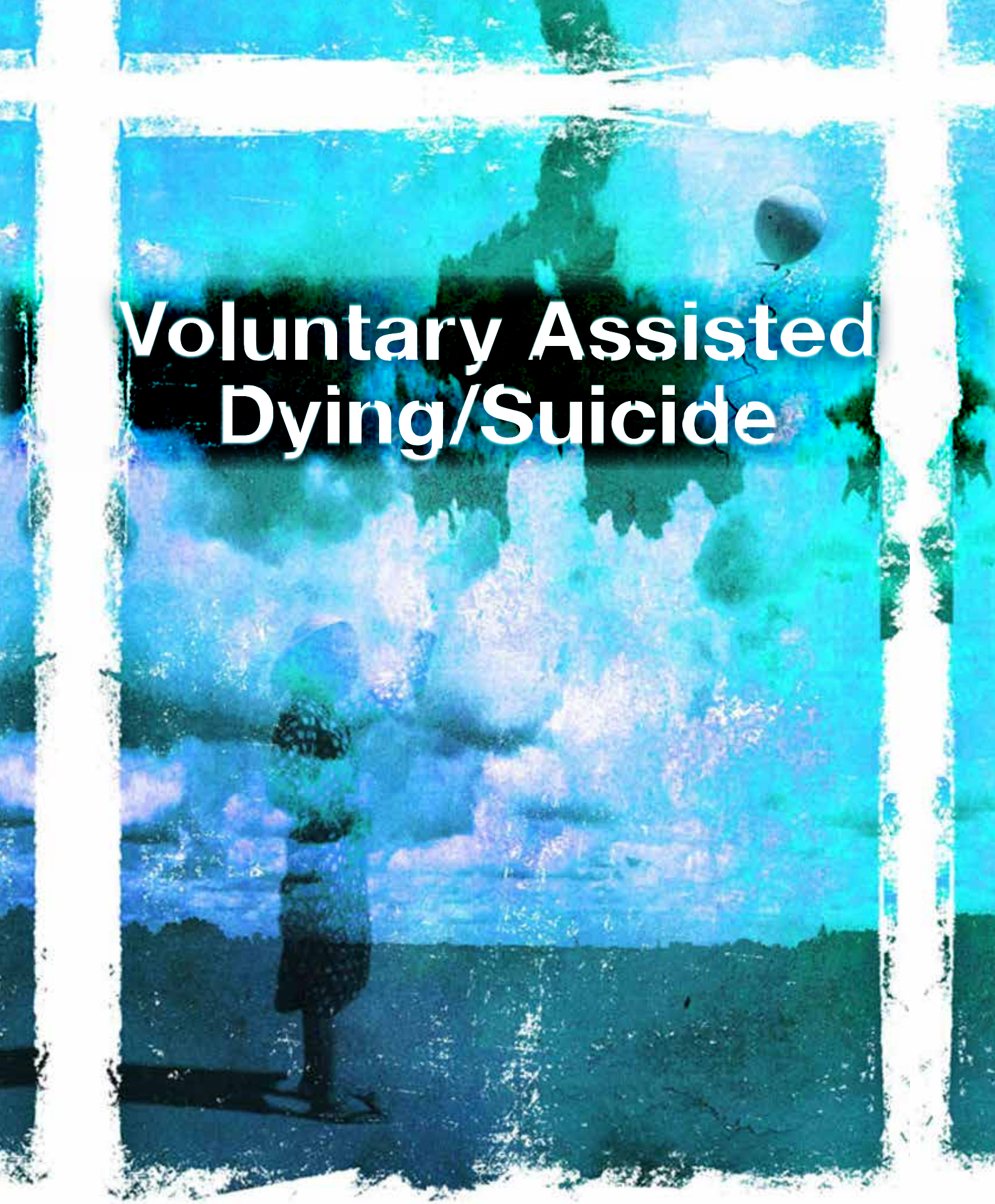

Voluntary Assisted Dying/Suicide

CONSULTATION PAPER

for Uniting Church Synod of Victoria and Tasmania
Presbyteries, Congregations and Individuals

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INTRODUCTION

Over the past 20 years there have been more than 30 bills made in state and territory parliaments to introduce legislation to allow euthanasia/assisted dying, most without success. The Northern Territory Act on euthanasia/assisted dying, the *Rights of the Terminally Ill Act* was passed on 25 May 1995, but was subsequently overturned by a federal law in March 1997.

In response to a cross-party Parliamentary Committee's findings that the current medical system does not adequately provide for the pain and suffering some people experience at the end of their life, the Victorian Government proposes to introduce legislation for voluntary assisted dying/suicide in Victoria in the second half of 2017. It is proposed that people with decision-making capacity who are experiencing unbearable pain and suffering at the end of their life be able to access medical intervention to end their lives in certain and limited circumstances.

The then Synod of Victoria had previously considered the issue of euthanasia/assisted dying/suicide in 1995 and the Synod meeting decided, "That it is not yet ready to express an opinion on whether to support or oppose legislation to provide for active euthanasia in Victoria." There was clear division in the views of church members on the issue. This consultation paper is to determine if church members have reached a new view after prayerful discernment.

The role of the Justice and International Mission Unit is to try and gauge if the Synod should take a new position. The JIM Unit is not proposing any specific position be taken. Further, the JIM Unit recognises there will be strongly held views to support or oppose laws to actively assist in dying/suicide. This paper attempts to provide an overview of the diversity of Christian responses to this issue.

The language used by those who already hold strong views differs markedly. Those who are supportive use terms such as "assisted dying" and "dying with dignity". Those opposed to such measures use language such as "euthanasia" and "suicide". Wherever possible, in sections written by the JIM Unit and not by other parties, the language of both sets of views is used in an attempt to make it clear the JIM Unit is not taking sides in the discussion and is seeking guidance from the church members.

If the Victorian Parliament passes the proposed legislation, the Synod must make decisions about how its own bodies will respond. For example, will the Synod allow people to end their lives within its facilities, such as aged care facilities? Will the Synod allow employees of Synod bodies to assist or facilitate someone ending their life under the new law?

The following details the timeline of consultation processes and reporting undertaken by the Victorian Government to date.

VICTORIAN PARLIAMENTARY INQUIRY INTO END OF LIFE CHOICES

On 7 May 2015, the Parliament of Victoria's Legislative Council agreed to the following motion:

That pursuant to Sessional Order 6 this House requires the Legal and Social Issues Committee to inquire into, consider and report, no later than 31 May 2016, on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices and, in particular, the Committee should:

(1) assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life, including the role of palliative care;

(2) review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian states and territories and overseas jurisdictions; and

(3) consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation.

In June 2016, the Legal and Social Issues Committee of the Parliament of Victoria's Legislative Council published its report on the "Inquiry into End of Life Choices". The full report and a summary booklet can be found online here:

https://www.parliament.vic.gov.au/lsic/inquiry/402

The Victorian Government response to this report was tabled in Parliament on 8 December 2016 and can be found online here:

https://www.parliament.vic.gov.au/lsic/article/3098

On 25 January 2017, following the Parliamentary Committee's Inquiry into end of life choices, the Victorian Government appointed a Ministerial Advisory Panel to develop voluntary assisted dying/suicide legislation for introduction into Parliament in 2017. This discussion paper sought feedback on the Parliamentary Committee's recommendations to help create a safe and practical voluntary assisted dying/suicide framework (not on opinions for or against assisted dying/suicide). The discussion paper was published in January 2017 and feedback was sought until Monday 10 April, 2017.

In May 2017, the Victorian Government released the *Interim report of the Ministerial Advisory Panel: Consultation overview – Voluntary Assisted Dying Bill*.

On 21 July 2017, the Victorian Government released the *Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report*.

The Discussion Paper, the Interim Report and the Final Report can all be found online here:

https://www2.health.vic.gov.au/about/health-strategies/voluntary-assisted-dying-bill

The final report sets out the Panel's recommendations for a voluntary assisted dying/suicide framework for Victoria. It follows from the Panel's interim report, released in May, which outlined the key themes that have arisen from the consultation process with stakeholders. The proposed framework provides access to voluntary assisted dying/suicide for adult Victorians who are at the end of their lives and suffering.

There are 66 recommendations put forward in the report, which address the details of how voluntary assisted dying/suicide would work in practice. The report explains the detailed considerations of the Panel in making its recommendations. The starting point for each of the discussions is the voluntary assisted dying/suicide recommendation set out by the Parliamentary Committee. The Panel considers the consultation feedback, and reviews the research, evidence and experience of other jurisdictions where this is relevant.

In terms of next steps, the Victorian Government will consider the Panel's Final Report in shaping its *Voluntary Assisted Dying Bill*. The bill is due to be introduced to Members of Parliament for a conscience vote later in 2017.

The preparation of the *Voluntary Assisted Dying Bill* (the Bill) will be supported by expert legal advice and a Ministerial Advisory Panel (the Panel) that will provide advice on the practical and clinical implications of the Bill.

If the bill passes, the Panel has recommended an 18-month period prior to commencement to allow sufficient time for establishment of the voluntary assisted dying/suicide framework.

The *Medical Treatment Planning and Decisions Act 2016* (Vic), which is due to come into operation on or before 12 March 2018 aims to simplify the existing legislative framework for medical treatment decision-making in Victoria. Among other things, the Act repeals the *Medical Treatment Act 1988* (Vic); provides for binding advance care directives; and replaces powers of attorney (medical treatment) with medical treatment decision-makers. The new laws will not affect the operation of the voluntary assisted dying/suicide framework.

SUBMISSIONS TO THIS CONSULTATION

You are invited to make submission to the Justice and International Mission Unit in response to the issues raised within this consultation paper. You are free to address the questions included in the consultation paper, but you are no way constrained to respond simply to these questions.

Submissions will be accepted up until Friday 20 October 2017 and can be sent to:

End of Life Options Submission
c/- Justice and International Mission Unit
Uniting Church Synod Centre
130 Little Collins Street
Melbourne VIC 3000
Email: jim@victas.uca.org.au

Submissions can be in any written format that you choose.

Submissions will be made public unless confidentiality is requested. The submissions will help shape the Synod's response to this important issue.

The JIM Unit is happy to visit Presbytery meetings, Congregations and/or small groups to hear people's views on the issues raised by the consultation paper. To arrange a time, please call (03) 9251 5271 or email jim@victas.uca.org.au

Questions for consideration

The following are questions that you, your faith group or your congregation might like to use to guide your discussion of this issue:

- Should the Synod take a position on the proposed laws the Victorian Government plans to introduce on voluntary assisted dying/suicide? If so, what should that position be?
- If the laws are passed through the Parliament, should the Synod allow people to end their lives in Synod facilities, such as aged care facilities, if such action by the person complies with the requirements of the laws?
- If the laws are passed through the Parliament, should people ultimately employed by a Synod body be permitted to assist or facilitate people using the laws to end their lives while they are employed by the Synod?

MINISTERIAL ADVISORY PANEL RECOMMENDATIONS

The final report of the Government's Ministerial Advisory Panel puts forward 66 recommendations, which address the details of how voluntary assisted dying would work in practice.

Guiding Principles

Recommendation 1
That the following principles are included in the legislation to help guide interpretation:

- Every human life has equal value.
- A person's autonomy should be respected.
- A person has the right to be supported in making properly informed decisions about their medical treatment and should be given, in a manner that they understand, information about medical treatment options, including comfort and palliative care.
- Every person approaching the end of life has the right to quality care to minimise their suffering and maximise their quality of life.
- The therapeutic relationship between a person and their health practitioner should, wherever possible, be supported and maintained.
- Open discussions about death and dying and peoples' preferences and values should be encouraged and promoted.
- Conversations about treatment and care preferences between the health practitioner, a person and their family, carers and community should be supported.
- Providing people with genuine choices must be balanced with the need to safeguard people who might be subject to abuse.
- All people, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

Part A: Eligibility Criteria

Recommendation 2
That to access voluntary assisted dying, a person must meet all of the following eligibility criteria:

- be an adult, 18 years and over; and
- be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with an incurable disease, illness or medical condition, that:
    - is advanced, progressive and will cause death; and
    - is expected to cause death within weeks or months, but not longer than 12 months; and
    - is causing suffering that cannot be relieved in a manner the person deems tolerable.

Recommendation 3
That the capacity test in the *Medical Treatment Planning and Decisions Act* is used to assess a person's decision-making capacity in relation to voluntary assisted dying.

Recommendation 4
That when an assessing medical practitioner is in doubt about whether a person has decision-making capacity in relation to voluntary assisted dying, a referral must be made to an appropriate specialist for assessment.

Eligibility Considerations

Recommendation 5
That mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does mental illness exclude a person from eligibility to access voluntary assisted dying.

Recommendation 6
That disability does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does disability exclude a person from eligibility to access voluntary assisted dying.

Part B: Request and Assessment Process

Initiating a request for voluntary assisted dying

Recommendation 7
That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Recommendation 8
That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Recommendation 9
That a request for information about voluntary assisted dying does not constitute a first request.

Recommendation 10
That the person may withdraw from the voluntary assisted dying process at any time.

When the person withdraws from the voluntary assisted dying process, they must commence the process from the beginning if they decide to make a subsequent request for voluntary assisted dying.

Receiving a request for voluntary assisted dying

Recommendation 11
That the legislation support access to voluntary assisted dying for people who are from culturally and linguistically diverse backgrounds and for people who require alternative means of communication, by allowing appropriately accredited, independent interpreters to assist them to make verbal and written requests for voluntary assisted dying.

Recommendation 12
That two medical practitioners must undertake independent assessments of a person's eligibility for voluntary assisted dying.

Recommendation 13
That the roles of the two assessing medical practitioners be clearly defined as:

- the coordinating medical practitioner; and
- the consulting medical practitioner.

Recommendation 14
That both the coordinating medical practitioner and the consulting medical practitioner must be qualified as Fellows of a College (or vocationally registered); and

- at least one of the medical practitioners must have at least five years post fellowship experience; and
- at least one of the medical practitioners must have expertise in the person's disease, illness or medical condition.

Recommendation 15
That both the coordinating medical practitioner and the consulting medical practitioner must complete specified training before undertaking an assessment of a person's eligibility for access to voluntary assisted dying.

Recommendation 16
That the specified training comprise of obligations and requirements under the legislation including:

- assessing the eligibility criteria under the legislation;
- assessing decision-making capacity in relation to voluntary assisted dying and identifying when a referral may be required; and
- assessing the voluntariness of a person's decision to request voluntary assisted dying and identifying risk factors for abuse.

Recommendation 17
That the coordinating medical practitioner or the person may request that the role of the coordinating medical practitioner for the voluntary assisted dying process be transferred to the consulting medical practitioner.

Recommendation 18
That a health practitioner may conscientiously object to participating in the provision of information, assessment of a person's eligibility, prescription, supply or administration of the lethal dose of medication for voluntary assisted dying.

Making a request for voluntary assisted dying

Recommendation 19
That the person must make three separate requests to access voluntary assisted dying: a first request, followed by a written declaration of enduring request, and then a final request.

Recommendation 20
That the formal process for requesting voluntary assisted dying proceeds for the person as follows:

- The person makes their first request to a medical practitioner.
- The person undergoes a first assessment by the coordinating medical practitioner.
- The person undergoes a second independent assessment by the consulting medical practitioner.
- The person makes a witnessed written declaration of enduring request to the coordinating medical practitioner.
- The person makes a final request to the coordinating medical practitioner.

Recommendation 21
That the coordinating medical practitioner and the consulting medical practitioner must ensure that the person is properly informed of:

- their diagnosis and prognosis;
- treatment options available to them and the likely outcomes of these treatments;
- palliative care and its likely outcomes;
- the expected outcome of taking the lethal dose of medication (that it will lead to death);
- the possible risks of taking the lethal dose of medication;

- that they are under no obligation to continue with their request for voluntary assisted dying, and that they may withdraw their request at any time; and
- any other information relevant to the person's needs.

Recommendation 22
That the coordinating medical practitioner and the consulting medical practitioner undertake independent assessments to form a view as to whether:

- the person meets the eligibility criteria;
- the person understands the information provided;
- the person is acting voluntarily and without coercion; and
- the person's request is enduring.

Recommendation 23
That the final request may only be made after a period of at least 10 days has passed since the first request.

Recommendation 24
That there is an exception to the 10 day requirement when the coordinating medical practitioner believes that the person's death is likely to occur within 10 days and this is consistent with the prognosis provided by the consulting medical practitioner.

Recommendation 25
That the final request cannot be made on the same day that the second independent assessment is completed.

Recommendation 26
That a person's written declaration of enduring request must be in writing, be signed by the person, and be witnessed by two persons in the presence of the coordinating medical practitioner. The two witnesses must certify that the person appears to be voluntarily signing the declaration, to have decision-making capacity, and to understand the nature and effect of making the declaration.

Recommendation 27
That one of the witnesses to the written declaration of enduring request must not be a family member. The two witnesses must be 18 years and over and cannot be:

- a person who knows or believes that they are a beneficiary under the will of the person making the written declaration of enduring request, or a recipient, in any other way, of a financial or other material benefit resulting from the person's death; or
- an owner or operator of any health care or accommodation facility at which the person making the written declaration of enduring request is being treated or any facility in which the person resides; or
- directly involved in providing health or professional care services to the person making the written declaration of enduring request.

Recommendation 28
That the written declaration of enduring request allows the person to make a personal statement about their decision to access voluntary assisted dying.

Completing the voluntary assisted dying process

Recommendation 29
That the person appoint a contact person who will take responsibility for the return of any unused lethal medication to the dispensing pharmacist within 30 days after the person has died and act as a point of contact for the Voluntary Assisted Dying Review Board.

Recommendation 30
That, to conclude the assessment process, the coordinating medical practitioner complete a certification for authorisation to confirm in writing that they are satisfied that all of the procedural requirements have been met.

Recommendation 31
That the prescription of the lethal dose of medication requires an authorisation process.

Recommendation 32
That at the point of dispensing the lethal dose of medication, the dispensing pharmacist must:

- attach labels clearly stating the use, safe handling, storage and return of the medication; and
- provide the person with information about the administration of the medication and the likely outcome.

Recommendation 33
That the person be required to store the lethal dose of medication in a locked box.

Recommendation 34
That the legislation not preclude health practitioners from being present when a person self-administers the lethal dose of medication if this is the preference of the person.

Recommendation 35
That there be protection in the legislation for health practitioners who are present at the time a person self-administers the lethal dose of medication, including that the health practitioner is under no obligation to provide life-sustaining treatment.

Recommendation 36
That not being able to self-administer is defined as being physically unable to self-administer or digest the lethal dose of medication.

Recommendation 37
That if the person is not able to self-administer, the coordinating medical practitioner may administer the lethal dose of medication.

Recommendation 38
That, in the rare circumstance the person loses the capacity to self-administer the medication after it has been prescribed, they must return to their coordinating medical practitioner if they wish to proceed with voluntary assisted dying. After the previously prescribed medication has been returned to the pharmacist, the coordinating medical practitioner may undertake the process to administer the medication.

Recommendation 39

That, in the rare circumstance where both the coordinating and consulting medical practitioners conscientiously object to administering the lethal dose of medication, the coordinating medical practitioner can refer the person to a new consulting medical practitioner willing to administer the medication. The new consulting medical practitioner must conduct their own independent assessment, after which the coordinating medical practitioner may transfer the role of coordinating medical practitioner to them.

Recommendation 40

That, if the coordinating medical practitioner administers the lethal dose of medication, a witness who is independent of the coordinating medical practitioner must be present. The coordinating medical practitioner and the witness must certify that the person's request appears to be voluntary and enduring.

Part C: Oversight

Monitoring after death

Recommendation 41
That the death certificate of a person who has accessed voluntary assisted dying identifies the underlying disease, illness or medical condition as the cause of death.

Recommendation 42
That accessing voluntary assisted dying should not affect insurance payments or other annuities.

Recommendation 43
That the medical practitioner who certifies death must notify the Registrar of Births, Deaths and Marriages if they are aware that the person has been prescribed a lethal dose of medication or if they are aware that the person self-administered a lethal dose of medication under the voluntary assisted dying legislation.

Recommendation 44
That the Registrar of Births, Deaths and Marriages and the Voluntary Assisted Dying Review Board share information relating to voluntary assisted dying.

Recommendation 45
That a death by means of voluntary assisted dying in accordance with the legislative requirements not be considered a reportable death for the purpose of the Coroners Act.

Voluntary Assisted Dying Review Board

Recommendation 46
That a Voluntary Assisted Dying Review Board be established under statute to review every case of voluntary assisted dying and report on the operation of voluntary assisted dying in Victoria.

Recommendation 47
That the role and functions of the Voluntary Assisted Dying Review Board be:

- reviewing each case of voluntary assisted dying and each assessment for voluntary assisted dying to ensure the statutory requirements have been complied with;
- referring breaches of the statutory requirements to the appropriate authority to investigate the matter such as Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency;
- collecting information and data, setting out additional data to be reported and requesting additional information from medical practitioners or health services, for the purpose of performing its functions;
- monitoring, analysing, considering and reporting on matters relating to voluntary assisted dying,
- supporting improvement by facilitating and conducting research relating to voluntary assisted dying and maintaining and disseminating guidelines to support the operation of the legislation, in collaboration with other agencies and professional bodies and services; and
- any other functions necessary to promote good practice.

Recommendation 48
That the membership of the Voluntary Assisted Dying Review Board be appointed by the Minister for Health, and that the appointments reflect the appropriate knowledge and experience required for the Board to perform its functions.

Monitoring of voluntary assisted dying

Recommendation 49
That there is mandatory reporting by medical practitioners to the Voluntary Assisted Dying Review Board within seven days of:

- completing the first assessment (regardless of the outcome);
- completing the second independent assessment (regardless of the outcome);
- completing the certification for authorisation (which will incorporate the written declaration of enduring request and appointment of contact person forms); and
- when the lethal dose of medication is administered by a medical practitioner.

Recommendation 50
That, in order to monitor the lethal dose of medication, there is mandatory reporting within seven days to the Voluntary Assisted Dying Review Board:

- by the Department of Health and Human Services when the prescription is authorised;
- by the pharmacist when the prescription is dispensed; and
- by the pharmacist when unused lethal medication is returned by the contact person.

Recommendation 51
That reporting forms are set out in the legislation to provide certainty and transparency about the information that is collected. That these forms include a:

- first assessment report (which includes record of first request);
- second assessment report;
- written declaration of enduring request;
- appointment of contact person;
- certification for authorisation;
- dispensing pharmacist report;
- administration by medical practitioner report; and
- return of medication notification.

Recommendation 52
That the Voluntary Assisted Dying Review Board report to Parliament: every six months in the first two years after commencement, and thereafter annually.

Recommendation 53
That the voluntary assisted dying legislation be subject to review five years after commencement.

Protections and offences

Recommendation 54
That the legislation provides clear protection for health practitioners who act in good faith and without negligence to facilitate access to voluntary assisted dying under the legislation.

Recommendation 55
That a health practitioner must notify the Australian Health Practitioner Regulation Agency if they believe that another health practitioner is acting outside the legislative framework.

Recommendation 56
That any other person may notify the Australian Health Practitioner Regulation Agency if they believe that a health practitioner is acting outside the legislative framework.

Recommendation 57
That there be offences for:

- inducing a person, through dishonesty or undue influence, to request voluntary assisted dying;
- inducing a person, through dishonesty or undue influence, to self-administer the lethal dose of medication;
- falsifying records related to voluntary assisted dying; and
- administering a lethal dose of medication to a person who does not have decision-making capacity.

Part D: Implementation

Voluntary assisted dying in the context of existing care options

Recommendation 58
That the implementation of voluntary assisted dying should occur within the context of existing care available to people at the end of life, and ensure voluntary assisted dying activity is embedded into existing safety and quality processes.

Implementation planning and governance

Recommendation 59
That work to establish the Voluntary Assisted Dying Review Board begin at least 12 months before the commencement of the legislation and is supported to develop a clear work plan to meet its legislated obligations including collection requirements and processes for receiving and recording data, procedural requirements related to its review, reporting and quality functions, and protocols for engaging and sharing information with other partners (such as the Department of Health and Human Services, Safer Care Victoria, and services and providers) for quality improvement purposes.

Recommendation 60
That the Department of Health and Human Services establish and support an Implementation Taskforce to investigate and advise on the development of voluntary assisted dying. The Implementation Taskforce should have the coordinating role in overseeing and facilitating the work set out in these implementation recommendations.

Recommendation 61
That the functions proposed by the Parliamentary Committee for End of Life Care Victoria be subject to a gap analysis in relation to existing entities and their functions to determine a clear role for the proposed agency.

Implementation support

Recommendation 62
That appropriate workforce support, information, clinical and consumer guidelines, protocols, training, research and service delivery frameworks to support the operation of the legislative framework are developed in a partnership between Safer Care Victoria, the Voluntary Assisted Dying Review Board and the Department of Health and Human Services in consultation with key clinical, consumer and professional bodies and service delivery organisations.

Recommendation 63
That the Implementation Taskforce establishes a collaborative coordination process across responsible agencies to periodically review the resources and frameworks that support the operation of voluntary assisted dying.

Research

Recommendation 64
That the Implementation Taskforce provide advice to the Department of Health and Human Services on engaging with a university to undertake research on the best practice identification and development of medications for use in voluntary assisted dying.

Recommendation 65
That a collaborative research program is developed with existing research entities to identify key clinical, policy and practice issues and align research with these priorities.

Commencement

Recommendation 66
That, in order to prepare for implementation, there is an 18-month period between the passage and commencement of the voluntary assisted dying legislation.

EXISTING UNITING CHURCH SYNOD OF VICTORIA RESOLUTIONS

The relevant Synod of Victoria resolutions that have been made on this issue to date are detailed below:

1992 Re: Euthanasia, Abortion

92.5.1.1 The Synod resolved:

That the Synod Commission for Mission be requested to ensure that the issues of euthanasia and abortion are appropriately addressed, and report to Synod 1993.

1994 Re: Euthanasia, Abortion, Genetic Engineering

94.4.2.10 The Synod resolved:

(a) To request the Synod Commission for Mission to reproduce and distribute to each Presbytery and Parish in the Synod the report on Euthanasia and Abortion of the Bioethics Committee for the information of members of the Church, together with a study guide.

(b) To encourage Presbyteries and Parishes to respond to the Bioethics Committee no later than 30th June 1995.

(c) To request the Synod Commission for Mission to ensure that in the future work of the Bioethics Committee, particular attention is given to ways in which genetic engineering and genetic mapping relate to bioethics.

1995 Re: Euthanasia

95.6.9.5.2 The Synod resolved:

(a) That it is not yet ready to express an opinion on whether to support or oppose legislation to provide for active euthanasia in Victoria.

(b) To request the Commission for Mission to continue its program of research, study and debate on issues relating to euthanasia and after seeking assistance from the Committee on Doctrine and Liturgy to develop further its statement on euthanasia within a broad theological context.

(c) To inform the Victorian Government that the Synod is actively encouraging discussion on the issue of euthanasia and asks to be consulted about any proposed legislation in the future.

(d) To make strong representation to the State and Federal Ministers for Health urging:

  (i) that an increased range of quality palliative care services be made accessible and affordable to all in the community; and

  (ii) that increased resources be made available for specialist training in palliative care for health care professionals.

(e) To request the Synod Commission for Mission, in consultation with the Commission on Education for Ministry, to develop and promote further

training opportunities for specialist and lay pastoral carers, including staff of Uniting Church aged care facilities for ministry in palliative care.

(f) To request the Commission for Mission to produce and distribute information and study material on *The Medical Treatments Act 1988* with encouragement for the wider use of the provisions of the Act.

(g) To encourage members of the church to offer strong pastoral support to doctors, nurses, chaplains and others who care for terminally ill patients and their relatives and friends.

The Uniting Church Synod of Victoria and Tasmania has yet to make a definitive statement regarding voluntary assisted dying/suicide or euthanasia.

A response submitted by the Presbytery of Tasmania in 2016 considered the complexity of the issue as part of the Tasmanian *Dying with Dignity* submissions, and stated that the Church was neither for nor against the introduction of the Bill.

In addition to the Synod of Victoria resolutions, in 1996 the Synod of Queensland passed a resolution to oppose "the legislation of active voluntary euthanasia".[1]

1 Synod of Queensland resolution 96.100.

THEOLOGICAL REFLECTIONS ON THE ISSUE

In order to resource discussions among Uniting Church members, we have sought theological reflection from people who have already been involved in thinking and practice around the issues of dying, assisted suicide and euthanasia. We have attempted to ensure that a diversity of positions are represented.

A good death

Rev. Lauren Mosso

> *'We do not live to ourselves, and we do not die to ourselves. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord's. For to this end Christ died and lived again, so that he might be Lord of both the dead and the living.' Romans 14:7-9*

As a Pastoral Carer in a hospital setting, the presence and possibility of death is around us all the time. Patients and families are anxious, holding that possibility whether spoken or unspoken, even with the knowledge that the health care they are receiving is excellent.

Life-changing events happen to people in completely unexpected ways. Sometimes there is a long, slow progression of disease which still takes people by surprise when the end is near. The pain of anticipating the death of a loved one can make it very difficult for family members to discontinue medical treatment. We cannot imagine the final parting, and feel we are somehow failing our loved one if we do not continue to fight for them.

Sometimes we hear from patients that they have 'had enough.' We are often privileged to hear a 'life review' from a patient as he or she sums up what they have accomplished in their life, moving toward a sense of completion. Sometimes we hear of unresolved issues and broken relationships. Mostly we hear about love that has sustained the person in their life. It is comforting to know that the person has come to a place of acceptance that death is coming. This is a key ingredient of a good death.

Conversation about the end of life is important, and can alleviate stress and worry. Yet we are so reluctant to 'go there'. Another key ingredient is the family/carer's acceptance that death is coming. This painful realisation can be softened when medical staff give clear reasons as to why further treatment is no longer an option.

When treatment is withdrawn, care does not cease. The nursing team, whether in hospital or in community palliative care, treat the person with dignity and respect ensuring as far as possible that they do not experience pain. Gentle care and support is offered to the family, who are encouraged to be fully present with their loved one as they share in this sacred liminal time.

We are privileged to gather with families in their loved one's last days. Stories are shared, tears are shed, and deep connections of love and support strengthen the bonds that will hold them in the coming days and into the future.

Offering ministry in a hospital setting has made me aware of my own mortality. I now realise that we fool ourselves into thinking that we are in control. In fact, very little is within our control!

A compassionate response is needed when life becomes 'out of control'. We as a society need to ensure that all are cared for with dignity and respect at the end of life, and that a good death happens wherever possible. To that end we are invited to have the difficult conversation, make our wishes known through 'Advanced Care Planning,' and live each day to the full.

Whether we live or whether we die, God is with us.

Rev. Lauren Mosso is a Uniting Church Minister of the Word, currently serving as a Uniting Church Chaplain. Before that time, Lauren was the Synod's Ethical Standards Officer, based at the Centre for Theology and Ministry in Parkville.

Love is stronger than death

Rev. Gordon James Bannon

Love is born
With a dark and troubled face
When hope is dead
And in the most unlikely place
Love is born:
Love is always born. (Michael Leunig)

It may seem strange to begin this conversation by quoting a Leunig prayer about birth and love, but I believe that love should be at the centre of this conversation about assisted dying. This prayer also encapsulates for me that acts of love are sometimes fraught and difficult and painful, yet love can still be born in those spaces of darkness and hopelessness. I want to ground my argument in the teachings of Jesus who told us to live by two basic commandments. "Love the lord your God with all your heart mind and soul and to love your neighbour as yourself". These two commandments are supposed to sum up all the 'law' and the second in particular gives me a guide to moral behaviour when I relate to the issue of assisted dying.

My argument is focussed on allowing people to find a way to end their own life when faced with a painful and prolonged death. It is an argument for people to take their own lives only when it is their will and when other pathways to a peaceful and dignified death have been exhausted.

Sadly, the current law of the land and our ethics, defines this act as illegal both by the person themselves and by those assisting. This puts both the person wishing to die, and those wishing to care for them (in many cases doctors and nurses) in the position of either acting deceitfully to enable a dignified and peaceful death (and thereby becoming a criminal) or to mindlessly prolong a life of agony and distress to fulfil the law. A passive form of euthanasia is already happening in hospitals everywhere as medical practitioners find a way to surreptitiously end life by withholding medical intervention or by giving pain relief at a dosage which is likely to end life. It is wrong that these medical practitioners or relatives (or the person themselves) has to do this in a way which has them being seen as performing an immoral and illegal act. When they are helping someone die in accordance with their wishes and in a manner that brings relief to their suffering, then I believe they are acting with mercy and with love. I would go so far as to say that they are showing the love and mercy of God in such acts.

If we are to live a compassionate life, I believe that can mean not standing in the way of someone finding a way of ending their own life if they are in unbearable pain. I find myself asking, what does the parable of the Good Samaritan mean in this context? If I am travelling with someone who is facing months or years of unbearable pain and I am able to open the way for them to die and end their suffering, then I feel that it can be a loving act to enable their death. Arguably, to do nothing or to take away the sufferer's power over their own life, is (at best) to be like the priest and walk by on the other side of the road, and at worst, to be one who continues their suffering needlessly. As the parable implies, not to act, is still to act.

As far as I am aware the Bible does not explicitly forbid suicide. St Augustine used the argument that suicide was illegal because it was against the 6th commandment. (I find it interesting that very few of those who make this theological argument are pacifists.)

This is an argument still used against assisted dying, yet the sixth commandment actually forbids murder, which I would argue is quite different to either the taking of one's own life or assisting another to end their suffering.

Pope John Paul II has said that suicide or assisted dying are a rejection of God's gift of life and love. This to me implies an image of God as one who is happy to stand by and watch someone suffer horrible and long-lasting pain rather than be given the gift of a merciful and peaceful death. John Paul's very statement implies that whilst life is a gift, death is not. Yet in death we are promised a greater union with the divine and, as people of faith, we believe that death is not an end. Part of our faith is the understanding that life is a journey with God that does not have death as an absolute end, but a pathway into a different way of being with God. This does not mean that we are to seek death, but it also means that we are asked not to fear it.

Some opponents to assisted dying see euthanasia and suicide as mortal sins which have God condemning them to eternal punishment. I do not believe that suicide is a mortal sin and I do not believe that the scriptures portray a God who wants us to suffer needlessly. I do not believe in the kind of Divine being who condemns a person to eternal damnation for taking their own life, but rather see the divine as looking with mercy and love on those who suffer.

I know that the issue is not a simple one and I have sympathy for those who are concerned that any change in the law is the 'thin edge of the wedge' in regards to the value of human life. And I feel strongly that it is vital to set legal boundaries that guard as much as possible against abuses of any law that allows a person to end their own life. Nevertheless it seems wrong to stand by and let someone suffer an agonising death when we are able to alleviate their suffering and it is their will to do so. As the writer of the Song of Solomon so famously said "Love is stronger than death." No more starkly is that statement portrayed than in the agony of considering the death of someone we love, yet at times I believe that to allow death can be an act of greater love than to prolong a life of great agony.

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The Christian conscience that permits assisted death or Yes to Voluntary Assisted Death (VAD)

Rev. Kenneth Ralph

With voluntary euthanasia law reform now unstoppable in western democracies it is no surprise that it has landed on Australian shores. In the spring of 2017 it is very likely the Victorian State Parliament will approve a voluntary assisted death proposal which means Victorians will be able to access its death hastening provisions somewhere in 2019. Some will see this as an overdue day of natural justice and compassion, others as a day of shame and folly.

So how will our Uniting Church respond to the pastoral challenges presented by such a Bill? Will it, for example, refuse to conduct the funerals of terminally ill persons who do accelerate their dying? Probably not. But what about this more problematic issue: will it say yes to those clergy who have intimated that they are prepared to enter the room of the dying patient with the sacrament of the church at the same time the doctor enters it with her or his death hastening liquid or pill? And this: will it compose appropriate last-rite liturgies for those who elect to take up the provisions of the new law.

I imagine that if the ebullient and much loved Desmond Tutu, Bishop of Durham were asked about these possibilities he would likely endorse them all. He recently indicated that now he is 85 and 'closer to the departure hall than the arrival,' he has reversed his lifelong opposition to assisted death. He now believes that dying people 'should have the right to choose how and when they leave Mother Earth.' Alongside the 'wonderful palliative care that exists,' he states, dying people's choices 'should include a dignified assisted death.' Bravo say some. Bad form say others.

But Tutu has done nothing novel or extraordinary in this thing. Oodles of clergy and laypersons have endorsed the moral right of an individual to accelerate a bad dying that makes no sense to them and involves them in suffering and/or indignity that is intolerable to them. Death control, like birth control, they have argued, is entirely consistent with a Christian conscience.

Ever since the first voluntary euthanasia bill was introduced into a western democracy in the House of Lords in 1936, this movement has benefitted from Christian input. Clergy and lay became chairpersons or committee members in scores of local, voluntary euthanasia movements throughout the world. Over twenty clergy once marched in the streets of New York banners aloft in advocacy of voluntary euthanasia law reform. Some wrote significant ethical material that under-girded the world wide Right to Die ethical platform. Books by the score have flowed from the pens of Christians worldwide. Thousands of Christian have argued the case for the self-elected hastening of death in the public domain through speeches, news presentations, sermons, letters to editors, and TV appearances.

These Christian leaders have never been audacious enough to say that their view is the only one in Christendom. They speak of a diversity of viewpoints. Some also remind us that in the 1990s the Ethics committee of the UCA Synod of Victoria noted that three views existed within Christendom regarding voluntary euthanasia. When a motion was put to have it resolved that the view of the Synod be that voluntary euthanasia be condemned this was defeated.

A cluster of big themes have been held in common by those Christians who over the centuries have supported the option of voluntary assisted death

- the minimisation of non-beneficial suffering
- the right of the individual to self-determination
- a vision of an empathic, nurturing, respectful deity who wills only good for humans
- a rejection of the view that life possesses absolute value

No Christian in modern times has championed these views more than the Reverend Dr Hans Kung, for a long time one of the Roman Catholic Church's most esteemed religious thinkers. In his co-authored book *A Dignified Dying* he argued that terminally ill people have the right to determine the timing and manner of their dying. In 2014 he followed this up with a public statement that he intended to seek suicide in a Swish clinic if his medical condition continued to worsen, suffering as he then was from Parkinson's, hearing loss and osteoarthritis.

Early in his career Kung accepted the teachings of his church that God as unconditional lord and owner makes the end-time decision. But watching his brother die badly over twelve months with an inoperable tumour had a big influence on changing Kung's thinking from No to Yes on voluntary euthanasia. First he rejected the notion that all suffering is bearable or has value or purpose – if not now then in some after life. Second he came to believe that God wants human beings to be 'free responsible partners.' God not only gave humans life, Kung claims, but 'the utter right to self-determination.' The whole of life is under our responsibility, he writes and this responsibility 'applies to the last phase of our lives.' Prominent Australian philosopher, Roman Catholic layman and voluntary euthanasia supporter Max Charlesworth was of the same view. He wrote about what he called 'an autonomous death, a death I have as a moral agent, after serious reflection, determined for myself.'

I sometimes play a fantasy game in my mind that if Kung were to a time travel backwards he would have had some good chats with the Reverend Dr. Leslie Weatherhead minister of the City Temple Church in London. In 1965 he wrote that helping a person to die who was enduring 'a long, incurable, useless and intolerable painful illness' far from being 'cowardly or selfish,' was reasonable, liberating and altruistic.' Perhaps Kung might have persuaded Weatherhead to be with him in that final end of life moment at that Swiss suicide clinic, for it was Weatherhead who wrote that provided proper safeguards were drawn up he would be more than willing 'to give the patient the Holy Communion and stay with him while a doctor whose responsibility I would thus share, allowed the patients to lay down his useless body and pass in dignity and peace into the next phase of being.'

And perhaps Kung could call to his bedside another pro-euthanasia clergyman, American Dr Joseph Fletcher – who argued that death control at one end of life lies as much in the hands of humans as birth control lies at the other. Fletcher who claimed to coin the phrase 'bio-ethics', wrote numerous papers on voluntary euthanasia, spoke often at Right to Die rallies and conferences. He was not of the view that 'life as such is the highest good.' He called that the 'vitalist fallacy.' He quoted with approval the words from a submission made by a group of New York clergymen in support of euthanasia law reform: 'We believe in the sacredness of personality, but not in the worth of mere existence of length of days.' Dignity, meaning, self-awareness, control of one's own existence, inter-personal capacity, these are what give value to life, according to this way of looking at things.

Fletcher certainly would have agreed with James Gustafson, Professor of Divinity at the University of Chicago, when he wrote 'sometimes the powers that bear down

on a person can be greater than the powers that sustain them.' In his view the conscientious choice of an individual to kill themselves 'in the face of unrelievable and unbearable suffering,' may be a 'reasonable choice.' To these deaths 'one must consent,' he wrote. Gustafson has little time for those who argue that even if life is a burden we have to hold on to it as a gift from God. He claims that if God does not guarantee some good out of the afflictions or provide the conditions of possibility for a way out, then we must raise questions about the assertions that God is benevolent and beneficent.

So there we are – a brief selection from a large range of Christian writers – all promoting the right of the terminally ill person to call a halt to a distressing dying that no longer makes sense to them. For myself, a long term, active supporter of accelerated assisted death and an Ambassador to Death With Dignity Victoria (DWDV) my own view on this issue is summed up in brief by two affirmations. I am sure I have modified them from other individual's originals but I can't recall who they were. Here they are. (1) We do not have to live for as long as we can but only for as long as we choose. (2) All should be free to access assisted death, but none should be obliged to.

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Playing God with Death

Rev. Prof. Andrew Dutney

Excerpt from Dutney, Andrew (2001), "Playing God: Ethics and Faith", Harper Collins, Melbourne, Australia

How do patterns of Christian support for voluntary euthanasia, and especially the theological explanations of that support, reflect the influence of the social and historical context within which Christians seek to live out their faith?

In this discussion, then, my primary interests are twofold. First, I want to register the fact of the presence of voices in the Christian churches. It seems to me that simple honesty, as much as the integrity of the church, requires that they be recognised. Second, it particularly interests me that Christian support for voluntary euthanasia has been supported by the way modern Christians have come to think about God. Changes in society that have no obvious theological relevance can enable members of society who are Christians to think differently about God and their relationship with God. These new theological insights are non-denominational or trans-denominational and can have a significant bearing on Christian bioethical activity. This is demonstrated in the spiritually and theologically serious way in which large numbers of Christians came to support voluntary euthanasia in the twentieth century.

Christian Support for Voluntary Euthanasia

As it happens, Christians have always been active in the modern voluntary euthanasia lobby. Among the founders of the American Euthanasia Society, in 1945, were prominent Christians such as Henry Sloane Coffin, the President of Union Seminary in New York, and Harry Emerson Fosdick, the minister of the Baptist Riverside Church in New York.

Theological Support for Voluntary Euthanasia

Among the experts and authorities there is also a diversity of opinion. Catholicism has an official position of unqualified opposition to any form of euthanasia. According to the *Catechism of the Catholic Church*, "Intentional euthanasia, whatever its forms or motives, is murder. It is gravely contrary to the dignity of the human person and to the respect due to the living God, his [sic] Creator." Nonetheless there are Catholic voices expressing disagreement with that position.

The philosopher Max Charlesworth is one. He takes a position that has been characteristic of Christian supporters of voluntary euthanasia, affirming that God has created human beings to make their own decisions and to accept responsibility for themselves and their neighbours.

Hans Küng, a Catholic theologian, has taken a similar position. In his view, "God, who has given men and women freedom and responsibility for their lives, has also left to dying people the responsibility for making a conscientious decision about the manner and time of their deaths."

Similar views have been expressed by Protestant Christians. Kenneth Ralph, a Uniting Church minister, argued that, "self-determination is central to what it means to be a human being or person", and that "Christianity has always been a champion of this position.

The great German historian and liberal theologian, Adolf Harnack (1851-1930) crystallised the faith of the age at the turn of the twentieth century:

In the combination of these ideas – God the Father, Providence, the position of men [sic] as God's children, the infinite value of the human soul – the whole Gospel is expressed.

For Harnack these were inseparable ideas. The man [sic] who affirms that "the being who rules heaven and earth" is his divine Father, that he is God's child, and that they can have utter confidence in the benevolence of this divine ruler is beginning to grasp how greatly God values his individual soul. From this message, this Gospel, he can then live confidently, positively and prosperously – just as the project of nineteenth century liberalism proposed he might.

The American theologian Reinhold Niebuhr (1892-1971) belonged to a later generation. The experiences of the twentieth century – especially the Great War, the horrors of Nazism and Stalinism, and the nihilistic madness of the nuclear arms race – had given the lie to the optimism of the liberal project. Niebuhr was one of the most influential theologians of his generation. He earned particular fame for his contribution to social ethics – reinstating the doctrine of original sin and developing a model of prophetic social engagement known as "Christian realism".

Yet even as he distances himself from the discredited liberalism of the previous generation the unqualified value of the individual remains the organising principle of his thought – the heroically defiant individual, the vulnerable individuality of the citizen, the paradox the individual's freedom.

John Cobb, a Methodist theologian, has made a similar point in a more careful way. He maintains that, "Theologically, few would now accept the view that one range of actions belongs wholly to the sphere of human free will and another wholly to God. God is at work everywhere, but in a way that does not set aside the decisions of the creatures. Instead God makes such decisions possible and works in and through them." It is his contention that God does not lay exclusive claim to decisions about ending one's life. It is not a special case. In this as in all things, we may find ourselves having to be in partnership with God. We even find ourselves playing God – but just because we must. We were created for this, in Cobb's view. And the developments in biotechnology that have so suddenly increased our burden of responsibility for our own lives and destinies need not be viewed as sinister, or as corroding our relationship to the Creator. Rather they may be interpreted theologically as an opportunity to give fuller expression to the image of God within us.

Liberalism and Christian Support for Voluntary Euthanasia

It is helpful to recognise that such Christian expressions of support for voluntary euthanasia are consistently couched in the language of "liberal" theology. "Liberalism" as a social or political philosophy emphasises the value of the individual and, in particular, the rights of the individual to personal freedom and autonomy. Liberalism has been the dominant philosophy in modern western societies, and especially in Australia. "Liberal theology" describes those styles of Christian thought, which evolved in partnership with the liberal society, rather than in isolation from it (as did eastern Orthodox theology) or in resistance to it (as did Roman Catholic theology, some evangelical, and fundamentalist theologies).

The strength of liberal theology has been the way it speaks about God and the nature of human life in the same language as the surrounding (liberal) society. That is, it is a theology that makes sense to people. The members of our churches are also members of Australian society, a liberal society. It would be expected that they would tend to understand God and human life in liberal terms. And from this historico-cultural

perspective it is no surprise that a majority of them support voluntary euthanasia, nor that the theological articulation of that support uses the language of liberal theology.

But, at the same time, a weakness of liberal theology has been the way it has served the enculturation of Christianity in a (liberal) culture that many now regard as being in decline. If liberalism is failing, liberal theology is failing with it.

Post-Liberal Theology

For some decades a "post-liberal" approach to theology has been in formation. Two features of these theologies are relevant to this discussion. First, whereas liberal theology elevated the value of the individual in the doctrine of the human person, post-liberal theologies have given more emphasis to the way personhood is *relationally* constituted. That is, the "image of God" in the human person is located not so much in the exercise of autonomy (being "like" God in authority) as it is in building relationships and being-in-relationship (being "like" God in mutuality and love). This shift is related to the marked movement from the effectively monistic doctrine of God in liberal theology to explicitly trinitarian theologies in the critique of liberal theology. In Trinitarian theology, the being of God is to be found in the dynamic relations between the persons of the Trinity – the mutuality of self-giving love between the Father, Son and Holy Spirit. As the theologian Colin Gunton would have it,

> *The persons are what they are by virtue of what they give and receive from each other. As such, they constitute the being of God, for there is no being of God underlying what the persons are to and from each other. God is a being in relation, without remainder relational.*

There is no God anterior to the living relationship of the persons of the Trinity. The being of God is all the inter-personal mutuality of love. A second feature of post-liberal theologies is related to this: the recognition of the importance of *community*. "Individualism" and "libertarianism" have become pejoratives, especially where their ready acceptance by liberalism has been seen to rebound on the weakest members of society. Instead "solidarity" has become a leitmotif in the various types of post-liberal theological ethics.

It needs to be acknowledged that post-liberal theologies have tended to line up against voluntary euthanasia. But my specific purpose here is to recognise and interpret patterns of Christian *support* for voluntary euthanasia. And, with the decline of liberalism, it is important to register the fact that there is support of a post-liberal variety too.

Post-Liberal Theology in Support of Voluntary Euthanasia

For example, the Anglican theologian Duncan Reid argues from a Trinitarian position that the practice of voluntary euthanasia can be ethically legitimate for Christians. Reid draws attention to the way Trinitarian anthropology critiques the individualist models of the human person that have been characteristic of modern thinking. A Trinitarian anthropology, he says, "suggests an ethic of relationality and care rather than one of rights." So he insists,

> *We can no longer argue for euthanasia on the basis of the right of the individual to decide, nor against euthanasia on the basis of the right of biological human life to be preserved in abstraction from consideration of the personhood associated with that life and other persons connected to it.*

In addition, Reid sees Trinitarian theology as a critique of "a lordship model of God" as the one who unilaterally withholds or gives life, preserves or ends life. Rather, the Trinitarian emphasis on the inter-personal dynamic of mutuality as constitutive of the being of God – *perichoresis* to use the theological term for it – "opens up a relational view of a generous God who invites our adult and generous response and interaction." From this perspective voluntary euthanasia does not represent a usurping of the exclusive prerogative of God.

Kenneth Vaux, a Reformed theologian and ethicist, is somewhat more provocative. Vaux accepts the arguments of liberal theology in support of voluntary euthanasia, but he sees them as partial and inadequate to the fullness of the human person. Instead of reiterating arguments based on autonomy and personal freedom he is determinedly focussed on the church, the *communal* matrix of Christian life. For him, it is not just that the individual has the moral and spiritual authority to make choices about the manner of his or her death, but that church has to become the kind of community that helps its members (and others) to deal well with death and dying. So he says to local churches, "let us not only preach and teach on a regular basis about dying, death, and God's purposes through these culminating events, but let us also have planning sessions: opportunities to lay out our wishes and enlist others to safeguard those wishes against any who would override them." This will help the local church to be prepared for when any of its members is dying. The solidarity of the well and the sick can be expressed in "helping, consoling, grappling for meaning, providing meals, caring for children and guests who arrive from around the country, and just distracting to allow relief." An absence of this solidarity is a religiously and morally flawed as wresting the right to choose from a dying person.

Conclusion

In its submission to the Senate inquiry into the Euthanasia Laws Bill 1996, the Board for Social Responsibility of the NSW Synod of the Uniting Church seemed to catch journalists off balance. The Board was critical of "politicians claiming the high moral ground without commensurate moral responsibility for the human beings who are affected by their decision." It expressed its concern at the way opponents had misused the inquiry "to promote criticisms which are based on simplistic and inaccurate views of euthanasia and of the Northern Territory legislation". In the Board's view, "There is no simple right and wrong in this situation." However, such is the level of general ignorance of the diversity of Christian opinion on this and other ethical issues that the press could only deal with the Board's moderate and cautionary comments under the exaggerated headline, "Church rift emerges on euthanasia legislation." The article then opened with the extravagant claim that the Uniting Church had "attacked other Christian churches for their opposition to voluntary euthanasia".

The belief that Christians and churches are united and unambiguous in their opposition to voluntary euthanasia is false. There is in fact strong support for voluntary euthanasia among both nominal and active church members. There are also numerous Christian thinkers and theologians who have set about to show that the holding of Christian faith and doctrine is consistent with supporting voluntary euthanasia. Liberal theology has been dominant in Christian statements of support for voluntary euthanasia, identifying *autonomy and personal freedom* as integral to the "image of God" in the human person, and emphasising human partnership with God in decisions about death. More recently some post-liberal constructions of Christian faith have introduced new emphases in the patterns of Christian support for voluntary euthanasia, especially the inherent *relationality* of the human person and the *communal* nature of Christian existence.

None of this is to say that Christians *should* support particular initiatives to legalise voluntary euthanasia – only that they *may*. It is high time that church authorities and experts gave more attention and respect to the perspectives and insights of ordinary Christians, who daily test their faith against the realities of the world in which they must live and allow their faith to light a way through the world. It is not good enough that when the discussion gets serious – as did the discussion on voluntary euthanasia in Australia in the mid-nineties – they are ignored, talked over or bullied into silence.

In any case, the really interesting thing that emerges when we focus on Christian support for voluntary euthanasia is the way our understanding of God is not static but is constantly being reconsidered, revised, retrieved and renewed as the Christian community makes its journey through history within societies and civilisations. And this process which we have now seen in at work in Christian reflection on the tragic decisions that people make around abortion and euthanasia we can also see in the joyous, hopeful decisions by which people become parents.

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Euthanasia in biblical and theological perspective

Associate Professor Rosalie Hudson and Rev Ross Carter

From the doctrine of creation, we learn that God is both the origin and destiny of created human life: our beginning and our end. Made in the image of God, our worth and dignity as unique persons is a gift of grace. Hence all human life is precious in God's sight. From the doctrine of the trinity we learn that we are made for fellowship with God and with each other; we live only in relationship. From St Paul, we learn that in 'the body of Christ' (1 Cor.12) all members are equally important to the whole and that the weakest members are to be respected and loved. The New Testament teaches that questions of biological life and death have been decided through the death and resurrection of Jesus Christ.

We cannot therefore say suffering and death are of no consequence; neither can we say death is the greatest evil. The paradox for Christians is that death must ordinarily be resisted, but death must also at some point be accepted. Christians believe that ultimately our end is not in death but in God: in the raising of Jesus Christ from the dead by the power of the Holy Spirit we also are raised to new life. The strong consensus of the church over its history has been that Christians never aim at death, as an end or a means to an end, either for themselves or others.

Autonomy and dignity. Many people are concerned about autonomy and dignity, believing that euthanasia provides a choice and control over the time and manner of dying. However, vulnerable disabled and/or elderly people may be placed under pressure from relatives to request euthanasia. This may take the course of gentle persuasion or coercion towards believing this to be the preferred course of action.

Allowing some people the right to choose, places an obligation on everyone to make a choice. If euthanasia were an option, it would add to the distress and guilt of those who worry that they are too great a burden on others. At present, they are protected by the fact that euthanasia is illegal, and if this protection were removed tremendous stress could be placed on them. Is the pressure of sensing that you are a financial handicap, a worthless burden or 'having passed one's use-by date' compatible with being an autonomous individual? All frail or elderly people would be faced with the dilemma: 'should I be euthanised instead of giving all this trouble to my family or adding to the burden on the health services?' The following example illustrates the point.

> *A mother of a large family repeated, 'I wish I could go to sleep and not wake up'. She had no pain and said she was comfortable. Finally, it was discovered that she was concerned that her family had gathered, some from interstate, to be with her. The staff had believed her death to be imminent, when in fact she improved and was not actually dying. She felt that she was interrupting the busy lives of her family. When they could go home and arrangements were made for her to return to the little country hospital in her home town she was contented.*

It is essential to uncover what is underlying a request for euthanasia or assisted suicide.

Public opinion. It is claimed that public opinion surveys show that a large majority of the population support euthanasia: therefore, it should be legalised. For many

years euthanasia was regarded as necessary to prevent people from dying in pain. Opinion polls since 1946 have asked the hypothetical question, 'If a hopelessly ill patient, in great pain, with absolutely no chance of recovery asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose or not?' The poll question is not 'Do you think euthanasia should be legalised?' but 'Would you favour dying in agony or euthanasia?' Naturally, many people chose euthanasia. Pain relief is not given as an option, as the hypothetical patient's pain cannot be relieved.

The great advances in pain management since 1946 make this scenario extremely unlikely today, with new drugs and analgesic techniques being continually developed. This sort of question does a disservice to dying patients. It suggests that they might suffer great pain which could only be relieved by killing them.

Other opinion surveys have asked 'Should euthanasia be legalised?' but when respondents are self-selected readers of a newspaper the results may not reflect the opinions of the general population. Whatever the case, legislation should be based on *informed* opinion rather than *public* opinion.

Palliative care. Palliative care recognises that even when we can't *cure* we can *care*. Suffering is relieved by treating symptoms and giving support to patient and family, so that individuals are helped to live as fully as possible until they die. To 'palliate' is derived from the Latin, meaning 'to cover with a cloak'. In English, it means 'to alleviate the symptoms of a disease' or 'mitigate the suffering of it'. Palliative care is not confined to the last stage of illness. Some people recoil from the term 'palliative' in the mistaken belief that it suggests 'giving up' or 'no more treatment' or 'being left to die'. More emphasis is now being given to interventions throughout the disease process which can improve the quality of life for people whose illness is not amenable to cure, and for their families. Evidence of the benefits of palliative care earlier in the illness is becoming increasingly apparent. Benefits include improved pain control, improved symptom control, reduced anxiety, reduced hospital admissions, reduced care-giver distress, improved survival with a type of lung cancer, fewer emergency presentations, fewer days in intensive care and reduced costs. The result is better living, not just easier dying.

Made in the Image of God. From the doctrine of creation, we learn that God is both the origin and destiny of created human life: our beginning and our end. Made in the image of God, our worth and dignity as unique persons is neither earned nor self-created; it is a gift of grace. Hence all human life, whether unborn child or older adult, whether healthy or malformed, is precious and underscored by the gracious commandment, 'Thou shalt not kill' (Deut 5:17). The same creation doctrine teaches that human life is not created in or for isolation; we live only in relationship. As the Son is one with the Father, so we are one with Christ as Christ is one with us, and we are one with each other in Christ (John 17: 20-23). This claim follows from the fact that Christ takes the part of all who, like him, share the human likeness. Therefore, the issue of one person's life and death cannot be viewed in isolation from who we are as persons created in God's image. St. Paul describes the church as the 'body of Christ' (1 Cor. 12) in which the weakest members are to be respected and loved, and where all parts are equally important to the whole.

Human rights. The task of Christian theology regarding human rights is not to try to represent what thousands of experts, lawyers, legislators, and others have already accomplished. Theology's task is different. It aims to ground human rights in God's right to human beings. The question arises: How does the exercise of our human rights occur within the freedom given in Jesus Christ? Individuals and groups create many lists of human rights, and often one set of rights conflicts with the claims of

other individuals or groups. For example, an individual's claimed right to assisted suicide depends on the agreement of another individual.

Many people react against the notion that God has a right to human beings because it is heard as an imperious claim that devalues the freedom of individuals to decide for themselves the meaning and purpose of their lives. That notion suggests that God rides roughshod over human freedom. This is an appropriate response if God is conceived as all-powerful and distant, albeit kindly and compassionate, who stands over and against human beings. But if God's relationship to us is based on his gracious action for us, the claim that human rights should be grounded in God's right to human beings will be heard differently.

According to this understanding, God's right is neither imperialistic nor totalitarian. It is the claim of the Creator who gives us life which we cannot give ourselves and which is not at our disposal. We may say that God has a right to us because everyday life is a gift from beyond our own resources. God's right to us is our fortunate destiny, allowing us the freedom and the right to respond to God's abundant goodness toward us. The tragedy is that instead of accepting the freedom to welcome others into our lives we use it to close ourselves to others, especially those who need protection and love at the beginning and end of life. For this we can only repent.

Suffering. The capacity to suffer, to bear grief and misfortune, is, along with our capacity for pleasure, joy and happiness, what makes us human. Humanity cries out for the removal of suffering, especially in view of our helplessness in many situations. We may not stand idly by and watch a person suffer without intervening. The best available means of response are called for – medical, therapeutic and pastoral – to relieve unnecessary pain, together with patience and courage in the face of the suffering we cannot totally alleviate.

There are two well-known views on euthanasia which deny the transcendent, redemptive aspect of suffering. One is an indiscriminate 'pro-life' stance that arises when sanctity of life is made a self-referencing end separated from God's gift of grace. The result is to make life an inherent 'good' and biological existence to be preserved at all costs, even at the cost of profound suffering. On the other hand, 'quality of life' proponents strive to avoid all debilitating pain and suffering, believing that suffering is inherently 'bad' and must be overcome in all situations and by whatever means. Biblical faith, however, understands that suffering never removes us from the loving care and mercy of God. Thus, quality of life and sanctity of life are not opposed; in Christian terms, they are complementary.

Care for others. The challenge for Christians is how to care for people who find themselves increasingly dependent on others for their needs and who perhaps more than ever before need to retain that most valuable of all self-understandings – the dignity of personal worth. What quality of care for those who are approaching death can help them find purpose and joy in whatever span of life remains? This is a challenge for individuals and congregations alike. It may be one of the ways by which Christianity demonstrates not only the compassion of Christ, but the resilience of faith in that article of the creed which states 'I believe in the resurrection of the body'. In the face of death Christian hope is in Jesus Christ who said: 'I am the resurrection and the life; those who believe in me, though they die, yet shall they live; and whoever lives and believes in me shall never die' (John 11: 25, 26).

Associate Professor Dr. Rosalie Hudson is an Honary Senior Fellow, School of Nursing & Social Work at the University of Melbourne and Adjunct Associate Professor at Charles Sturt University. She is a consultant/educator in palliative aged care and dementia care,

Rev. Ross Carter is a Uniting Church Minister of the Word currently in placement at South Port Uniting Church Parish Mission in South Melbourne. Both Rosalie and Ross served on the Synod's Bioethics Committee for several years.

THE VIEWS OF OTHER CHURCHES

Anglican Diocese of Melbourne

In 2012, The Synod of the Anglican Diocese of Melbourne passed the following motion:

That this Synod reaffirms the resolutions of the General Synod of Australia (1995) concerning Euthanasia, namely:

- We affirm that life is a gift from God not to be taken, and is therefore not subject to matters such as freedom of individual choice
- We case doubt on whether a practice of voluntary euthanasia can be prevented from sliding into a practice of involuntary euthanasia.
- We affirm the right of patients to decline treatment but not to expect the active intervention by medical staff to end their lives.

And calls upon

(1) Members of the Victorian State legislature to vote against legislation to legalise euthanasia when such matters come before our Parliament; and

(2) Governments to further improve access to high quality palliative care to ensure that all people will be able to die with dignity.

Australian Catholic Bishops Conference

Real care, love and compassion

Compassion for the sick and suffering is something which unites us all. Many of us have accompanied friends or family as they face the fear and uncertainty of a serious illness. Our heart goes out to them and we wish only the best for them.

From time to time euthanasia or assisted suicide is proposed as the compassionate choice for people who are facing such illness. Euthanasia may be defined as intentionally bringing about death by active intervention, or by neglect of reasonable care in order to end suffering. Physician Assisted Suicide is when a person is prescribed lethal drugs with which to kill themselves, with the purpose of eliminating suffering.

We hear people saying that this would allow people to 'die with dignity' and that it is each individual's 'right' to choose the timing and manner of their death.

This view, although born of compassion, is misguided and even dangerous. Killing people is wrong, and this principle is fundamental to our law. In the very few jurisdictions overseas where euthanasia or assisted suicide have been introduced, there is already ample evidence that the system is being abused and the legislated safeguards are being ignored.

All Australians seek a compassionate response to illness and suffering. We ask you to consider the following myths and facts outlining why euthanasia, or government authorised killing, is never the best expression of compassion.

Myth 1: Euthanasia can be legislated for safely

Fact: Euthanasia and assisted suicide can never be safe. Because terminally ill people are vulnerable to powerful feelings of fear, depression, loneliness, not wanting to be a burden, and even to coercion from family members, no law can adequately protect them from succumbing to euthanasia if it is available.

Experience in other countries has shown clearly that it is impossible for government-authorised killing to be made safe. This is one of many strong reasons that the principle of prohibiting killing is so deeply embedded in our law and ethics throughout the world, recognised in international human rights documents, and basic to our common morality.

Myth 2: Dying with dignity

Fact: Our dignity is not dependent on our usefulness or health, but simply on our humanity. Our society should be judged by how well we care for the sick and vulnerable. Everyone should be loved, supported and cared for until they die. There is nothing truly dignified about being killed or assisted to suicide, even when the motive is compassion for suffering. Suicide is always a tragedy. People at a very low ebb are not helped by being told by our laws that we think they would better off dead or that we would be better off if they were dead. The community is rightly concerned about the high level of suicide in Australia and much effort is put into reducing it. To then introduce government authorised killing on request, or assisted suicide, would be to create a dangerous double standard, and promote a false idea of dignity.

Myth 3: Euthanasia is an issue of personal liberty and personal choice

Fact: Euthanasia always involves a second person and is therefore a public act with public consequences. One person assisting the death of another is a matter of significant public concern because it can lead to abuse, exploitation and erosion of care for vulnerable people. Euthanasia would forever change the nature of doctor

patient relationships, from one of a duty to care, and heal and comfort, to one where a doctor is given the power to kill or to help you kill yourself.

Myth 4: It's worked well in other places, like The Netherlands, Belgium & Oregon in the US

Fact: The overseas models are not working well. The so-called strict guidelines are failing badly, with deadly consequences. When euthanasia was introduced in Belgium in 2002 it was considered to be only for terminally ill adults, deemed to be in their right mind, with full consent given. Doctors were required to report cases of euthanasia to a nominated authority. A little over a decade later, the Belgian parliament has now legalised euthanasia for children of all ages and dementia patients. Studies show only half of euthanasia cases are reported to the authority and in a study in Flanders, 66 of 208 cases of euthanasia occurred without explicit consent. Similarly in the Netherlands, despite the supposed safeguards, the Dutch government's own statistics show that more than 300 people die each year from euthanasia without explicit consent. From its strictly controlled beginnings, euthanasia in the Netherlands has now grown to include the unconscious, disabled babies, children aged 12 and over, and people with dementia and psychiatric illnesses. In Oregon the legislation allows lethal drugs to be administered without oversight, leaving enormous scope for family pressure or elder abuse to be applied.

Myth 5: Euthanasia should be legalised because opinion polls support it

Fact: Parliaments don't legislate on opinion polls alone. Parliaments are elected to consider all the relevant arguments, to legislate in favour of the common good, to endorse responsible action and to protect the vulnerable, whose voices and concerns are often not heard in opinion polls. The devil is very much in the detail when it comes to euthanasia, and when parliaments across the world have had a chance to examine all the evidence and all the dangers, the great majority of them have voted against it, even in the face of strong opinion poll support.

Myth 6: Euthanasia is necessary to relieve pain

Fact: Good palliative care, not killing, is the answer to relieving pain for the dying. Palliative Care Australia says that good, well-resourced palliative care gives people the ability not only to live well in their illness, but to die well too, "free from pain, in the place of their choice, with people they wish to be present, and above all, with dignity". Great medical gains are being made in palliative care and many families speak of palliative care as providing very precious time with their loved one. But the fact is that palliative care is not offered to many dying people in Australia and in some places there would be no opportunity to receive it, even if a person in great pain asked for it. No one should be talking euthanasia in Australia until we have righted this wrong.

Author: Australian Catholic Bishops Conference

Public Policy Office

https://www.catholic.org.au/bishops-commission-for-pastoral-life/alternative-to-euthanasia

Baptist Union of Victoria (BUV)

The Baptist Union of Victoria have released a resource kit for consultation forums which they hope will discern what God's will for them is as a movement of churches. The forums are for any Baptist from the Victorian Baptist Church and they are especially hoping that church delegates will attend these forums, but they are open to anyone. Those who represent their Church as Delegates of the Baptist Union of Victoria, do so with a responsibility and the trust of individual congregations to represent what they have discerned God leading in each local setting.

The forum opportunities are not about individual views – but for people to come together as representatives of the different parts of the one body. Their resource kit says "we set aside this time to listen to God, to each other, and to discern Gods ways, not our own preferences. We come together to seek God's best purpose for us – together, as a movement of Baptist Churches, intent on advancing the Kingdom of God".

Each Consultation Forum will discuss issued identified through feedback from Delegates Dinners, through BUV networks, and from matters raised by churches within the BUV Office. Union Council determines each year which key issues should be addressed and discussed.

The BUV discernment process timetable includes consultations, delegates dinners and gatherings taking place from February to October, and in November and December issues for broader consultation, discussion and discernment will be determined by Union Council for the next 12 months' discernment process.

Catholic Archdiocese of Melbourne

The Catholic Archdiocese of Melbourne will be releasing its' **formal statement** following the tabling of the draft legislation into the Parliament later in 2017.

On 18 April 2017, the Archbishop of Melbourne; Bishop of Ballarat; Bishop of Sale and Bishop of Sandhurst Dioceses wrote *"A Pastoral Letter to the Catholics of Victoria"*.

That letter follows:

There is a renewed push in Victoria and in many other parts of Australia for euthanasia and assisted suicide to be legalised. Misplaced compassion leads some to call for the deliberate ending of life by the direct action of a doctor or by a doctor helping someone to suicide. This is never justified (Catechism of the Catholic Church #2277).

In this latest push the term 'assisted dying' is being used to describe both euthanasia and assisted suicide. While it is never easy to face the end of life of a loved one, we cannot support this kind of legalisation however it is described. Assistance in our time of dying is something that we should all want for ourselves and for others – however, this should not involve a lethal injection or offering a lethal dose.

As Pope Francis recently reminded us, "The predominant school of thought sometimes leads to a 'false compassion' which holds that it is … an act of dignity to perform euthanasia. Instead, the compassion of the Gospel is what accompanies us in times of need, that compassion of the Good Samaritan, who 'sees', 'has compassion', draws near and provides concrete help."

Euthanasia and assisted suicide are the opposite of care and represent the abandonment of the sick and the suffering, of older and dying persons. Instead, we encourage all people of goodwill, to respond to this new challenge with truth and compassion. We wish to affirm that our task is to protect, nurture and sustain life to the best of our ability.

We thank the Government for its recently increased commitment to palliative care. We encourage them, rather than taking the negative path towards euthanasia or assisted suicide, to continue to invest in the care and support of all Victorians in need. There is clearly much more work to be done.

Last year a Parliamentary Committee recommended Victoria move towards legalising assisted suicide and euthanasia. This was endorsed by the Government in December with a consultation currently underway to look at how such laws can be made 'safe'.

We should be clear – there is no safe way to kill people or to help them to their own suicide. For millennia, the Church and civil society has understood such actions to be morally and ethically wrong. The commandment, 'Thou shalt not kill' is both a biblical and civil dictum and should remain so for very good reason.

Since the Northern Territory's brief experiment with euthanasia in 1996, euthanasia and assisted suicide legislation have been continually rejected in state parliaments around Australia. Why? Because when parliamentarians take the time to debate the issue fully and to consider all the consequences they realise that to legalise euthanasia and assisted suicide would threaten the lives of vulnerable people.

During 2008, this issue was at the forefront of the public debate in Victoria. Since then little has changed. The proposals then, as now, would allow some people to be treated differently under the law, where their lives could be taken at their request. It would create a lower threshold of care and civil protection afforded to the sick,

suffering and vulnerable. Such a law would serve to exploit the vulnerability of those people, exposing them to further risk.

Such legislation is usually presented as being limited: only for terminal illness; only for those in the last weeks and months of life etc. However, the evidence from jurisdictions where assisted suicide and euthanasia are practiced legally show that incremental changes follow over time once the notion that some lives are not worth living becomes accepted in the community. Euthanasia for children was adopted in Belgium in 2014. Likewise, euthanasia for psychological illness is now legal in Belgium. In Holland, there is pressure to allow assisted suicide for people over the age of 70 who have simply become 'tired of life'.

We must, therefore, urge our elected representatives to resist this 'first step'.

As medical advances increasingly lead to a longer life for many people, we should view older people as a blessing for society rather than a problem. Each generation has much to teach the generation that follows it. We should therefore see care of the elderly as repayment of a debt of gratitude, as a part of a culture of love and care.

The Catholic community already does much to care through our network of hospices, hospitals, aged care facilities and other services. We call on the Catholic community and people of goodwill to continue to care for the frail, elderly, the sick and the dying, at every stage of life. We ask you to continue to journey with those who are sick and in pain, to visit them, and ensure they have appropriate care, support and pain management and most of all someone to remain close to them.

We thank those healthcare professionals and palliative care specialists, nurses, doctors, psychologists, pain management teams, pastoral carers, religious, volunteers and others who work every day to reduce pain as well as social and spiritual suffering, in positive and life-affirming ways.

We ask Victorians to continue to love and care for those who are sick and suffering rather than abandoning them to euthanasia or supporting them to suicide. Our ability to care says much about the strength of our society.

At this time we especially also want to encourage you, our sisters and brothers, to pray and to act. We commend the efforts of lay groups and associations and all people of good will who respectfully let their parliamentary representatives know of their concerns.

Please do what you can to stay informed about this issue.

If you would like to contribute to the efforts of your local parish, ask your parish priest how you can be involved. If you would like more information on this issue or would like to find out how you can contribute locally, contact the Life, Marriage and Family Office of the Melbourne Archdiocese on: lmf@cam.org.au or (03) 9287 5587.

In all our efforts, let us never cease to call on Jesus Christ and the intercession of Mary our Mother.

Yours sincerely in Christ,

Most Reverend Denis Hart DD
Archbishop of Melbourne

Most Reverend Paul Bird CSsR DD
Bishop of Ballarat

Most Reverend Patrick O'Regan DD
Bishop of Sale

Most Reverend Leslie Tomlinson DD
Bishop of Sandhurst

In addition to the pastoral letter, the Catholic Archdiocese of Melbourne has published a reflection by Dr. Caroline Ong RSM entitled *"When Life is Ending: Discussing dying, assisted suicide and euthanasia".* Dr. Ong is a Sister of Mercy, a practising general practitioner and a bioethicist.

A copy of that book can be downloaded from the Archdiocese of Melbourne's website: http://www.cam.org.au/euthanasia/Be-Informed/What-is-euthanasia

Salvation Army

The National Salvation Army Moral and Social Issues Council are currently discussing the issue of Euthanasia.

The Moral and Social Issues Council is the body that creates Positional Statements and resources to assist Salvationists in thinking through issues of social justice.

Victorian Council of Churches

At the time of writing (July 2017), the Standing Committee of the Victorian Council of Churches (VCC)* is considering making the following public statement:

Victorian Churches Condemn Lack of Consultation on Euthanasia Bill

In an extraordinary move today (26 July) a majority of the major churches in Victoria have issued a joint statement condemning the Andrews Government's euthanasia legislation.

The State Government of Victoria intends to introduce "End of Life" legislation in the spring session of Parliament and the churches, through the Victorian Council of Churches (VCC), are calling for widespread community debate and discussion. "There are far-reaching consequences of such legislation" said Bishop Peter Danaher, the outspoken President of VCC.

"We call for open and frank discussion across the whole community about all aspects of death and dying. There is a wide range of views and interpretations about end of life" he said.

Though recent Australian Bureau of Statistics data shows a decline in faith and religion, approximately 68% of Victorians still claim some form of belief. Consultation has been limited and the churches are far from confident that the views of all members of society have been heard and taken into consideration.

The churches assert that euthanasia, the deliberate talking of the life of a terminally ill person in order to bring that person's suffering to an end, should not be legalised in Victoria.

Since 1988,[2] patients in Victoria have had the right to refuse life-sustaining treatment. The churches played a constructive role in the development of that legislation and they believe they should play a similar role in preserving its integrity.

The churches understand that many Victorians want to uphold the current legislation which affirms that life should be preserved rather than destroyed and which supports the common law right of any individual to refuse medical treatment in certain circumstances.

They also assert that consistent, universally available, high quality palliative care is the gold standard for end of life management. "Dying at our place of choice with the people we choose and with the religious and cultural practices of our choice are all important factors" said Bishop Danaher. "We claim inclusivity to be a hallmark of Victoria, but this legislation threatens the cultural sensitivities of so many. We have to allow end of life to occur with maximum respect and dignity".

The churches are calling on state politicians not to pass this legislation.

** Please note, the Uniting Church Synod of Victoria and Tasmania is not a formal signatory to the above statement.*

2 By virtue of the Medical Treatment Act (1988)

The previous statement from the Victorian Council of Churches came in the form of a Joint Statement by the Heads of Churches on 17th July, 1995. That statement follows:

"At a recent meeting of the Heads of Churches in Victoria it was agreed to release a joint statement on euthanasia:

The Churches recognise that there is considerable community debate and discussion about euthanasia. The Northern Territory has responded by introducing legislation and other States have indicated that they may follow suit.

The churches welcome and encourage open and frank discussion within the community about all aspects of death and dying. They recognise that there is in Australian society a wide range of views and interpretations about euthanasia.

Euthanasia – the deliberate taking of the life of a terminally ill person in order to bring that person's suffering to an end – is illegal in Victoria. However, by virtue of the *Medical Treatment Act 1988* a patient in Victoria can refuse burdensome life-sustaining treatment provided certain conditions are met. The churches played a constructive role in the development of this legislation and should play a similar role in preserving its integrity.

While we recognise that there are others in the community who do not hold the same views as the Churches, we believe that the vast majority of Victorians agree with the current legislation which affirms that life should be preserved rather than destroyed and which upholds the common law right of any individual to refuse medical treatment in certain circumstances.

The churches affirm the following principles as they apply to euthanasia:

Life is a gift from God which must be protected by all reasonable means. It should be the primary intent of law to sustain and enhance life, not to destroy it.

Dying is a natural process, an integral part of the cycle of life and death. While we naturally cling to life, at some point death must be accepted as inevitable.

The refusal or withdrawal of drugs and of other interventions are not of themselves euthanasia. To describe them as "passive" euthanasia causes confusion in the public debate.

Optimal palliative care should be available to all people regardless of their economic or social circumstances.

Economic expediency must not become the occasion for the introduction of euthanasia.

Human beings are not separate, disconnected individuals. It is integral to a Christian understanding of creation that individual rights must be framed in relation to the common good. As a community we have the duty to care form and to enhance the life of an individual.

The measure of society's integrity is its capacity to care for the most weak and vulnerable. People should never be made to feel that they are a burden, and they have a "duty to die" and that they need to take measures to cause their own death.

The churches believe that the current *Medical Treatment Act 1988* provides a useful framework for the medical profession and the community to care for dying people with compassion and integrity whilst preserving their intrinsic rights and dignity.

Signatories:

The Most Revd Dr Keith Rayner, Anglican Archbishop of Melbourne;
the Rt Revd David Silk, Anglican Bishop of Ballarat;
the Revd Canon Alfred Austin, Administrator Anglican Diocese of Bendigo;
The Revd Dr Bill Brown, President Baptist Union of Victoria;
Mrs Pat Greig, President Churches of Christ;
the Revd Fr Tadros Sharobeam, Coptic Orthodox Church;
the Rt Revd Bishop Ezekiel, Greek Orthodox Church;
the Revd Dr David Stolz, Lutheran Church;
the Rt Rev R P Betts, Moderator Presbyterian Church of Victoria;
The Most Revd T F Little, Roman Catholic Archbishop of Melbourne;
the Most Revd R A Mulkearns, Roman Catholic Bishop of Ballarat;
the Most Revd Noel Daly, Roman Catholic Bishop of Sandhurst;
The Most Revd Jeremiah Coffey, Roman Catholic Bishop of Sale;
Commissioner John Clinch, Southern Territory Commander Salvation Army;
the Revd Dr Warren Bartlett, Moderator Uniting Church in Australia."

THE JUSTIFICATION FOR ASSISTED DYING/SUICIDE LAWS

The obvious question is why should assisted dying/suicide laws be considered at all. This section points out the reasons why such laws might be considered. One of the key reasons the Victorian Parliamentary Committee supported the introduction of voluntary assisted dying/suicide laws was due to the stories from relatives about the suffering of their loved ones at the end of life and the cases of desperate suicides committed by those who found the pain they were in unbearable. The Committee reported:[3]

> *People suffering from terminal illness and serious chronic and degenerative diseases gave evidence about the angst and frustration they feel at being unable to choose to end their irremediable pain and suffering, and to die at home surrounded by loved ones.*
>
> *Some people are choosing to stop having treatment, knowing that this will result in their imminent death.*
>
> *Others spoke to the trauma of watching seriously ill loved ones refuse food and water to expedite death and finally relieve their suffering.*
>
> *Family members, the Coroners Court of Victoria and Victoria Police gave evidence about how people experiencing an irreversible deterioration in health are taking their own lives in desperate but determined circumstances.*

The Committee also reported that:[4]

> *The Committee heard evidence from health providers that palliative care is effective in alleviating pain and suffering in the vast majority of end of life cases. For those for whom palliative care is effective, it provides comfort and support and improves the quality of life of patients and their families….*
>
> *The Committee also heard from patients, carers and health practitioners that there is a proportion of people who continue to experience irremediable pain despite receiving palliative care.*

Ann Woodger wrote to the Committee of her father who suffered motor neurone disease and decided to cease percutaneous endoscopic gastronomy feeding so he would die of starvation and dehydration:[5]

> *While the law respected his right to decide to end his life, it gave him no help to do it and insisted that he must die slowly of starvation and dehydration… Mucous solidified in the back of his throat and needed to be regularly prized out with cotton buds, causing him to gag. His mouth was dry and could only be swabbed with water… He died after 12 days.*

The Coroners Court of Victoria presented evidence to the Committee that around 50 Victorians a year are taking their own lives after experiencing am irreversible deterioration in physical health.[6] An example of such a death involved:[7]

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3 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 193.

4 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 194.

5 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 196.

6 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 197.

7 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final

A 93-year-old woman with crippling arthritis and back pain had gone into an aged care facility and smuggled a razor blade into her wallet which she then used, and she died of exsanguination with her arm dangling over the toilet bowl. Her daughter made a very compelling statement about her mother's death. The essence of it is that, from the family's point of view, if only there was a better way, that their loved ones did not have to die in such violent circumstances and alone.

Acting Commander Rod Wilson of Victoria Police described to the Committee the effect of these violent deaths on first responders:[8]

… the desperation and the will of some people to take their lives have exposed our police to fairly horrific scenes of suicide. I think that the police who attended these events, like ambulance officers and others – our police are only fairly junior and inexperienced and quite young – and I think the impact of dealing with the deceased persons at those horrific scenes, and also having to prepare inquest briefs for the coroner and taking statements from family members who are clearly desperate and frustrated with the system. I would just like to say that that does have some impact on our frontline police officers.

The Committee noted that it is currently lawful for doctors to provide treatment for pain and suffering even when such therapy may shorten a patient's life.[9] However, to put the matter beyond doubt the Committee recommended that Victoria introduce explicit legislation that medical professionals be permitted to administer pain relief which may have the unintended effect of ending a patient's life, with such legislation already in place in Queensland, Western Australia and South Australia.[10]

In addition to the examples above the following example is from a Uniting Church minister. As a Uniting Church minister, Rev Carolyn 'Caro' Field is perhaps more familiar with death than most people, having offered pastoral care to parishioners when they, or a loved one, is dying. She thinks that if society re-thinks ideas around death and dying, the arguments against assisted death would be different. People naturally fear death, so to hasten it seems unnatural.

Since caring for her mother in the last months of her life, Ms Field has reflected on what it truly means to 'die with dignity'.

"Towards the end, it would take two hours for an Endone (painkiller) to work effectively, it was doing nothing for her".

"I would sit with her on the side of her bed rubbing her back waiting for the pain to go. She would say to me 'This is so bloody cruel, why can't I just die?'

"On the wall were wedding photos of her and Dad taken back in 1957. Here was this beautiful young woman full of life and here is this shell of a woman in agony just wanting it to be over. It was just so cruel."

Opponents of assisted dying often cite improvements in palliative care and pain management as options for those facing a painful death. But as Ms Field explained, even though her mother's palliative care team was terrific, towards the end of her life her mother's body was unable to absorb medication efficiently, so she would endure hours of unbearable pain.

Report', June 2016, 198.

8 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 200.

9 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 201.

10 Victorian Legislative Council Legal and Social Issues Committee, 'Inquiry into end of life choices – Final Report', June 2016, 202.

Ms Field has little doubt that, had her mother been offered the choice to continue suffering or end her life, her final days alive would have been less traumatic. But, because the legal option wasn't available, it was something they never considered.

"Mum wouldn't do anything unless it was legally recognised or advised by a doctor".

"She would have been worried that if we'd 'accidently' given an overdose it could have had implications for me as her carer, and I could have been in trouble with the law."

Ms Field is also aware of the religious objections to assisted dying, but says her faith enables her to see the importance of ending life with dignity and self-determination.

"I'm not going to throw around a whole lot of Bible verses, I'll leave that to the scholars ... my reflection is more of my experience and my own personal journey of faith."

"Human life is sacred and God holds the key. The dice had already rolled; God had made the decision that Mum was going to die. Whether it was tomorrow or next week was immaterial in the scheme of things".

"It was interesting for me that I never once thought about praying for God to miraculously cure Mum of the cancer. I just thought 'OK she's got this cancer and it's going to kill her'. So my prayer was for a good death.

"Certainly for Mum and I both, if there had been a legal option to end her life sooner we would have both grabbed it with both hands. Because the level of suffering that she had towards the end – I'm talking the last two to three weeks – there was nothing that could be done."

OTHER JURISDICTIONS

There is much debate about what impact assisted suicide/dying would have, so an important contribution is to consider those parts of the world that have already implemented such a regime.

Assisted dying/suicide has been permitted under law in the following places:

- Netherlands
- Switzerland
- Belgium
- Luxembourg
- Canada
- Colombia
- Oregon, USA
- Washington State, USA
- Montana, USA
- Colorado, USA
- District of Colombia, USA
- Vermont, USA; and
- California, USA.

Details of these jurisdictions are given below. Overwhelmingly the experience is that the legislation in these jurisdictions appears to function as intended. However, overwhelmingly these assessments of whether the law has been complied with, are based on a self-report of the medical professional who ended the person's life or assisted in the person dying. It is unlikely a medical professional would report their own non-compliance with the law. That said, opponents of the laws are able to produce few cases that demonstrate the laws are not being complied with.

The Victorian Ministerial Advisory Panel on Voluntary Assisted Dying asserted that the "rigorous request and assessment process provide protection from abuse", asserting that the evidence from other countries is that the safeguards work to detect people who are not requesting assisted dying/suicide of their own free will.[11] The Ministerial Advisory Panel cited only one reference from 2007 to back its claim. This study examined whether particular groups were over-represented amongst those requesting assisted dying/suicide or euthanasia, including women, the uninsured, people with low educational status, low income people, physically disabled, minors, people with psychiatric illness including depression and racial or ethnic minorities.[12] The study showed these groups were not over-represented amongst those accessing assisted dying/suicide or euthanasia. However, this is not the same thing as testing if doctors are capable of assessing whether someone requesting assisted dying/suicide is really doing so freely or if they are being subject to direct or indirect pressure to do so from carers or family members. The Ministerial Advisory Panel provided no references that assessed this latter issue to back its claim that the safeguards would provide "protection from abuse". Clearly safeguards will provide

11 'Ministerial Advisory Panel on Voluntary Assisted Dying. Final Report', Victorian Department of Health and Human Services, July 2017, 88.

12 Margaret Battin, Anges van der Heide, Linda Ganzini, Gerrit van der Wal, and Bregje Onwuteaka-Philipsen, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact of patients in "vulnerable groups"', *J. Med Ethics* 33, 2007, 591 – 597.

a level of protection against abuse, but evidence of the level of protection was not provided by the Ministerial Advisory Panel.

It needs to be noted that there is a vast difference in what the laws of different governments allow in terms of assisted dying/suicide and euthanasia. Generally European jurisdictions have the most liberal laws relating to assisted dying/suicide and euthanasia with the fewest safeguards compared to US states that have introduced assisted dying/suicide laws. Belgium stands out as allowing assisted dying/euthanasia for people who are not suffering from terminal illnesses and can be applied to children and people who are unconscious. Also, Belgium authorities appear to show little interest in ensuring the safeguards in the law are complied with and it would appear the safeguards can be breached with impunity provided the person freely wishes to die, including when they do not have a terminal illness. There is no such evidence of disregard for the safeguards in US States that have allowed such laws.

European jurisdictions have generally widened the group of people who can be assisted to die or be euthanised over time, as feared by opponents of such laws. By contrast, US states have not done so.

Only the governments of Belgium and the Netherlands allow children to be assisted to die/ euthanised. Only the Swiss government allows non-residents to travel to Switzerland for the purpose of being assisted to die. North American governments require that a person have decision-making at the time they seek assisted dying/ suicide, whereas some European governments allow people to make written requests for assisted dying/suicide in advance of the time it will be carried out. The European governments of the Netherlands, Belgium and Luxembourg all require that a person be experiencing some degree of suffering to be eligible to access assisted dying/suicide or euthanasia. The US state governments of California, Oregon and Washington have a requirement that a person have a 'terminal disease'. There is no additional requirement that a person be suffering.

The laws in the Netherlands, Belgium and Luxembourg do not say anything about excluding people with mental illness from assisted dying/suicide or euthanasia. The law in the Netherlands requires that a request for assisted dying/euthanasia must be 'well-considered'. The US state governments of Oregon and Washington expressly require that an assessing medical practitioner refer a person for counselling when they are suspected to be suffering from a psychiatric or psychological disorder or depression causing impaired judgement. In Canada, a person with a mental illness may be eligible for medical assistance in dying/suicide if they meet all of the eligibility criteria.

In all jurisdictions where the laws have been introduced, the number of people using the laws to end their lives has continued to increase with no sign of the number plateauing. However, the JIM Unit has not been able to find any research that definitively explains the increasing use of the laws.

Largely the use of the laws for assisted dying/suicide and euthanasia are used by well-educated people with higher incomes. In the US states, ethnic minority groups are under-represented in those using the laws. Further, opponents of such laws have expressed concern that women will feel pressure to end their lives by use of the laws.[13] However, the experience in the US does not support this concern, with 51.6%

13 For example this was raised by the Synod of Queensland Bio-Ethics Committee in their report 'A Christian Response to Euthanasia', 1996.

of those who have taken their lives using the *Oregon Dying with Dignity Act* between 1998 and 2016 being men.[14]

Concerns exist that in all places where assisted dying/suicide is permitted and a palliative care specialist needs to be involved in the process to authorise the assisted death/suicide, raising questions of if people are really given accurate information about all the alternative options that exist.

A concern has been raised by opponents of voluntary assisted dying/assisted suicide laws that it makes suicide generally more acceptable in the community. Data from the US state of Oregon has shown a significant increase in the suicide rate amongst the general population since the introduction of the laws. In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 percent higher than the national average. [15] The rate of suicide among Oregonians has been increasing since 2000. However, the increase in suicide rate is far from uniform across the community:[16]

- Suicide rates among adolescents aged 10 through 17 years has increased since 2011 after decreasing from 1990 to 2010.
- Suicide rates among adults aged 45 to 64 years rose more than 50 percent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012; the rate increased more among females than among males.
- Suicide rates among males aged 65 years and older decreased approximately 18 percent from nearly 50 per 100,000 in 2000 to 42 per 100,000 in 2012.

Those ending their lives under the Oregon *Death with Dignity Act* are not included in the above statistics.[17]

However, the national suicide rate in the US has also been increasing since around 2000 and Oregon's suicide rate has been much higher than the US national rate since 1980, almost two decades before the *Death with Dignity Act* started to be used. [18] That said, suicides among men and women aged 35-64 increased 49% in Oregon from 1999-2010, compared to 28% nationally.[19] However, this does not prove that the introduction of the Oregon *Death with Dignity Act* has caused the higher rates of suicide in Oregon and other causes might be responsible, such as Oregon's lax gun control laws.[20] Other key factors may be lack of access to mental health services and an individualist culture that deters help seeking.[21] Further, other states in the west of the US near Oregon have higher suicide rates than Oregon, being Nevada, Idaho, Montana, Wyoming, Utah, Colorado and New Mexico.[22] Of these Colorado also has assisted dying/suicide legislation and Montana allows for assisted dying/suicide by court ruling.

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14 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 8, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

15 X. Shen and L. Millet, 'Suicides in Oregon. Trends and Associated Factors 2003-2012', Oregon Health Authority, 2015, 3.

16 X. Shen and L. Millet, 'Suicides in Oregon. Trends and Associated Factors 2003-2012', Oregon Health Authority, 2015, 3.

17 X. Shen and L. Millet, 'Suicides in Oregon. Trends and Associated Factors 2003-2012', Oregon Health Authority, 2015, 7.

18 X. Shen and L. Millet, 'Suicides in Oregon. Trends and Associated Factors 2003-2012', Oregon Health Authority, 2015, 9.

19 David Stabler, 'Why Oregon's suicide rate is among the highest in the country', The Oregonian, 15 May 2013, http://www.oregonlive.com/living/index.ssf/2013/05/why_oregons_suicide_rate_is_am.html

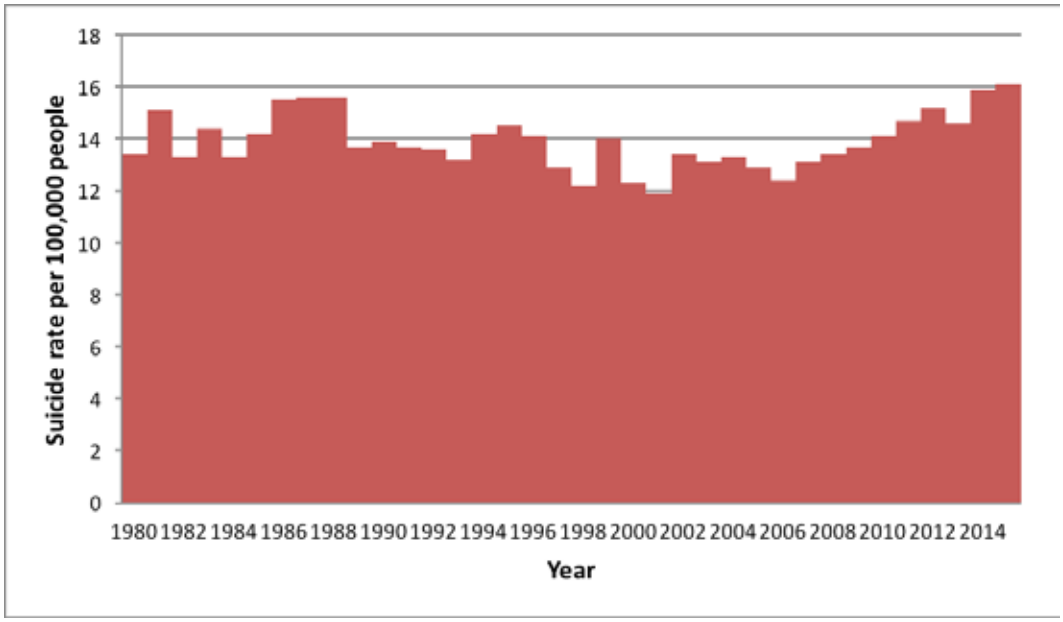
20 David Stabler, 'Why Oregon's suicide rate is among the highest in the country', The Oregonian, 15 May 2013, http://www.oregonlive.com/living/index.ssf/2013/05/why_oregons_suicide_rate_is_am.html

21 David Stabler, 'Why Oregon's suicide rate is among the highest in the country', The Oregonian, 15 May 2013, http://www.oregonlive.com/living/index.ssf/2013/05/why_oregons_suicide_rate_is_am.html

22 Centres for Disease Control and Prevention, https://wisqars.cdc.gov:8443/cdcMapFramework/

Looking at Washington State, there has been an upward trend in suicides since the introduction of the *Death with Dignity Act* in 2008, but again this does not prove that the introduction of the law caused this increase in rate.

Figure 1. Suicide rate in Washington State 1980 to 2015.[23]



Disturbingly, US States that record the motivation for the use of the laws record that around half identify the feeling of being a burden on others as a motivation for ending their lives, although this is far from the only motivation for these individuals to make use of the laws.

A small minority of people using the laws in US States that have introduced them, give the financial cost of medical treatment as a reason to make use of the laws. However, differences between the Australian healthcare system and the US healthcare system need to be considered before drawing any conclusion that a similar outcome would occur in Victoria.

The JIM Unit has been unable to establish if the introduction of assisted dying/suicide or euthanasia laws has had any impact on resourcing for other end of life options, such as palliative care, in the places where such laws have been introduced. The Victorian Ministerial Advisory Panel on Voluntary Assisted Dying used only one reference to state that in Belgium and the Netherlands, research published in 2014 suggested that the introduction of assisted dying/suicide and euthanasia has not stunted the development of palliative care, and that government funding grew at a consistent rate with countries such as the UK, that have not legalised assisted dying/suicide.[24] Researching the quality of palliative care and comparing between jurisdictions is complex. For example, attempting to use cost as a proxy measure for the quality of palliative care is not simple as cost will depend on a whole range of factors such as how much health professionals are paid in the country in question, the types of illness from which people are dying as different illnesses will generate different costs to treat and if private for-profit companies run the health system and demand high levels of profit. Examining a study looking at cancer patients in their last six months of life in 2012 in seven wealthy countries, there was no correlation between the rate at which they died while being provided with acute care in hospital

23 Washington Department of Health, http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/Death/DeathTablesbyTopic#Cause

24 'Ministerial Advisory Panel on Voluntary Assisted Dying. Final Report', Victorian Department of Health and Human Services, July 2017, 39.

and if the government in question had allowed assisted dying/ euthanasia legislation. For countries with assisted dying laws in 2012, Belgium had 51.2% of cancer patients in the last six months of life die in acute hospital care, while in the Netherlands it was 29.4%.[25] In the countries without such laws the rates were 52.1% for Canada, 44.7% for Norway, 41.7% for the UK, 38.3% for Germany and 22.2% for the US.

Netherlands

In the Netherlands, a court in 1973 allowed a doctor to lawfully shorten a person's life to prevent serious and irremediable suffering. In 1984 a court ruled that a doctor was entitled to assist a patient to die at their request under the doctrine of necessity to end unbearable and irremediable suffering.

The Netherlands passed the *Termination of Life on Request and Assisted Suicide (Review Procedure) Act* in 2002. Assisted suicide remains a criminal offence, but doctors are not prosecuted if they report to a Regional Euthanasia Review Committee and meet all due care criteria.

The due care criteria are that the doctor must:

- be satisfied that the person has made a voluntary and well-considered request;
- be satisfied that the person's suffering was unbearable, with no prospect of improvement;
- have informed the person about his or her situation and his or her prospects;
- have concluded, together with the person, that there is no reasonable alternative in light of the person's situation;
- have consulted at least one other independent doctor who must have seen the person and given a written opinion on the due care criteria referred to in 1–4 above; and
- have terminated the person's life or provided assistance with suicide with due medical care and attention.

In addition to the 'due care' criteria described above, the framework under the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* includes the following elements:

- generally accessible by adults aged 18 and over, but children aged 16–18 can also access assisted dying with parental consultation, as can children aged 12–16 with parental consent;
- it applies not only to the terminally ill, but also the chronically ill and people with mental suffering;
- there is no need for competency at the time of a person's death — a doctor may provide assisted dying to a person 16 years or older, where they made the request in writing prior to losing competence;
- there is no mandatory mental health assessment, but if a doctor determines that a person's judgment may be impaired by poor mental health, they may decide the request does not meet the 'well-considered' part of the due care criteria;
- there is no residency requirement;

25 Justin Bekelman, Scott Halpern and Carl Rudolf Blankart, 'Comparison of Site of Death, Health care Utilization and Hospital Expenditures for Patients Dying with Cancer', JAMA 2016, 315(3), 272-283.

- there is no mention of a specified cooling-off period, but the doctor must be satisfied that a request is 'well-considered'.

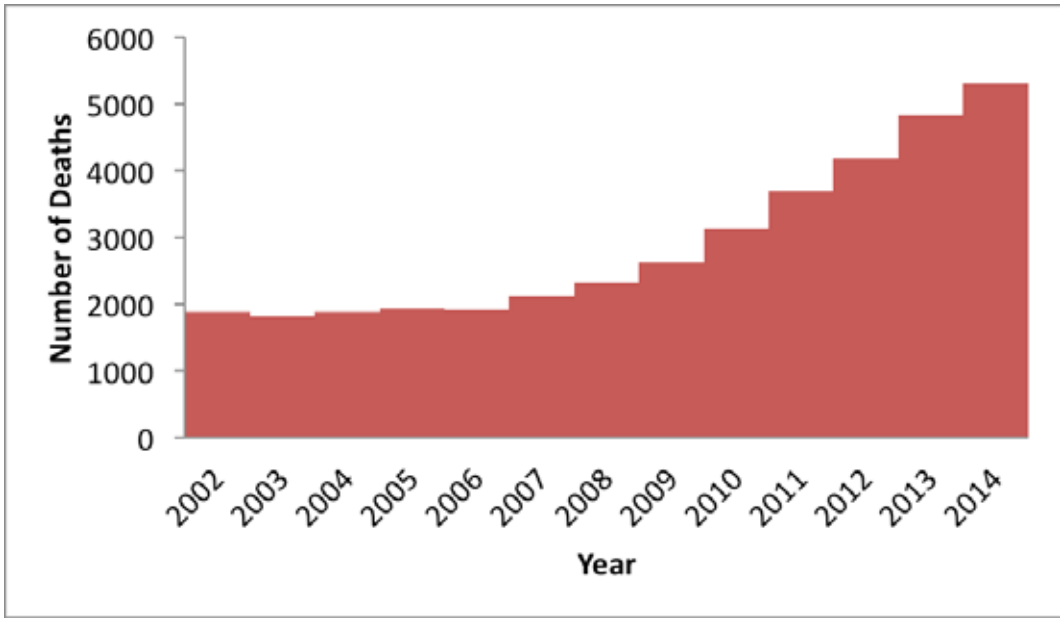
Assisted dying/suicide is most commonly carried out in the person's own home. Doctors typically administer a barbiturate intravenously, which puts the patient to sleep. This is followed by injection of a lethal neuromuscular blocker.

Where assisted dying/suicide occurs, doctors are required to report the death to the municipal pathologist, who then notifies a Regional Euthanasia Review Committee. These committees, which consist of a medical doctor, an ethicist and a legal expert, assess whether the doctor has fulfilled the statutory due care criteria. If the committee concludes that the criteria have been met, the doctor is exempt from criminal liability and no further action is taken.

If the committee finds that the doctor has not acted in accordance with the due care criteria, it reports its findings to the Public Prosecution Service and the Regional Health Inspector. These two agencies then consider what action, if any, should be taken against the doctor.

The number of deaths through assisted dying/suicide are provided in the graph below.

Figure 2: Number of deaths under the Netherlands *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* from 2002 to 2014.



In 2015, 3.75% of all deaths in the Netherlands were from medically assisted death/suicide.[26] Only 3.8% of these assisted deaths/suicides were self-administered, with the rest being carried out by medical professionals.[27] Between 2008 and 2011 between 3.5% and 8.5% of requests for assisted dying/euthanasia were rejected because a lack of voluntariness was identified.[28]

26 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
27 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
28 'Ministerial Advisory Panel on Voluntary Assisted Dying. Final Report', Victorian Department of Health and Human Services, July 2017, 87.

Switzerland

The Swiss assisted dying law primarily resides in the country's *Criminal Code*. Assisted suicide, if done without selfish motives is legal, while assisting or inciting suicide with selfish motives is illegal.

The practical effect is that assisted suicide is only a crime where the following elements are proven:

(1) a suicide was committed or attempted;

(2) a third party encouraged or helped in the suicide;

(3) the third party acted on selfish grounds; and

(4) the third party acted deliberately, with intent.

Swiss law does not contain a statute with a framework of eligibility criteria and safeguards for assisted dying/ suicide. As such there are none of the usual eligibility requirements such as terminal illness or unbearable and irremediable suffering. Neither is assisted dying/ suicide restricted to citizens or residents of Switzerland. Assisted dying/ suicide in Switzerland need not be performed by a doctor; in fact the vast majority of assisted deaths that take place in Switzerland are not supervised by doctors. A doctor is required, however, if a person wants to use a lethal drug which may only be accessed by prescription. Most deaths take place in a person's home, or at one of the premises of organisations that assist with suicide/ dying.

The four most prominent organisations in Switzerland that assist people to end their lives are:

- Dignitas
- Exit — German Switzerland
- Exit — French Switzerland
- Exit International.

These organisations notify the police and coroner when they assist a person to die. The police and coroner investigate to determine if any crime has taken place, in the most part determining whether there were selfish motives, but also examining any doubts about the deceased's competence and the autonomy of their choice. If the police and coroner find no wrongdoing the death is reported as suicide.

There are no official statistics on the number of assisted deaths in Switzerland. One study investigating the number of deaths assisted by Exit — German Switzerland found that between 1990 and 2000 Exit - German Switzerland assisted in 748 suicides among Swiss residents (0.1% of total deaths, 4.8% of total suicides).

Belgium

Euthanasia/assisted dying was legalised in Belgium on 28 May 2002.

Under the Belgium law, in the case of a patient in the final stages of his/her illness, euthanasia may take place if:

- the patient is an adult or a minor who has been granted adult legal status and is deemed to be in his/ her right mind and therefore able to express his/ her wishes;
- the request has been made on a voluntary, thoughtful and repeated basis and does not arise from being pressured into it;
- the request has to be made in writing;

- the medical situation does not allow for a positive outlook and causes constant and unbearable physical or psychological suffering which cannot be alleviated and is caused by a life-threatening and incurable accidental or pathological illness;
- the medical practitioner has talked to his/her patient on various occasions about his/her state of health, his/her life expectancy, his/her request for euthanasia;
- the medical practitioner must discuss the possible options available to his/her patient regarding both therapeutic treatment of the illness and the palliative care available and the consequences thereof;
- the medical practitioner has consulted another independent and competent medical practitioner who has drawn up a report setting out his/her findings;
- the medical practitioner has discussed his/her patient's request with the medical team treating the patient and with the patient's close family, if the patient so requests;
- after euthanasia, the medical practitioner fills out both pages of the form designed to ascertain the legality of the death/assisted suicide.

If the patient is not in the final stages of his/her ill- ness, two further conditions apply:

- the medical practitioner must consult a second independent medical practitioner, psychiatrist or a medical practitioner specialized in the relevant pathology; and
- the period of reflection required between the patient's written request and the assisted death/suicide has to be at least one month.

In Belgium a person who is not conscious can be subject to euthanasia if:

- the person is an adult or a minor who has been granted adult legal status;
- the person is not conscious and the situation is irreversible according to current medical knowledge;
- the person is suffering from a life-threatening and incurable accidental or pathological illness;
- the person has drawn up and signed a declaration in advance requesting euthanasia. This declaration is valid for a period of 5 years and may appoint one or several reliable individuals who have been entrusted with voicing the patient's wishes;
- the medical practitioner has consulted another independent doctor;
- the medical practitioner has discussed the declaration, which was drawn up and signed by the patient in advance, with the patient's medical team and any close family members; and
- after euthanasia, the medical practitioner fills out both pages of the form designed to ascertain the legality of the death.

Under the Belgium law the medical professional is the one to euthanise/assist the person to die, although cases have been reported of medical professionals providing lethal medications for the person to end their life themselves.

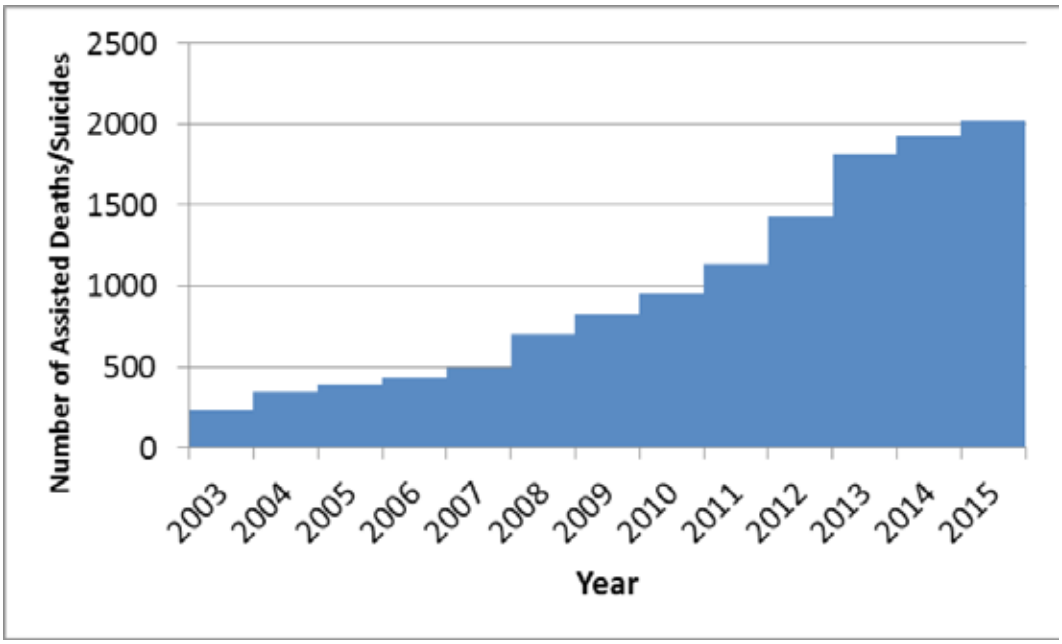
Belgium extended the scope of its law in 2014 to allow euthanasia for minors of any age suffering from incurable diseases if they were capable of making a rational

decision about their fate.[29] The first child, aged 17, was assisted to die/euthanised in 2016.[30]

In 2010 to 2011, 2% of the cases of assisted death/euthanasia were carried out on people who were unconscious.[31] In 2014 and 2015 a total of 67 people were assisted to die/be euthanised on the basis of a prior declaration, as at the time of their death they were no longer able to give consent.[32]

In 2010 and 2011 9 % of declared cases of euthanasia, death was not envisaged in the very short term. The most often declared illnesses mentioned to justify this type of request are first and foremost neuropsychiatric diseases, followed by degenerative neuromuscular diseases.[33] By 2014 and 2015 this had grown to 15% of cases.[34]

Figure 3. Number of assisted deaths/suicides in Belgium under the euthanasia law between 2003 and 2015.[35]



In 2015 1.83% of all deaths in Belgium were medically assisted deaths/suicides.[36] In 2014 and 2015 the youngest person assisted to die/euthanised was aged 40.[37]

29 Expatica, 'Belgium euthanasia cases hit record high', 27 January 2016, http://www.expatica.com/be/news/CORRECTED-Belgian-euthanasia-cases-hit-record-high_580213.html

30 CBS News, 'First child dies by legal euthanasia in Belgium', 19 September 2016, http://www.cbsnews.com/news/child-dies-by-euthanasia-in-belgium-where-assistance-in-dying-is-legal/; and NZ Herald, 'Belgium assisted-dying case makes impact in NZ', 18 Sept 2016, http://www.nzherald.co.nz/world/news/article.cfm?c_id=2&objectid=11712150

31 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 3, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf

32 Institut Européen de Bioéthique, 'Analysis of The Seventh Report of the Federal Commission for Euthanasia Control and Evaluation of the Legislative Chambers (for the Years 2014 and 2015)', 4, http://www.ieb-eib.org/en/pdf/20161008-en-synthese-rapport-euthanasie.pdf

33 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 3, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf

34 Institut Européen de Bioéthique, 'Analysis of The Seventh Report of the Federal Commission for Euthanasia Control and Evaluation of the Legislative Chambers (for the Years 2014 and 2015)', 5, http://www.ieb-eib.org/en/pdf/20161008-en-synthese-rapport-euthanasie.pdf

35 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 3, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf; Kennedy Institute of Ethics, Bioethics Research Library, Georgetown University, 'Euthanasia continues to rise in Belgium', https://bioethics.georgetown.edu/2016/01/euthanasia-continues-to-rise-in-belgium/; and Simon Caldwell, 'Five people killed every day by assisted suicide in Belgium as euthanasia cases soar by 25 per cent in last year alone', Daily Mail Australia, 29 May 2014, http://www.dailymail.co.uk/news/article-2641773/Five-people-killed-EVERY-DAY-assisted-suicide-Belgium-euthanasia-cases-soar-27-cent-year-alone.html.

36 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html

37 Institut Européen de Bioéthique, 'Analysis of The Seventh Report of the Federal Commission for Euthanasia

However, the introduction of assisted dying/euthanasia legislation has not overtaken people having their lives shortened through pain relief and withdrawal of treatment as the main forms by which people die in Belgium. In 2013, the intensified alleviation of pain and other symptoms with the use of drugs with the side effect of shortening the person's life accounted for 24.2% of deaths, while the withholding or withdrawing of life-prolonging treatment accounted for 17.2% of deaths. These remained the most prevalent end-of-life practices.[38]

In 2013, a survey to physicians in Belgium that had signed death certificates which had a response rate of 60.6%, found that in 73.7% of cases of assisted dying/ euthanasia it was reported that the person was receiving palliative care services, which suggests it is not an absence of access to palliative care services that drive a majority of people in Belgium to access assisted suicide/euthanasia.[39]

The Belgium Commission for Control and Assessment that monitors if cases of assisted dying/euthanasia have been in compliance with the requirements of the law, has been criticised for dispensing with the need for the patient to be in unbearable and unrelievable pain.[40] Further, it has been alleged that the Commission has approved assisted dying/suicide for a very small number of people suffering from Alzheimer's disease, depression and psychosis.[41] In 2014 and 2015 a total of 124 people had their lives ended/ were euthanised as a result of mental or behavioural disorders.[42]

The Belgium Commission has included members of the Association pour le Droit de Mourir dans la Dignité (Association for the Right to Die in Dignity), which campaigns for the expansion of euthanasia, which has called into doubt the objectivity of the Commission from some quarters.[43]

In October 2015 the Belgium Commission for the first time referred a doctor to a public prosecutor for violating the Belgium assisted suicide/euthanasia law. On 22 June 2015, Dr Marc Van Hoey, president of the association Recht op Waardig Sterven (RWS) [Right to Worthy Dying], assisted in the suicide of 85-year-old Simona De Moor, whose death was filmed live by an Australian journalist in her report *Allow me to die* for the SBS Dateline program. Dr. Van Hoey provided a lethal drink to Simona De Moor who was not suffering from any particular physical or psychological illness other than depression and described an unbearable grief from the recent death of her daughter. Dr Van Hoey did not appeal to a third physician, as required by law when the person is not in an imminent end-of-life situation.[44] However, it appears the

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Control and Evaluation of the Legislative Chambers (for the Years 2014 and 2015)', 2, http://www.ieb-eib.org/en/pdf/20161008-en-synthese-rapport-euthanasie.pdf

38 Kenneth Chambaere, Robert Vander Stichele, Freddy Mortier, Jochim Cohen and Luc Deliens, 'Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium', *The New England Journal of Medicine*, 19 March 2015, 1179, http://www.nejm.org/doi/pdf/10.1056/NEJMc1414527

39 Kenneth Chambaere, Robert Vander Stichele, Freddy Mortier, Jochim Cohen and Luc Deliens, 'Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium', *The New England Journal of Medicine*, 19 March 2015, 1179, http://www.nejm.org/doi/pdf/10.1056/NEJMc1414527

40 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 6, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf

41 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 6, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf

42 Institut Européen de Bioéthique, 'Analysis of The Seventh Report of the Federal Commission for Euthanasia Control and Evaluation of the Legislative Chambers (for the Years 2014 and 2015)', 3, http://www.ieb-eib.org/en/pdf/20161008-en-synthese-rapport-euthanasie.pdf

43 European Institute of Bioethics, 'Euthanasia in Belgium: 10 years on', April 2012, 6, http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf

44 Institut Européen de Bioéthique, 'Belgium first case of euthanasia transmitted to the Public Prosecutor's Office', 28 October 2015, http://www.ieb-eib.org/fr/bulletins/belgique-premier-dossier-deuthanasie-transmis-au-parquet-348.html#sujet1016; and SBS, 'Belgian euthanasia doctor could face criminal charges', 29 October 2015, http://www.sbs.com.au/news/dateline/article/2015/10/29/belgian-euthanasia-doctor-could-face-criminal-charges

public prosecutor declined to proceed with the case as there is no public reporting that the case was followed through on.

Canada

Legislation to legalise assisted dying in all of Canada was introduced in the Canadian Parliament in April 2016, as required by the Supreme Court's ruling in *Carter v Canada (AG)*, and passed into law on 17 June 2016.

In 1972, Canada decriminalised suicide, but assisted suicide/dying remained a crime.

In June 2014, the Québec National Assembly passes *An Act Respecting End-of-Life Care*, which legalised assisted dying/suicide.

On 6 February 2015 the Canadian Supreme Court in the case *Carter v Canada (AG)* unanimously ruled that Canada's prohibition of assisted dying/suicide in certain circumstances is unconstitutional. The Court ordered the Canadian Government to introduce legislation to legalise assisted dying for consenting adults with intolerable physical or mental suffering by 6 February 2016. This was later extended to 6 June 2016 after the Canadian Government sought an extension to the time frame.

The Québec National Assembly *An Act Respecting End-of-Life Care* came into effect on 10 December 2015.

The Act provides for 'medical aid in dying' in the form of voluntary euthanasia and assisted suicide for people who are:

- 18 years of age and capable of giving consent;
- at the end of life;
- suffering from a serious and incurable illness;
- in an advanced state of irreversible decline in capability; and
- experiencing constant and unbearable physical or psychological pain which cannot be relieved in a manner they deem tolerable.

The Act contains the following safeguards:

- two doctors must be satisfied the request is an informed one, that it is made freely and without external pressure;
- the person must be informed of their prognosis and other therapeutic possibilities and their consequences; and
- no specified cooling-off period, but a doctor must verify the persistence of suffering and that the wish to obtain assisted dying remains unchanged at reasonably spaced intervals.

The legislation does not specify whether depression or mental illness is a limiting factor for eligibility, however, the patient must be capable of giving consent.

The Québec legislation established a Commission on end-of-life care to oversee the application of assisted dying.

A doctor who provides assisted dying/suicide must notify the Commission within 10 days. The Commission assesses whether the doctor complied with the requirements of the Act.

If at least two-thirds of members of the commission believe the Act was not complied with, the conclusions are forwarded to the institution concerned and to the Collège des Médecins du Québec.

The law was challenged in December 2015, and was temporarily suspended by Québec's Superior Court until the federal prohibition against assisted dying/suicide was lifted. This suspension was later overturned by Québec's Court of Appeal.

Representatives from Canada's justice ministry noted that Québec's assisted dying legislation does not conform to the Canadian Charter due to its limitation to terminal patients. As a result of the *Carter* decision, Québec's assisted dying/suicide framework will need to be extended to accommodate those who are not terminally ill.

The number of medically assisted deaths/suicides under Québec legislation between 10 December 2015 and 10 June 2016 was 167.[45] The number of medically assisted deaths/suicides in Canada under Québec and federal legislation between 17 June and 31 December 2016 was 803.[46] Only 0.4% of the deaths/suicides were self-administered, with the rest being carried out by medical professionals.[47] The average age of the people assisted in dying/suicide was 72 and the ages ranged from 69 to 74. Of those assisted to end their lives 56.8% were suffering from cancer-related illness, 23.2% from neuro-degenerative illnesses and 10.5% from circulatory/respiratory system illness.[48]

The province of Alberta has rejected 36 requests for assisted dying/suicide and the province of Manitoba has rejected 20.[49]

From June to December 2016, 0.6% of all deaths in Canada were medically assisted deaths/suicides.[50]

A case has been reported in late 2016 calling into question the effectiveness of the safeguards in Canada. It was reported by a relative of the person assisted to die/euthanised:[51]

> *My Aunt ... was just Euthanized today Nov 9, 2016 by Lethal injection at ... Retirement Home ... in BC. We were called to a meeting at ... Hospice on Nov 7, 2016 to be told for the first time that our ... Aunt had requested to be Euthanized. We were told it would take at least 10 days. My sister and I argued that our Aunt appears to only have a severe Bladder infection. The Hospice Doctor said he would look into having her urine tested for this before they proceed with Euthanasia.*
>
> *The same day we were sent over to our Aunts apartment to witness the doctor (that is going to give our Aunt the Lethal injection) having our Aunt sign the document to give her the permission to do the euthansia. After the Doctor read out the document to My Aunt; the doctor went and got a woman that works in the kitchen to initial all the questions for my Aunt. The Doctor brought two people to be witnesses into the room that had been witnesses for other Euthanisations.*
>
> *When we mentioned the urine tests we had asked to be done; the euthanising Doctor said it would make no difference because my Aunt has already signed permission for her euthanasia. The euthanising Doctor said she is going to put*

45 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
46 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
47 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
48 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
49 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
50 https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html
51 Alex Schadenberg, 'Woman dies by euthanasia may only have had a bladder infection', Euthanasia Prevention Coalition, 14 November 2016, http://alexschadenberg.blogspot.com.au/2016/11/woman-who-dies-by-euthanasia-may-only.html

a rush on the Euthanasia. To my even more shock the Doctor gave My Aunt the lethal injection today. It all took less than three days from start to finish. The Doctor did the three Doctor visits to my Aunt in three consecutive days. I am so upset.

This was so wrong ..

It is unknown if this case was reported to Canadian authorities or if any attempt has been made by Canadian authorities to investigate the case.

Oregon, USA

In 1994 the *Death with Dignity Act*, a citizens' initiative, was passed by Oregon voters by a margin of 51 per cent in favour and 49 per cent opposed. However, the implementation of the Act was delayed until late 1997 by a legal injunction. The Act was subject to multiple legal proceedings, including a petition to the United States Supreme Court.

People who are approved in Oregon for assisted dying/suicide most commonly ingest a lethal barbiturate without the presence of their doctor or other healthcare provider.

In Oregon, only assisted dying/ suicide is legalised, not euthanasia. Doctors can prescribe people who meet certain criteria a lethal medication. People who choose to take the medication must do so without assistance.

To be eligible to access a lethal medication under the *Death with Dignity Act*, a person must:

- be 18 years of age or older and 'capable';
- be a resident of Oregon;
- have a terminal disease from which they will die within six months; and
- make three separate requests; an initial verbal request, a written request, then a second verbal request. The verbal requests must be separated by a minimum of 15 days.

In assessing and granting a request to access lethal medication under the *Death with Dignity Act*, two doctors must:

- confirm the diagnosis of the terminal disease;
- confirm the person is capable of making and communicating health decisions;
- confirm the person's request is voluntary;
- ensure that the person is making an informed decision, and in doing so inform the person of:
    - their medical diagnosis and prognosis;
    - the potential risks, and probable result of taking the lethal medication; and
    - the feasible alternatives, including comfort care, hospice care, and pain control.

If either of the two doctors believes the person's judgement is impaired by a psychiatric or psychological disorder or depression, the person must be referred for counselling. The person cannot be prescribed lethal medication unless the counsellor determines the person is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement.

Doctors must document in a person's medical record information concerning a person's request for lethal medication. This includes information regarding eligibility as described above, as well as all verbal and written requests for lethal medication made by a person.

Doctors are required to report all prescriptions for lethal medication to the Oregon Health Authority. The Oregon Health Authority is responsible for notifying the Board of Medical Examiners of any failures in prescribing or reporting requirements.

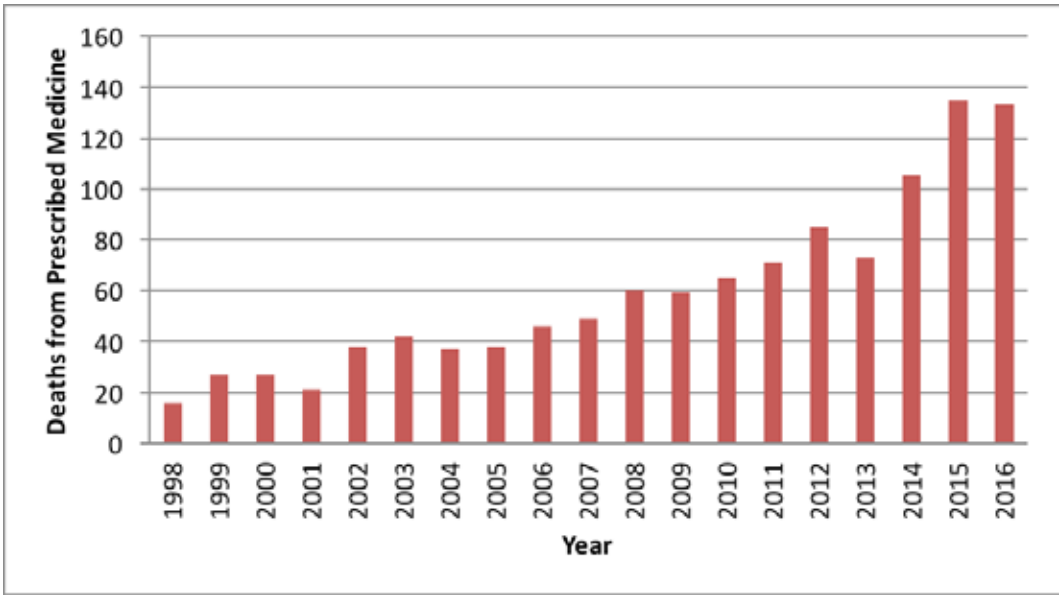
Data on activity under the *Death with Dignity Act* is reported annually, and published on the Oregon Health Authority website.

The table below shows the number of prescriptions for lethal medications written each year and the number of patients who died as a result of taking the medication. The discrepancy in prescriptions and deaths each year is due to people not taking medication, dying of other causes and using prescriptions written during previous years.

Table 1. Prescriptions and deaths under the Oregon *Death with Dignity Act* between 1998 and 2015.

Year	Prescriptions written	Deaths due to prescribed medicine	Percentage of total deaths
1998	24	16	0.055
1999	33	27	0.092
2000	39	27	0.091
2001	44	21	0.070
2002	58	38	0.122
2003	68	42	0.136
2004	60	37	0.120
2005	65	38	0.120
2006	65	46	0.147
2007	85	49	0.156
2008	88	60	0.194
2009	95	59	0.193
2010	97	65	0.209
2011	114	71	0.225
2012	116	85	0.235
2013	121	73	0.219
2014	155	105	0.310
2015	218	135	0.386
2016	240	133	0.372

Figure 4. Deaths from prescribed medicine under the Oregon *Death with Dignity Act* from 1998 to 2016.[52]



During 2016 most of the people who were assisted to end their lives were aged 65 years or older (80.5%) and had cancer (78.9%). The median age at death was 73 years. As in previous years, decendents were commonly white (96.2%) and well-educated (50.0% had a least a baccalaureate degree).[53] During 2016, no referrals were made to the Oregon Medical Board for failure to comply with the *Death with Dignity Act* requirements.[54]

Between 1998 and 2016 a total of nine people in Oregon aged 18 to 34 have been assisted to end their lives through the *Death with Dignity Act*.[55] In that period 57 people requesting to be assisted with dying/suicide were referred for psychiatric evaluation.[56] Six people have regained consciousness after taking the medication to end their life between 1998 and 2016.[57] The time between unconsciousness and death ranged from one minute to just over four days.[58]

The Oregon Health Authority has also collected information about the end of life concerns of those that have been assisted to end their lives, which are listed in the table below.

52 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 4, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

53 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 6, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

54 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 3, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

55 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 8, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

56 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 9, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

57 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 10, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

58 Kimberly Leonard, 'Drug Used in 'Death with Dignity' Is the Same Used in Executions', US News, 16 Oct 2015, https://www.usnews.com/news/articles/2015/10/16/drug-shortage-creates-hurdle-for-death-with-dignity-movement

Table 2. End of Life Concerns of those assisted to end their lives under the Oregon *Death with Dignity Act* between 1998 and 2016.[59]

End of Life Concern	Number of people	% of people
Losing autonomy	1,025	91.4
Less able to engage in activities making life enjoyable	1,007	89.7
Loss of dignity	767	77.0
Losing control of bodily functions	524	46.8
Burden on family, friends/caregiver	473	42.2
Inadequate pain control or concern about it	296	26.4
Financial Implications of Treatment	38	3.4

There are issues about the cost of the drugs in the US to carry out the assisted death/suicide. Pentobarbital in liquid form cost about US$500 until about 2012, when the price rose to between US$15,000 and US$25,000. The price increase was caused by the European Union's ban on exports to the US because of the drug being used in capital punishment. Users then switched to the powdered form, which cost between US$400 and US$500.[60]

The dose of secobarbital (brand name Seconal) prescribed under Death with Dignity laws costs US$3,000 to US$5,000.[61]

Due to the increase in the cost of Seconal, alternate mixtures of medications have been developed by physicians in Washington state. The phenobarbital/chloral hydrate/morphine sulfate mix produces a lethal dose that is similar in effect to Seconal. The cost of this alternate mix is approximately US$450 to US$500. A second alternative, consisting of morphine sulfate, Propranolol (Inderal), Diazepam (Valium), Digoxin and a buffer suspension costs about US$600.[62]

When pentobarbital or secobarbital work as intended, people drink a solution in which the drug has been dissolved and then fall into a coma within five to 10 minutes. Soon the drug depresses the part of the brain that controls respiration, which causes them to stop breathing, generally within 20 to 30 minutes. However, in rare cases there are complications include regurgitation and remaining in a coma for days – complications similar to those seen when the drugs are used for carrying out the death penalty.[63]

Washington State, USA

The Washington State *Death with Dignity Act* was passed on 4 November 2008 and came into force on 5 March 2009. The Act allows terminally ill adults who are residents of Washington State and are believed to have less than six months to live to request a lethal dose of medication from medical and osteopathic physicians.

The person must be competent and needs to voluntarily express their wish to die. To ensure that the person is making an informed decision the physician must inform the person:

59 Oregon Health Authority, 'Oregon Death with Dignity Act. Data summary 2016', 10 February 2017, 10, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

60 https://www.deathwithdignity.org/faqs/

61 https://www.deathwithdignity.org/faqs/

62 https://www.deathwithdignity.org/faqs/

63 Kimberly Leonard, 'Drug Used in 'Death with Dignity' Is the Same Used in Executions', US News, 16 Oct 2015, https://www.usnews.com/news/articles/2015/10/16/drug-shortage-creates-hurdle-for-death-with-dignity-movement

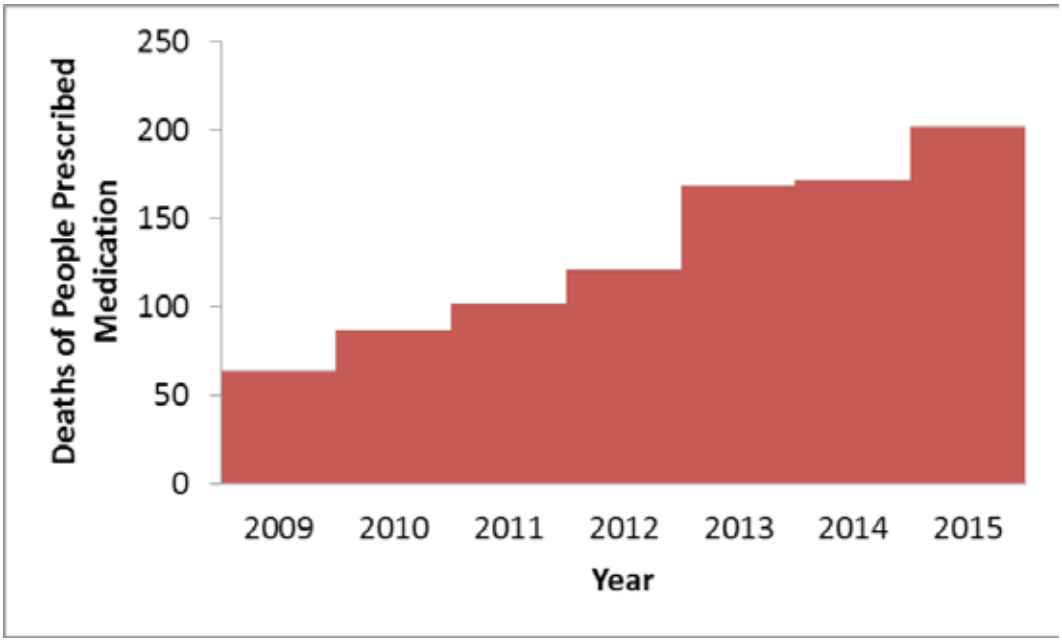
- of their medical diagnosis and prognosis;
- the potential risks associated with taking the medication to be prescribed;
- the probable result of taking the medication to be prescribed; and
- the feasible alternatives including comfort care, hospice care, hospital care and pain control.

The physician must refer the person to a consulting physician for medical confirmation of the diagnosis and for a determination that the person is competent and acting voluntarily.

In 2015, 213 people were prescribed medication to end their lives and 166 died after ingesting the medication.[64] Those prescribed the medication were aged 20 to 97 and 72% had cancer.[65]

Below the figure shows the number of deaths of people who have been prescribed lethal medication under the Washington State *Death with Dignity Act* between 2009 and 2015. However, these figures include those who died of other causes before taking the medication.

Figure 5. Number of deaths of people prescribed lethal medication under the Washington State *Death with Dignity Act* between 2009 and 2015.[66]



Like Oregon, Washington State health authorities record the end of life concerns for people seeking assistance to end their life. The Table below provides the proportion of people for 2015 that had the concerns listed.

64 Washington State Department of Health, '2015 Death with Dignity Report', 1, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf
65 Washington State Department of Health, '2015 Death with Dignity Report', 1, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf
66 Washington State Department of Health, '2015 Death with Dignity Report', 4, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf

Table 3. End of Life Concerns of those assisted to end their life under the Washington State Death with Dignity Act in 2015.[67]

End of Life Concern	% of people
Losing autonomy	86
Less able to engage in activities making life enjoyable	86
Loss of dignity	69
Losing control of bodily functions	49
Burden on family, friends/caregiver	52
Inadequate pain control or concern about it	35
Financial Implications of Treatment	13

Montana, USA

On 31 December 2009, Montana's Supreme Court ruled in *Baxter v. Montana* that physicians are authorised under state law to provide aid in dying: that is, to prescribe medication that a terminally ill adult can take to shorten their dying process should the suffering become unbearable.

The original lawsuit was brought by four Montana physicians and Robert Baxter who was dying from lymphocytic leukaemia. The plaintiffs asked the court to establish a constitutional right 'to receive and provide aid in dying.'

The Court found that "we find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against "public policy" and therefore, the physician who assists is shielded from criminal liability by the patient's consent."

Vermont, USA

In Vermont, the *Patient Choice and Control at End of Life Act* was signed into law on 20 May 2013. Under the Act a physician may prescribe a person with a terminal condition medication to be self-administered for the purpose of hastening the death of the person provided:

- the person made an oral request to the physician for the medication twice, at least 15 days apart;
- the physician at the second request offered the person the opportunity to rescind the request;
- the person made a written request for the medication that was signed by the person in the presence of at least one witness who was not an interested person.

The physician needs to have determined the person:

- was suffering from a terminal condition;
- was capable;
- was making an informed decision; and
- was a Vermont resident.

The physician also needs to inform the person of:

67 Washington State Department of Health, '2015 Death with Dignity Report', 7, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf

- their prognosis;
- the range of treatment options available to the person;
- all feasible end-of-life services, including palliative care, comfort care, hospice care and pain control; and
- the range of possible results, including potential risks associated with taking the medication to be prescribed.

The physician must also refer the person to a second physician for medical confirmation of the diagnosis, prognosis and a determination that the person was capable, was acting voluntarily and made an informed decision.

As of 8 June 2017, physician reporting forms have been completed for 53 people being prescribed lethal medication, according to the Department of Health.[68]

California, USA

In California, "An individual seeking to obtain a prescription for an aid-in-dying drug... shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section."

Colorado, USA

Colorado, "Allows an eligible terminally ill individual with a prognosis of six months or less to live to request and self-administer medical aid-in-dying medication in order to voluntarily end his or her life; Authorizes a physician to prescribe medical aid-in-dying medication to a terminally ill individual under certain conditions; and Creates criminal penalties for tampering with a person's request for medical aid-in-dying medication or knowingly coercing a person with a terminal illness to request the medication."

District of Colombia, USA

In the District of Columbia, to obtain the medication, "a patient shall make two oral requests, separated by at least 15 days, to an attending physician. Submit a written request, signed and dated by the patient, to the attending physician before the patient makes his or her second oral request and at least 48 hours before a covered medication may be prescribed or dispensed."

68 CNN Library, 'Physician-Assisted Suicide Fast Facts', 10 June 2017, http://edition.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html