The myth of the 68 safeguards and the "safest and most conservative" law for euthanasia and assisted suicide in the world

"With 68 safeguards, the Voluntary Assisted Dying framework is the safest, and most conservative, in the world."

Andrews government media release

The factoid that Victoria's *Voluntary Assisted Dying Act 2017* has "68 safeguards" has been mindlessly echoed by a compliant mass media obviously incapable of doing basic research.

- SBS reports that "Victorian adults … who meet 68 safeguards can request their doctor's help in dying."

- ABC AM reports that the "68 safeguards" will "ensure only eligible patients can die with medical help."

- AAP managed to turn the "68 safeguards" into "68 criteria" reporting that "terminally ill Victorians who meet 68 criteria will be able to ask their doctor for access to a lethal concoction of drugs".

- 4BC opines that there are "68 strict safeguards and conditions that patients must meet before they can be given approval to access voluntary assisted dying."

Has any reporter (with the notable exception of Peta Credlin, from Sky news) bothered to track down and examined the actual list of 68 alleged safeguards?

They can be found in Appendix 3 of the Ministerial Advisory Panel on Voluntary Assisted Dying Final Report.

As can be seen form even a casual glance down the list many of the 68 alleged safeguards refer to processes which take place after a person is dead from assisted suicide or euthanasia and are clearly not (as reported by AAP) criteria that a person must meet before requesting access to a lethal substance.

Some of the items in the list involve double counting, for example, items 1-7 specify the eligibility criteria but then item 8 is "all of the eligibility criteria must be met". Items 43 and 44 tell us that reporting forms are set out in the legislation, are mandatory and from different participants and at different points in the process. Items 45-48 then specify individual reports that are required.

However, the more important observation is that none of these safeguards, or all of them taken together, can ensure that there are no wrongful deaths under the Victorian law.

There is no guarantee that there will be no deaths involving:

- a wrong diagnosis
- inaccurate prognosis
- missing out on effective treatment
- lack of access to best practice palliative care

- issues with the financial cost of treatment or care
- undiagnosed or untreated mental illness affecting decision making
- discrimination against people with disability who are seen as better off dead
- subtle or overt coercion for a range of motives including inheritance impatience and carer fatigue
- suicide contagion both under and outside the terms of the law
- involuntary deaths as doctors get used to ending lives
- painful, lingering, complicated deaths using the lethal substance
- inaccurate assessment of decision making capacity

This is the fundamental problem with all schemes for euthanasia and assisted suicide. None of the 14 schemes that have preceded the Victorian experiment have succeeded in addressing the problem of wrongful deaths.

Proponents are usually extremely reluctant to admit that anything can go wrong. However, occasionally there is a moment of candour such as when noted British neurosurgeon and champion of assisted suicide Henry Marsh said "*Even if a few grannies are bullied into committing suicide, isn't that a price worth paying so that all these other people can die with dignity?"*

Even Andrew Denton has admitted that "*there is no guarantee ever that doctors are going to be a hundred percent right*".

Eligibility criteria

Items 1-10 in the list of 68 safeguards deal with the basic eligibility criteria – that is who is legally allowed to access assisted suicide or euthanasia in Victoria.

Item 8 is redundant as it simply specified that the criteria set out in items 1-7 must be met. These items are reflected in the provisions in section 9 of the *Voluntary Assisted Dying Act 2017.*

In that section each of the criteria is expressed as mandatory by using "must": e.g. the person must be aged 18 years or more. This is fine for objective, easily established criteria such as age or the residency requirement. However, to say that a person "must have decision-making capacity" is only as effective as the mandated processes for establishing whether or not this is the case.

Notably the wording of the provision about having a "a disease, illness or medical condition" that is expected to cause death within six months (or twelve months for neurodegenerative conditions) states that the person must "be diagnosed with" not that the person actually has such a condition.

These criteria are only as effective as the processes mandated to determine them, and are subject to unavoidable rates of error in diagnosis and prognosis.

1. Voluntary

This is a criterion, not a "safeguard". It is only as useful as the means required to assess it. As explained below, these means are inadequate (e.g. procedures for verifying decision making capacity, for ensuring the person has all relevant information, and for identifying coercion are all defective.)

2. Limited to 18 years and over

A limitation not a safeguard. It doesn't safeguard adults!

3. Residency requirement

A limitation not a safeguard. It doesn't safeguard Victorians!

4. Limited to those with decision-making capacity

This is a criterion not a safeguard. It is only as useful as the means required to assess it. The mandatory training for doctors includes a whole 5 minutes on assessing decision-making capacity. It is very basic. Evidence shows that doctors are poor at accurately identifying the level of decision making capacity in terminally ill patients.

Referral for expert assessment (item 26) is optional and will depend entirely on the assessing doctors self-assessment of their capacity to assess decision-making capacity. Evidence from other jurisdictions with an optional referral provision in relation to decision-making capacity shows it is rarely used.

It is inevitable that some Victorians lacking decision-making capacity will be wrongly assessed by the two doctors as having it and may consequently die a wrongful death.

5. Must be diagnosed with condition that meets restrictive set of criteria

This is a criterion not a safeguard. The mandated processes essentially require each of the two doctors to certify that they are "satisfied that" the person has "been diagnosed with a disease, illness or medical condition" meeting the criteria. Only one of the two doctors need have any "relevant expertise and experience in the person's disease, illness or medical condition". Note that the act does not require that either doctor be a specialist, that is a fellow of the relevant specialist college, both doctors may be GPs.

There is a known error rate in diagnosis and cases of assisted suicide where it was only after an autopsy that a person was found not to have the terminal condition that was the grounds for them accessing assisted suicide.

6. End of life is clearly defined

This is a criterion not a safeguard. Prognosis is not an exact science and there will be mistakes. Apart from the two assessing doctors "being satisfied" that a person is expected to die within six months there are no procedural steps required to verify the validity of the prognosis. It is clearly anticipated that some Victorians assessed as "expected to die within six months" and provided with a lethal substance will outlive their diagnosis by months or even years as there is no plan to retrieve lethal substances even if the person is still alive and has not used it within this timeframe.

7. End of life condition combined with requirement for suffering

The suffering criterion is based solely on an assertion by the person. So clearly it is not a safeguard of any kind. Existential suffering that should be red flags "feeling like a burden" are treated as valid as forms of suffering justifying assisted suicide.

8. All of the eligibility criteria must be met

This is not an additional safeguard!!!

9. Mental illness alone does not satisfy the eligibility criteria

This is a limitation on the eligibility criterion not a safeguard. It does not exclude mental illness that may result in death within six months (e.g. anorexia or even persistent suicidal ideation), nor requests rooted in depression and demoralisation. Apart from provision for a purely optional referral to a psychiatrist (see item 4 above) there are no specific safeguards in the Act for persons with mental illness, leaving them at risk of wrongful death, especially due to undiagnosed or untreated depression which may influence their request for assisted suicide.

10. Disability alone does not satisfy the eligibility criteria

This is a limitation on the eligibility criterion not a safeguard. The Act does not exclude disability that may result in death within six months, nor requests that are influenced by discrimination against the disabled by society, family or health professionals all of whom may consider, and communicate to a person with disability, that such a person may be better off dead. The Act contains no specific safeguards for persons with disability.

Note: A total of 3 minutes and 15 seconds is included in the mandatory training for doctors on assessing the eligibility criteria!!

The request process

The next 17 items (11-27) in the list of safeguards deal with the request process.

11. Must be initiated by the person themselves

Tellingly, at the Voluntary Assisted Dying Implementation Conference in a workshop for medical practitioners they were told that while they were prohibited from initiating a discussion on assisted suicide or euthanasia it was perfectly acceptable to continue asking leading questions of a person in order to elicit an initial request. Furthermore, once an initial request, even one elicited in this way, is made there is no prohibition on the medical practitioner initiating further discussion on assisted suicide or euthanasia in subsequent meetings with the person – even if they never raise it themselves again!

12 No substitute decision makers allowed

This is a limitation not a safeguard.

12. Cannot be included as part of an advance directive

This is a limitation not a safeguard.

13. Health practitioner prohibited from raising voluntary assisted dying

This is just a repeat of number 11. See the discussion above.

14. Person must make three separate requests

There are really only two requests – a first request (section 11 of the Act) which simply involves "a clear and unambiguous request" by a person made either verbally or by gestures or other forms of

communication for "access to voluntary assisted dying". It can be made before any information is given to the person, and so, by definition, does not need to be a fully informed request.

The second request must be in the form of a written declaration section 34) and can be made only after the person has been assessed by the two doctors and given certain information.

The so-called "final request" can be made during the same appointment as the written declaration is signed! So it is somewhat precious to call it a "separate" request and imply it adds anything at all to the process. There is no specific form or content for a "final request".

15. Must have written request (section 34 of the Act)

This is an actual safeguard - as far as it goes.

16. Two independent witnesses to the request (section 35 of the Act)

One of the witnesses may be a family member and the other the spouse of that family member!! While a known beneficiary can't be a witness that person's spouse or best friend could.

Neither of the witnesses are required to have any prior knowledge of the person or to have any specified expertise or qualifications and yet they are asked to witness that "the person making the declaration appeared to freely and voluntarily sign the declaration, to have decision-making capacity in relation to voluntary assisted dying, and to understand the nature and effect of making the declaration". There are no procedures to make sure that witnesses actively consider these matters. In many cases witnesses will simply sign on request by the person or by a medical practitioner.

17. Specified time must elapse between requests

The 9 days between first and final request can be shortened to 1 day in certain circumstances. This could occur immediately after a person is first given a diagnosis with a prognosis of less than 6 months to live and therefore within the known risk period for suicide based on depression caused by the shock off such a diagnosis. There is no requirement for any lapse of time between either the first request and the written declaration or between the written declaration and the final request. The training module specifies that "It is possible to make the second request, final request and appoint the contact person at the same appointment. There is no need for separate appointments for each of these steps unless that is the patient's preference."

18. Additional time must elapse between steps of completing process

There are no other requirements in the Act or Regulations mandating time that must elapse between steps in the process other than that between first and final request (1 or 9 days) so it is not clear what this refers to.

19. Must use independent accredited interpreter (if an interpreter is required)

The Act itself only specifies that accredited interpreters are required for the written declaration or a (written) administration request. However, the mandatory training and other non-binding material implies that accredited interpreters should be used in other parts of the process that involve verbal communication or communication by gestures or other means.

20. No obligation to proceed, may withdraw at any time

This is a necessary implication of it being "voluntary" rather than an additional safeguard.

21. Eligibility and voluntariness assessed by medical practitioners

See comments above at items 4-10.

22. Must be two separate and independent assessments by medical practitioners

While the assessments must be separately conducted, there is no requirement that the second doctor be independent of the first. They could be in the same practice/health service or even spouses.

There is no preclusion of doctor shopping until two doctors that agree that a person is eligible are found. The training module specifically states "There is no limit to the number of consulting assessments that can be made."

23. Assessing medical practitioners must have high level of training/experience

*Only one has to have five years' experience, the other may be just newly registered with a college. Only one has to have "*relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed", the other doctor may never have treated anyone with that condition and know nothing whatsoever about it.

24. Assessing medical practitioners must have undertaken prescribed training

Six hours online training, mainly in procedural matters.

25. Requirement to properly inform person

There is a long list of things which the two doctors are supposed to inform a person about. However, this is not an effective safeguard as there is no enforcement mechanism other than filling out a tick a box form.

Although both doctors are supposed to inform the person of "the treatment options available to the person and the likely outcomes of that treatment" only one of the two doctors needs to have "relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed". The other may know nothing about it and so is evidently not qualified to fulfil this requirement – but can still, of course, tick the box.

Both doctors are supposed to inform the person of "palliative care options available to the person and the likely outcomes of that care" However, neither doctor is required to have any relevant expertise or up-to-date knowledge about palliative care. There is no requirement for referral for a specialist palliative care assessment. It is therefore that some people will be assessed as eligible for assisted suicide or euthanasia who could, if they were properly informed, have been effectively helped by palliative care.

26. Referral for further independent assessment if there is doubt about decision-making capacity

Purely optional. No enforcement mechanism for doctors who think they know best. See the discussion at item 4.

27. Coordinating medical practitioner must confirm in writing that they are satisfied that all of the requirements have been met

The forms are essentially a tick a box exercise and guarantee nothing.

Medication management

Items 28 to 33 deal with the lethal substance (poison).

28. Person required to appoint contact person who will return medication if unused

This is not a safeguard for the person but only against subsequent misuse of the lethal poison.

29. Medical practitioner must obtain a permit to prescribe the medication to the person

Regulations require the permit application to be turned around by bureaucrats in DHHS in 3 working days so this can only be a form checking process. It also directly involves the State in authorising suicide and killing by doctors of named individuals – a shocking world first.

30. Medication must be labelled for use, safe handling, storage and disposal

Not an additional safeguard for the person.

31. Pharmacist also required to inform the person

The pharmacist must inform the person "how to self-administer the voluntary assisted dying substance". This is of limited usefulness as the person may not take the lethal substance for weeks, months or even years and may in the meantime have diminished decision making and/or cognitive capacity.

33. Medication must be stored in a locked box

There is no penalty for breaching s61 nor is there any follow up after the locked box is delivered. Nor is there any requirement to keep the key apart from the locked box.

Administration

34. Medication must be self-administered (except in exceptional circumstances)

As there is no requirement for a witness to be present at the time of alleged self-administration this is not a safeguard and is incapable of being enforced.

35. If physical incapacity medical practitioner may administer

This is NOT a safeguard but an extension from assisted suicide to euthanasia!!

A single medical practitioner signs a form alleging that he or she is satisfied about various matters as follows

I, [co-ordinating medical practitioner's name], am satisfied that [name of person] has decision-making capacity in relation to voluntary assisted dying and that their request for access to voluntary

assisted dying is enduring. [Name of person] is physically incapable of the self-administration or digestion of an appropriate poison or a controlled substance or drug of dependence because [insert reason].”

36. Additional certification required if administered by medical practitioner

An additional form must be completed and witnessed. Note that although the administration request can be made (s 64) “verbally or by gesture or other means of communication available to the person” there is no requirement for an accredited interpreter and no provision on the relevant form for such an interpreter. There is no reference in the training module to the use of an accredited interpreter at this point in the process.

37. Witness present if medical practitioner administers

This witness can be a known beneficiary of the person. The witness need have no special qualifications or prior knowledge of the person and yet sign that “the person at the time of making the administration request appeared to have decision-making capacity in relation to voluntary assisted dying; and the person in requesting access to voluntary assisted dying appeared to be acting voluntarily and without coercion; and the person's request to access voluntary assisted dying appeared to be enduring.” None of these are things an unqualified witness could know with any certainty.

38. Health practitioner may conscientiously object to participating

Not a safeguard for the person.

39. Explicit protection for health practitioners who are present at time of person self-administering

Not a safeguard for the person

40. Explicit protection for health practitioners acting in good faith without negligence within the legislation

Not a safeguard for the person

41. Mandatory notification by any health practitioner if another health practitioner acting outside legislation

An actual safeguard but unlikely to be used

42. Voluntary notification by a member of the public of a health practitioner acting outside legislation

An actual safeguard but unlikely to be used

Mandatory reporting

The reporting requirements from item 43 to 50 simply double count earlier listed “safeguards”.

43. Reporting forms set out in legislation

This is purely administrative – not a safeguard. Forms are mostly tick a box

Double counting with 45-48

44. Reporting mandated at a range of points and from a range of participants to support accuracy

This is double counting safeguards with 45 and 46!!

45. First assessment reported

Forms are mostly tick a box

46. Second assessment reported

Forms are mostly tick a box

47. Final certification for authorisation reported

Forms are mostly tick a box

48. Additional form reported if medication administered by medical practitioner

Duplicate of 36

49. Prescription authorisation reported by DHHS

Not a safeguard

50. Dispensing of medication reported

Not a safeguard

51. Return of unused medication to pharmacist reported

Not a safeguard for the person

52. Death notification data reported by registry

Not a safeguard – just counting!

53. New offence to induce a person, through dishonesty or undue influence, to request voluntary assisted dying

The deterrent effect of the new offences will not be sufficient to protect vulnerable Victorians from being unduly influence or coerced into requesting assisted suicide.

Undue influence takes place behind closed doors. It is notoriously difficult to identify.

It would be very difficult after a person is dead from a lethal poison prescribed under the Act to prove beyond a reasonable doubt – the required standard for a criminal offence – that the initial request was the result of undue influence on the person. .

54. New offence to induce a person, through dishonesty or undue influence, to self-administer the lethal dose of medication

See under 53. Note that there is no requirement for any witness to be present at the time of alleged self-administration and that no assessment of the decision-making capacity of the person is required at the time of alleged self-administration which may have deteriorated over the days, weeks, months or even years since the permit was issued.

55. New offence to falsify records related to voluntary assisted dying

A safeguard as far as it goes.

56. New offence of failing to report on voluntary assisted dying

Not really a safeguard just procedural.

57. Existing criminal offences for the crimes of murder and aiding and abetting suicide continue to apply to those who act outside the legislation

In other words things that used to be murder and aiding and abetting suicide are no longer – hardly a safeguard!! Less of a safeguard than if they still applied in every case!!!

Oversight

58. Guiding principles included in legislation

Principles are simply "ideals" not a safeguard

59. Oversight body is an independent statutory body

This is just an administrative category. All its functions are post mortem.

60. Functions of oversight body described in legislation

All its functions are post mortem.

61. Oversight body reviews compliance

Compliance review is post mortem - checking all the boxes were checked!

62. Oversight body reviews all cases of voluntary assisted dying

This is a duplicate of 61

63. Oversight body has referral powers for breaches

Any referral is post mortem

64. Oversight body also has quality assurance and improvement functions

These may not lead to more safety but may be used to recommend streamlining procedures and expanding access

65. Oversight body has expanded multidisciplinary membership

Purely administrative

66. Oversight body reports publicly

Actual data to be reported is more limited than either Oregon or the Netheralnds.

67. Five year review of the legislation

Effectiveness will depend who is appointed to do the review and what process is used. Paucity of data (less than Oregon and the Netherlands) will not help.

68. Guidelines to be developed for supporting implementation

None of the guidelines issued add to the safeguards and in any case they are not legally binding.