Go Gentle Australia

Voluntary Assisted Dying

Frequently asked questions

Why do we need a Voluntary Assisted Dying law?

Simply, too many terminally ill Australians are dying bad deaths, denied the choice to decide when they have suffered enough at the end of life.

Since 2016, Australia has witnessed three of the most comprehensive examinations of end-of-life care ever undertaken. Though conducted independently, these cross-party parliamentary inquiries – in Victoria, Western Australia and Queensland – came to the same conclusions:

- Even the best palliative care cannot relieve all suffering for terminally ill patients;
- Doctors and nurses are delivering inadequate pain relief to dying patients for fear of breaking the law;
- Family and friends are being traumatised as they watch loved ones die agonising deaths;
- Doctors are breaking the law to assist patients suffering untreatably to die – but having to do so in secret, without consultation, oversight, or regulation;
- Elderly and terminally ill people are taking their lives, often in horrific circumstances.

All three inquiries found Australia's existing end-of-life laws to be inadequate. All recommended, by a clear majority, that Voluntary Assisted Dying be legalised as part of a broader approach to better end-of-life care including more resources for palliative care.

Is Voluntary Assisted Dying the same as Euthanasia?

The terms refer to similar, but distinct, processes. Voluntary Assisted Dying is when a terminally ill person in the final stages of their illness voluntarily self-administers lethal medication, usually in the form of a drink that is legally prescribed, in order to end their suffering. Voluntary Euthanasia is when a doctor legally administers the dose – sometimes via a cannula – at the dying person's request.

If we have good palliative care, why do we need VAD?

Australia has one of the best palliative care systems in the world. However, it is a fact that it cannot help everyone. In Palliative Care Australia's own words: "Even with optimal care, not all pain and suffering can be relieved".

Palliative Care Australia estimates the number of people beyond their help at about 4%. Others, including palliative care specialists, put that number at between 5% and 10%. The suffering of these patients and their families, as recorded in evidence to the parliamentary inquiries, can be savage. This is no criticism. It simply reflects the reality of modern medicine, which can keep us alive longer but which still has no cure for diseases like cancer and motor neurone disease. The question is: why should those whom palliative care can't help be left to suffer when we have the means to help them?

Voluntary Assisted Dying is not intended to replace palliative care. It adds one more end-of-life option alongside palliative care for doctors and their patients to explore.

What will happen to palliative care once a VAD law is passed?

The good news is that palliative care benefits from Voluntary Assisted Dying laws.

In an October 2018 report on the international experience of assisted dying laws and palliative care, Palliative Care Australia found:

> *"no evidence to suggest that the palliative care sectors were adversely impacted by the introduction of the legislation. If anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced".*

In countries such as Canada, Belgium and the Netherlands, and in the US states of Oregon and Washington, funding to palliative care services dramatically increased, and access to palliative care improved, following the introduction of assisted dying laws.

In Oregon and Washington State, the vast majority (90%) of people seeking assisted dying were also in hospice (palliative) care.

What are the conditions for accessing Voluntary Assisted Dying in Victoria?

The Victorian law, which was passed in late 2017 and came into effect in June 2019, has been described as the most conservative of its type in the world. It mandates that people can only access Voluntary Assisted Dying if they have a terminal illness that is:

- likely to cause their death within six months (or within 12 months for neurodegenerative diseases like motor neurone disease); and
- causing the person suffering that is unacceptable to them. They must have the ability to make and communicate a decision about Voluntary Assisted Dying throughout a formal three-part request process. They must also:
- be an adult 18 years or over;
- have been living in Victoria for at least 12 months; and
- be an Australian citizen or permanent resident.

What is being implemented in Western Australia?

The WA Voluntary Assisted Dying Act (2019) will come into effect sometime in mid 2021. It closely resembles the Victorian Voluntary Assisted Dying Act (2017), one of the most conservative laws of its kind anywhere in the world. It includes strict eligibility criteria and over 100 safeguards. As in Victoria, access to the process is restricted to adults who have decision-making capacity, who are in the final stages of a terminal illness, who are experiencing suffering that cannot be relieved, and who have repeatedly requested assistance to die.

However, there are several key departures from the Victorian model.

Self-administration of the lethal dose is the preferred method, but unlike in the Victorian regime, a patient could choose for a medical practitioner to administer the drug.

The WA Act also allows a medical practitioner to initiate a conversation with a patient about accessing the voluntary assisted dying option and does not require one of the assessing medical practitioners to be a specialist.

The Act is the result of more than 180 hours of parliamentary debate and extensive consultation with the community and medical, legal and cultural experts. It was informed by recommendations from a Ministerial Expert Panel, which was made up of 13 of the State's leading health professionals, health consumers, and cultural and legal experts.

This process followed the recommendations of a Joint Select Committee on End of Life Choices, which received more than 730 submissions, held 81 hearings and took evidence from more than 130 witnesses over a 12-month period (during 2017/2018). The recommendations are outlined in the report 'My Life, My Choice'.

How will vulnerable groups such as the elderly and people with disabilities be protected?

Despite claims to the contrary, independent and exhaustive reviews from Australia and overseas have shown no credible evidence that VAD laws inevitably expand in scope or lead to the abuse of vulnerable groups (the so-called 'slippery slope'). These reviews include:

- Australian palliative care physician Dr Linda Sheahan, whose 2012 Churchill Fellowship study of overseas jurisdictions concluded: **"The slippery slope in terms of risk to vulnerable groups has not been demonstrated by the data."**
- The cross-party parliamentary inquiries in Victoria and Western Australia, which found: **"no evidence of institutional corrosion or the often cited 'slippery slope'..."**
- The Victorian committee, which concluded: **"Assisted dying is currently provided in robust, transparent, accountable frameworks. The academic literature shows that the risks are guarded against, and that robust frameworks help to prevent abuse."**
- The WA Committee, which confirmed **"There is no evidence to suggest, from either Oregon or the Netherlands data, that people with disabilities are at heightened risk of assisted dying".**
- The Journal of the American Medical Association in 2016, whose conclusion stated: **"In no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or physician-assisted suicide at rates higher than those in the general population."**

  Perhaps most telling: representatives of peak elderly and disability groups in Belgium, the Netherlands and Oregon also report no abuse of their members under VAD laws.

VAD laws are designed for those at the end stage of a terminal illness whose suffering is beyond meaningful medical help. It is very hard to coerce a vulnerable person into a terminal illness they don't have. Even harder to coerce two doctors, whose work will be subject to review, to agree with them. That's why the safeguards work.

Why do I hear so many negative stories about assisted dying in Belgium and the Netherlands?

Opponents of Voluntary Assisted Dying like to manipulate official figures from Belgium and the Netherlands to paint an untrue picture of proposed assisted dying laws in Australia.

They partially quote from official reports to create an alarming, yet false, impression that there has been a sharp and sustained upward trend in the number of assisted deaths in those countries.

First, and most importantly, the assisted dying laws in Belgium and the Netherlands are fundamentally different from the laws in effect and proposed in Australia.

Unlike the Australian laws, the threshold to access the European laws is weaker – for example people do not have to be suffering from a terminal illness, only experiencing intolerable suffering. This has always been the case under those laws – there has been no expansion over time to weaken this eligibility or include more people.

For this reason, it is wrong to compare the proposed Australian laws with the laws in Belgium and the Netherlands. The European-style laws are not being proposed here and never will be. Australia's laws most closely resemble legislation in the US – it is these laws that we should look to for comparison.

Even so, when all the data from Belgium and the Netherlands are considered, the following becomes clear:

- Euthanasia deaths in Belgium and the Netherlands remain, as they have been since the inception of laws, a tiny percentage of all deaths. In the Netherlands, always around 4 per cent. In Belgium, never above 2 per cent;
- Euthanasia deaths have remained statistically tiny despite an upward trend in total deaths in both countries;
- There was actually a drop in total euthanasia deaths in 2014–15.

Importantly, **the numbers of people accessing assisted dying overseas is extremely low.** It turns out, when people have the option, few take it. Knowing they have a choice and are in control as they die is enough.

Opponents also claim that under the assisted dying laws

in Europe, there has been an increase in the number of people being assisted to die **without their consent.**

This is one of their most mendacious claims. Invariably, the statistics they quote relate to involuntary euthanasia – in other words 'palliative sedation' or 'terminal sedation' – which takes place even in jurisdictions where there are no assisted dying laws.

People should be aware of this sleight of hand and reject the tactic for what it is – blatant misrepresentation designed to sow fear and confusion.

What do Voluntary Assisted Dying laws mean for the doctor-patient relationship?

According to the AMA's code of ethics, doctors are obliged to:

> *Respect the right of a severely and terminally ill patient to receive treatment for pain and suffering, even when such treatment may shorten a patient's life.*

Some doctors object to assisted dying on the basis of the Hippocratic Oath which instructs "do no harm". Others see **leaving a dying patient to suffer as the opposite of 'do no harm'.**

The Declaration of Geneva, adopted by the World Medical Association in 1948, is considered an update of the 2400-year-old Hippocratic Oath. It requires medical professionals to consider the **autonomy and dignity** of the patient.

A Voluntary Assisted Dying law is voluntary for everyone. It respects and protects the rights of those doctors who object. Just as it protects and respects the rights of those doctors with a different ethical view.

In countries where assisted dying has existed for up to two decades, research shows **no negative impact on the doctor-patient relationship;** in fact, the exact opposite.

For example, the latest (2017) OECD report on the Netherlands notes that satisfaction with health care is high – 86% – compared to 70% across the OECD. This would hardly be the case if the public had lost confidence in – or were afraid of – the medical profession because of Voluntary Assisted Dying.

This confidence was confirmed by Australian palliative care physician Dr Linda Sheahan in her 2012 Churchill Fellowship report on assisted dying. She found no erosion of trust in doctors where assisted dying/voluntary euthanasia is legal.

In Australia, too, a majority of doctors who responded to a 2016 survey reported no fears that Voluntary Assisted Dying would damage the doctor-patient relationship – 51.6% agreed that **"euthanasia can form a legitimate part of medical care".**

In reality, with Voluntary Assisted Dying laws in place doctors do what they already do – make a careful diagnosis that a patient's condition is terminal and their suffering intolerable and go through with them their treatment options.

If the patient meets the legal requirements for assistance to die, a doctor writes them a prescription for a life-ending medication. After that, it is up to the patient whether or not they use it.

Only one person is being asked to make a life and death decision – the person who is dying.

What does support for Voluntary Assisted Dying say about our attitude to suicide?

Opponents of VAD routinely refer to assisted dying as suicide. This is wrong and dangerous. Voluntary Assisted Dying is NOT suicide. There is NO equivalence.

Suicide is an impulse, acted on in secret, in response to a problem that, with treatment, could most likely be fixed.

Voluntary Assisted Dying is a rational response from an already dying person who simply wants help to avoid the last, most distressing phase of a terminal illness.

This point was underlined by the WA Parliamentary Committee:

> *It is important not to conflate suicide with assisted dying. It is possible to distinguish temporary suicidal ideation from an enduring, considered and rational decision to end one's life in the face of unbearable suffering.*

This distinction was clearly understood by New York's chief medical examiner, Charles Hirsch, when investigating the deaths of office workers who jumped from the Twin Towers on 9/11. Faced with a terrible choice – a slow, agonising death by fire, or a quick death by jumping – many chose to jump. Seeing this as a rational choice to avoid needless suffering, Hirsch refused to classify their deaths as 'suicides'.

Also, there is no credible evidence of increased suicide rates as a result of VAD. The WA Parliamentary Inquiry's

final report found that "suggestions of suicide contagion are not supported in the evidence". Moreover, the data in European jurisdictions with assisted dying frameworks indicate that **suicide rates have either remained the same or have fallen.**

While so-called 'suicide contagion' as a result of VAD laws is a confection, suicides in Australia for those beyond the help of palliative care are very real.

What about unintended consequences?

The Voluntary Assisted Dying law in place in Victoria, and the one being implemented in Western Australia, are among the safest and most conservative in the world. All unintended consequences have been considered and protected against through strict eligibility criteria and multiple safeguards.

The biggest unintended consequence, however, is one opponents rarely talk about – and it is a result of the *absence* of Voluntary Assisted Dying laws.

Evidence to the Victorian Parliamentary Inquiry from the Coroner's Office showed that, in the absence of a Voluntary Assisted Dying law and faced with the fear of an agonising death or with unmanageable suffering, terminally ill Victorians were committing suicide at the rate of one a week.

These suicides included asphyxiation by plastic bags and carbon monoxide poisoning, gunshot wounds, overdoses and by hanging. The Victorian coroner even spoke of one 80-year-old man with brain cancer who shot himself repeatedly with a nail gun.

In Western Australia, the Parliamentary Inquiry found 10% of all suicides were by people with terminal or debilitating chronic illnesses who saw no other choice than to take their own life, often violently and alone. In South Australia, SA Police told a parliamentary inquiry that 10% of the suicides in that state were by terminally ill people.

It would be wrong to turn a blind eye to these violent deaths – all unintended consequences of the existing inadequate law – simply because of fears of hypothetical consequences that may never eventuate.

Isn't there a risk that elderly people will seek assisted dying because they don't want to be a burden?

Being elderly alone is not a sufficient reason for access to Voluntary Assisted Dying. The person must also be diagnosed with a terminal illness and be approaching death. The reasons why terminally ill people in the final stages of their illnesses choose assisted dying are numerous, and they vary according to the individual. However, the main motivation for seeking assisted dying is to be **in control of the timing of death** and for patients to be able to decide **when they have suffered enough.**

Another important motivation is to spare their family and friends the trauma of having to witness a 'bad' death.

There is no evidence from overseas that people choose VAD because they are being coerced or because they don't want to be a burden on their families.

In Oregon, for example, in surveys of terminally ill people, 'being a burden' is not the only – or even the main – motivating factor in their decision. It is just one of the many reasons people list for wanting to choose the time and manner of their death. These include loss of autonomy, loss of dignity, losing control of bodily functions, and fear of unmanageable pain.

In other words, the perfectly rational desire to avoid unnecessary suffering. And a perfectly rational response from terminally ill people to the reality that they are dying.

Australia's Voluntary Assisted Dying laws are among the safest and most conservative in the world. They explicitly guard against the risk of coercion, requiring a person requesting medical assistance to die to have a diagnosed terminal illness which is expected to cause death within six months (or twelve months for neurodegenerative diseases). They will have to have their application assessed by two independent medical professionals, and state three times their request to die, confirmed by two independent witnesses. Other strict eligibility criteria and safeguards will ensure no one is coerced into using these laws against their will.