### [Euthanasia](#)

Section 48 of the Act allows for euthanasia (practitioner administration of the poison) as an alternative to assisted suicide in the case where a single doctor certifies that he or she is satisfied that “*the person is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence*” and provides a reason for this incapacity in completing Form 8 of schedule 1 of the Act and Form 2 as set out in the [Regulations](#) .

It remains to be seen what criteria, if any, will be used by the Secretary in approving VADPAP requests. It is quite likely that any assertion of such physical incapacity by a doctor will be accepted at face value.

If so, given the overwhelming preference for euthanasia over assisted suicide in the two jurisdictions where both means of causing death are available, euthanasia could, over time, become the more prevalent method in Victoria.

Comparative statistics between jurisdictions permitting only assisted suicide and those permitting both assisted suicide and euthanasia suggest that where euthanasia is available the overall rate of deaths from assisted suicide and euthanasia is significantly higher.

How this plays out in Victoria remains to be seen.

### [Conclusion](#)

On 19 June 2019 Victoria embarked on the fifteenth in a series of experiments in legalised euthanasia or assisted suicide begun in the Northern Territory in 1996. Each of these experiments has proved to be fatally flawed resulting in wrongful deaths. There is nothing in the design of the Victorian experiment to justify any expectation of better results.