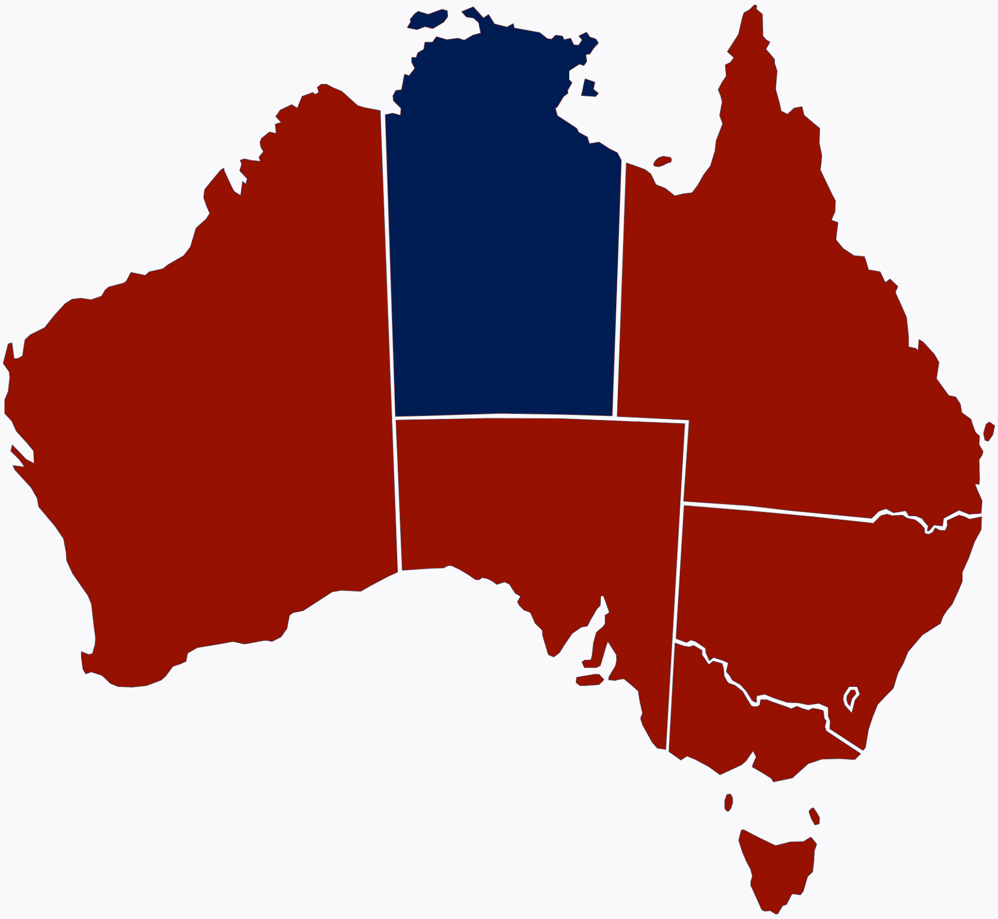
Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on 'Assisted Dying'

Professor David Albert Jones



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Executive Summary

Parliamentary Committees in Scotland and in England have been considering Bills that would legalise 'assisted dying' (meaning physician-assisted suicide). One striking feature of the conduct of these Committees is the heavily skewed evidence both have taken from pro-assisted suicide witnesses from Australia. This is problematic for a number of reasons:

- *The fact that the witnesses were all supporters of and most also involved in delivery of 'voluntary assisted dying' (VAD) gave the Committees a very one-sided view of the limited evidence;*
- *There is in fact very little evidence of the impact of these laws in Australia since Victoria has only five years of data and most other Australian jurisdictions have only one or two years;*
- *Other Australian jurisdictions have diverged from the law in Victoria, so data from Victoria is not a reliable guide to what is happening in those other jurisdictions;*
- *VAD in Australia is very different from what is proposed in the Bills in Scotland and in England and Wales – practice in most Australian states is predominantly euthanasia;*
- *Many of the safeguards enacted in the VAD law in Victoria have been abandoned by other States – increased access has been given priority over safety;*
- *While Australian witnesses stressed that, in Victoria, 'there have been no changes to the Act at all', and claimed that the Government in Victoria 'will not be reopening the law', the Minister of Health in Victoria has now announced plans to 'rewrite' the law.*

There is clear evidence of a slippery slope in Australia and the direction of travel is away from physician-assisted suicide for the terminally ill, as in Oregon, and towards euthanasia that is extended also to those with chronic conditions, as in Canada. For a more critical account of VAD in Australia, MPs and MSPs should read the written evidence supplied by the Plunkett Centre for Ethics and by Robert Clark, former Attorney-General of Victoria.

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Over-representation of Australian witnesses

In Scotland and in England and Wales, Parliamentary Committees have been taking oral evidence on Bills to legalise ‘assisted dying’ (meaning physician-assisted suicide) **[1]** for people with a terminal illness, though the Bills diverge on the definition of terminal illness and on various other provisions. **[2]**

In both cases, the Committees have given prominence to witnesses from Australia on the Australian practice of ‘voluntary assisted dying’ (VAD). This has been legalised in all six Australian States beginning with Victoria in 2017, and also in the Australian Capital Territory (ACT). **[3]** New Zealand passed similar legislation in 2019. **[4]**

In Scotland, at the Health, Social Care and Sport Committee hearings on the Assisted Dying for Terminally Ill Adults (Scotland) Bill, three out of five witnesses invited from other jurisdictions were from Australia **[5]** and two from Canada. **[6]** The Australian witnesses were heard first, even before hearing from Scottish witnesses. The Committee also heard evidence from Dr Amanda Ward **[7]**, adviser to Liam McArthur MSP on the Bill, who is also now based in Australia.

In England and Wales, at the Public Bill Committee hearings on the Terminally Ill Adults (End of Life) Bill, six out of eight witnesses invited from outside the UK were from Australia **[8]** and only two from the United States. **[9]** In addition, the Public Bill Committee also heard evidence from Ward. **[10]**

Who were these witnesses?

The three Australian witnesses invited to the Health, Social Care and Sport Committee were:

- Julian Gardner, chair of the Victorian Voluntary Assisted Dying Review Board (VADRB); **[11]**
- Professor Ben White, from the Australian Centre for Health Law Research (ACHLR) at Queensland University of Technology; **[12]** and
- Katherine Waller, from ACHLR (though she was unable to attend).

Ward is also now based at ACHLR. **[13]** Before working for Liam McArthur MSP, she was CEO of the Scottish campaign organisation Friends At The End which campaigns for ‘assisted dying’ for people who have ‘*either a terminal illness or an incurable condition*’. **[14]** In this respect, Friends At The End is similar to the English organisation My Death My Decision. **[15]** Neither organisation would restrict ‘assisted dying’ to people with a terminal illness.

The six Australian witnesses invited to the Public Bill Committee were:

- Dr Greg Mewett, palliative care physician and member of the Victorian VADRB; **[16]**
- Dr Cam McLaren, oncologist from Victoria and founder of Voluntary Assisted Dying Australia and New Zealand (VADANZ) **[17]**, an organisation that represents practitioners of VAD;
- Dr Clare Fellingham, anaesthetist in Western Australia who described herself as a former

'high-volume practitioner' of VAD **[18]**, and is now a board member of VADANZ **[19]**;
- Dr Chloe Furst, geriatrician and palliative care consultant in South Australia and also a board member of VADANZ **[20]**;
- Professor Meredith Blake, at the University of Western Australia; and
- Alex Greenwich, the Member of Parliament from Sydney who sponsored the VAD legislation in New South Wales.

Every one of these witnesses is a strong supporter of VAD and most are actively involved in delivering it and / or in providing training or governance. All but two witnesses are associated with one of three organisations: the research centre ACHLR, the practitioner organisation VADANZ, or the Victorian review body VADRB. These organisations are themselves closely related. ACHLR provides the statutory training for VAD practitioners in Victoria, Western Australia and Queensland. This also gives ACHLR a financial interest in VAD. **[21]** Together with the campaign group Go Gentle Australia **[22]**, ACHLR and VADANZ co-sponsored the 2024 Trans-Tasman Voluntary Assisted Dying Conference. **[23]** VADRBs all include practitioners among their members, and Mewett, a current member of Victoria's VADRB, is also a former colleague of McLaren who founded VADANZ. They have co-authored various pro-VAD publications. **[24]**

Absent from the evidence sessions in Scotland or in England and Wales were any witnesses who could have provided a critical counter-perspective on Australian law and practice. The evidence presented was purely one-sided leaving the Committees with little or no measure against which to assess the strength of this evidence.

There is very little evidence from Australia

Remarkably, the Health, Social Care and Sport Committee did not hear oral evidence from the United States. Similarly, the Public Bill Committee did not hear oral evidence from Canada, and neither Committee heard from witnesses from the Netherlands, Belgium, or Switzerland.

This is very striking as the US State of Oregon, the Netherlands, Belgium, and Switzerland each have more than twenty years of experience of assisted suicide and / or euthanasia, and Canada has eight years. In contrast, no jurisdiction in Australia or New Zealand has more than five years experience of assisted dying. Other than Victoria, most other jurisdictions have only one or two years of experience.

As a consequence, when, for example, Alex Greenwich MP gave evidence on the implementation of VAD legislation in New South Wales, he was speaking on the basis of less than one full year of data. Thus a statement such as '*the experience of voluntary assisted dying is that it has been a form of suicide prevention*' **[25]** was at best anecdotal. It did not reflect data on evidence of impact. Only Victoria can provide some limited evidence of the impact of VAD in Australia, and the available data does not show any beneficial impact of this legislation in relation to 'suicide prevention'. The (unassisted) suicide rate among those over 65 in Victoria did not decrease after VAD was legalised, either in itself or in relation to neighbouring New South Wales which at this point had not yet legalised VAD. In fact, such suicides increased. **[26]**

It is also important to note that other jurisdictions in Australia and New Zealand have all departed from Victoria's legislation to a greater or lesser extent. The data on initial rates of death in different jurisdictions show that practices are quite divergent (Queensland had more than five times the initial rate of VAD in Victoria). **[27]** This indicates that it is not possible to extrapolate from the evidence of impact in Victoria, such as it is, to the potential impact of legislation in other jurisdictions in Australia and New Zealand.

VAD in Australia is very different from PAS in Oregon

The rationale for inviting witnesses from Australia and New Zealand is that '*the law you are proposing in the UK is similar to the laws that exist in Australia and New Zealand and most of the laws in the United States* **[28]***… It is exactly the same as the laws that apply across Australia and New Zealand and very unlike the more permissive models that exist in Europe and Canada*'. **[29]**

Australia and New Zealand have sometimes been grouped with the United States in previous reports as well. For example, an earlier House of Commons Committee Report (the Health and Social Care Committee Report on Assisted Dying / Assisted Suicide) grouped together 17 jurisdictions in these three countries as ones '*where AD/AS is legal on the basis of a person receiving a terminal diagnosis*'. **[30]**

However, there are substantial differences between the laws in these various jurisdictions.

The first such jurisdiction to change its law was Oregon. '*On October 27, 1997 physician-assisted suicide* [PAS] *became a legal medical option for terminally ill Oregonians*'. **[31]** Since then, two key features have been maintained in all PAS laws in the United States **[32]**:

- self-administration (that is, assisted suicide rather than euthanasia);
- an expectation of natural death within 6 months.

These two features are shared by the proposed Terminally Ill Adults (End of Life) Bill. **[33]** The first feature, but not the second, is also shared by the Assisted Dying for Terminally Ill Adults (Scotland) Bill. **[34]**

In contrast, no jurisdiction in Australia or New Zealand universally requires self-administration. All allow euthanasia, that is, lethal injection by practitioner, at least in some cases. In most of these jurisdictions the overwhelming majority of assisted deaths are by euthanasia. **[35]**

Similarly, no jurisdiction in Australia requires expectation of death within 6 months in all cases. All extend this to 12 months, at least for some patients **[36]**, and two jurisdictions (Tasmania **[37]** and ACT **[38]**) allow VAD even beyond this point. Only New Zealand has kept the 6 month limit to date, and its law is currently under review.

The number of deaths in Australia from VAD is far higher than from PAS in Oregon. In the first year in Oregon deaths by PAS were just 0.06% of all deaths in the State, whereas the first year of VAD in Western Australia was 1.1% of all deaths, in Tasmania was 1.2% and in Queensland was 1.6% (more that 25 times higher than Oregon). The initial rate of assisted death in these Australian States was even higher than the initial rate in Canada. Note that 1.6% of the deaths in England and Wales for 2023 would be approximately 9,300 deaths, whereas 0.06% would be approximately 350 deaths. **[39]**

All jurisdictions in the United States that have legalised PAS provide not only a right of conscientious objection for doctors but also statutory protection for institutions such as hospices not to be forced to provide or facilitate

PAS. **[40]** In contrast, no jurisdiction in Australia or New Zealand provides such protection and several Australian States require institutions to facilitate VAD in some way or other. In ACT, failure to facilitate VAD can constitute a criminal offence. **[41]**

In all these ways Australia and New Zealand depart from the model of PAS in Oregon and move closer to the law and practice of 'Medical Assistance in Dying' (MAiD) in Canada. Indeed, while the House of Commons Select Committee placed Australia and New Zealand in the same category as the United States, the British Medical Association (whose map was the basis of the map produced by the Select Committee) placed Australia and New Zealand in the same category as Belgium, Canada, Luxembourg, the Netherlands and Spain. **[42]** These are all jurisdictions with euthanasia.

A slippery slope in Australia

Until 2019, one of the reassuring features of legislation in Oregon, and other States in the United States, was that in over twenty years no law had been amended. **[43]** This contrasts with Canada, Colombia, Belgium and the Netherlands which have all seen major legal changes in a shorter time-frame, for example, expanding to include people whose death is not reasonably foreseeable (Canada), or those not in the terminal phase (Colombia), or minors (Belgium), or people with dementia who can no longer consent (the Netherlands).

Since 2019, the situation in the United States has become much less stable. There have been nine amendments to PAS legislation enacted across seven States in the past six years, most in the direction of expansion. **[44]** There is also evidence of expansion in practice, for example evidence in Oregon of PAS being provided on the basis of conditions such as anorexia, hernias or arthritis. **[45]** Nevertheless, at least in relation to the key features of self-administration and expectation of death within 6 months, the law itself has not changed.

Victoria already departed from the Oregon model in relation to these two key aspects, neither restricting VAD to self-administration nor requiring an expectation of death within 6 months in all cases. What is more, unlike Oregon in the United States, jurisdictions in Australia and New Zealand that have followed Victoria have not retained its safeguards, such as they are, but have further weakened or abandoned them.

For example, in the first VAD legislation in 2017 in Victoria, practitioner administration (euthanasia) was legalised only for those who were not physically capable of self-administration **[46]**; whereas, in 2021 in Queensland, it could be provided if a doctor thought that self-administration was 'inappropriate' **[47]**; and in 2024 in ACT, patients have simply been given a choice of self- or practitioner administration. **[48]** Euthanasia has gone from the exception to the norm.

Again, in 2017 in Victoria, terminal illness eligibility included expectation of death within 6 months or 12 months for people with neurodegenerative diseases **[49]**; whereas, in 2021 in Queensland eligibility was expectation of death in 12 months for all diseases **[50]**; and in 2024 in ACT, there was no requirement of expectation of death within a certain timeframe. **[51]** The definition of a 'terminal illness' has become much looser and, arguably, the ACT definition could encompass chronic conditions.

Similar erosion of requirements in successive legislation can be seen in relation to: the right of professionals and institutions such as hospices not to have to participate; prohibiting doctors from proposing VAD to patients; residency requirements; waiting times; the requirement for specialist medical assessments; and the requirement that VAD be administered by a medical professional.

In all these respects the scope of the law has expanded and safeguards have been eroded between Victoria and Queensland and between Queensland and ACT. The same pattern is found, at least as a general trend, in each of the jurisdictions in New Zealand and Australia that have followed Victoria. At least as a general rule, the later the law, the fewer the safeguards.

In these and in other respects the law enacted in 2017 in Victoria is consistently closer than other Australian jurisdictions to the law in Oregon and the law in 2024 in ACT is consistently closer than other Australian jurisdictions to the law in Canada. **[52]** The direction of travel is clear, from Oregon to Canada.

From successive legislation to amendment of the law

While Australia has seen clear expansion of VAD laws and weakening of safeguards in successive legislation, it might still be argued that this is not a true 'slippery slope' as no law has yet been amended since it was passed. In evidence to the Commons Health and Social Care Committee in May 2023, Kyam Maher, a Minister in the Government of South Australia stated that:

> '*I do not think we are going to see much change one way or another any time soon. The argument often raised by those concerned about the introduction of the model is that it is a slippery slope or the thin end of a wedge, or that there will be creep in how it may operate, but there is absolutely no evidence of that in Australia.*' **[53]**

Similarly in evidence to the Scottish Health, Social Care and Sport Committee in November 2024, Gardner stated that:

> '*The Victorian legislation has been in operation for five and a quarter years, and there have been no changes to the act at all… no evidence of a slippery slope*'. **[54]**

This statement was supported by White:

> '*I can confirm that that is the position across all the Australian States. The law is still as it was passed at the time… the Victorian Government has publicly stated that it will not be reopening the law. There is a review, but the public statements to date have said that the law will not be changing.*' **[55]**

These reassurances ring hollow given that the consistent stance of ACHLR, as expressed in multiple publications, is that the legislation passed in Victoria in 2017 includes unnecessary 'barriers to access' and thus is in need of amendment. Go Gentle Australia, which successfully campaigned for VAD laws to be introduced across Australia has been campaigning for specific amendments to expand the VAD law in Victoria. **[56]** VADANZ in its submission to the five-year review of the law in Victoria argued for a similar list of amendments. **[57]** Last and not least, the Victoria VADRB, which Gardner chairs, also argued for a similar list of legislative amendments in its most recent annual report, published in September 2024 **[58]**, making his evidence to the Committee in November 2024 disingenuous to say the least.

In evidence to the Public Bill Committee in January 2025, Mewett, another member of the Victoria VADRB, stated that.

> '*We are in the process of finalising a number of recommendations to our Health Minister* [in Victoria] *to make some adjustments to the law. I am not at liberty to go into detail, but many of those things, such as the gag clause and the waiting period, are really up for challenge.*' **[59]**

These remarks suggest a direct back channel from the VADRB to the Government, additional to its submission of evidence to the five-year review of the law.

In this five-year review of the implementation of the law in Victoria, which was published on 20 February 2025, there are no recommendations for a change in the law. The Review states that, ’*Suggested or required amendments to the Act were out of scope for this review*’. **[60]**

Nevertheless, the Review noted that some stakeholders in their feedback ‘*expressed views that some elements of the legislation were resulting in unintended consequences, creating barriers to access and uptake of VAD*’. **[61]** These stakeholder views are set out in an appendix to the Review. **[62]** The views expressed largely reflect those of VADANZ and of the Victorian VADRB.

Though the Review did not recommend that the law be changed, the Government immediately signalled an intention to bring forward legislation, subject to consultation, to ‘rewrite’ the law. It is noteworthy that the Government specifically mentions being influenced by Victoria’s VADRB.

> *‘In response to this important review, feedback from the community and the recommendations made by the Voluntary Assisted Dying Review Board, the Labor Government will rewrite legislation to improve access to VAD, bringing it in line with other jurisdictions.’* **[63]**

It is noteworthy that elsewhere in this statement the Minister refers to VAD as a choice for people with ‘a life limiting illness’ **[64]**, rather than a choice for people with a ‘terminal illness’. The former phrase is used in Australia in a palliative care context to refer to conditions that people may live with for many years:

> *‘A life-limiting illness is an active, progressive, or advanced disease, that has little or no prospect of cure and that you’re likely to die from at some point in the future. If you have been diagnosed with a life limiting illness you may continue to live an active life for many years to come.’* **[65]**

In Table 6.2 in the appendix, the Review lists nine changes suggested by stakeholders each of which is present in some other Australian jurisdiction. **[66]** These are listed below with a brief comment on the implications of each. Note that all changes would expand / weaken the law. There are no proposals to tighten regulation or bolster safeguards.

- ‘*Allow conscientious objection and organisational non-participation but require provision of information and/or referral*’ [i.e. restrict conscience rights and force doctors and hospices to participate in some ways in the process];
- ‘*Allow VAD to be raised as part of end-of-life planning*’ [i.e. allow doctors to proactively suggest that patients consider ending their lives];
- ‘*Make residency requirements more inclusive*’ [i.e. expand the practice to recent immigrants];
- ‘*Extend admissible period of death prognostication to 12 months for all conditions*’ [a stepping stone to abandoning any timeframe as in ACT];
- ‘*Reduce requirements for specialist assessments*’ [i.e. prescribe premature death without full knowledge of the trajectory of disease or the possibilities of treatment];
- ‘*Allow nurse practitioners to be involved in VAD as an administering practitioner*’ [i.e. expand it to less medically-qualified practitioners].;
- ‘*Enable issuance of a single permit, allowing clinical indication and patient choice to inform route of substance administration*’ [which would abandon even the presumption

that intentional death should be self-administered rather than in the power of another];

- *‘Broaden the types of interpreters able to assist’* [this allows family members, beneficiaries of wills, managers of care homes and others with a financial interest to act as an interpreter, as an exception, if no other interpreter is ‘reasonably available’];
- *‘Remove forms to enable future adjustments without legislative change’* [which of course allows further change without Parliamentary scrutiny].

In addition to these nine, the Review mentions a further proposal **[67]** which would take the legislation further than any existing legislation in Australia:

- *‘Advance care directives were proposed as a mechanism for supporting people living with dementia to access VAD’* [i.e. permit people to be euthanised without their consent or knowledge at the time, and even under restraint, as occurs in the Netherlands]. **[68]**

It should be noted that New Zealand has also completed a three-year review of the implementation of its law, which was published on 20 November 2024. After lobbying by some of the same groups, that review has also included recommendations for specific amendments to the law, several of which are along similar lines to the amendments proposed in Victoria. **[69]**

In Western Australia, a three-year review of its law concluded that the law was working well and there was no need for it to be amended **[70]**, despite recommendations for legislative expansion from the Western Australian VADRB. **[71]** Nevertheless, two out of three reviews have now recommended legislative change and a clear precedent has been set. Western Australia will have a further review in 2028 and there is nothing to stop other jurisdictions from proposing changes at any time.

The slippery slope in Australia and New Zealand is evidently moving to the next phase, from expansion in successive legislation to expansion by amendment of existing legislation. After only five years (in Victoria) or only three (in New Zealand) the law is set to be rewritten. This clearly shows that, if one follows the example of Australia or New Zealand the law you pass today is not the law you get tomorrow. It is only the beginning of an expanding project. The slippery slope is real.

Destination Belgium

The current moves in Australia and New Zealand are mainly to align jurisdictions that legalised VAD / ‘assisted dying’ in 2017 or 2019 with the more expansive law in Queensland, or possibly with the law in ACT. Nevertheless, that is clearly not the end of the journey. The law in ACT is similar in at least some respects to the law in Canada as it was in 2016. However, the law in Canada has since been amended to take it closer to the law in Belgium, and further changes are scheduled. It already overtly includes death for people whose natural death is not reasonably foreseeable, and it is scheduled in March 2027 to expand this further, from chronic physical conditions to mental health conditions. Quebec has already overtaken Belgium in legislating for advance decisions to end the lives of people with dementia who are not able to provide contemporaneous consent. The rest of Canada is on the same path. It is notable that this cutting edge of expansion is already anticipated in the Victorian five-year review.

In a submission to the Public Bill Committee, White together with Professor Lindy Willmott, also of ACHLR, note that their *‘current work includes a four-year project “Optimal Regulation* *of Voluntary Assisted Dying" which includes research into assisted dying systems in Australia, Canada and Belgium*'. **[72]** In their description of this project, on their own website, they state that:

> *'The research includes learning from two case study countries where VAD is already legal: Canada and Belgium. How these countries regulate VAD will be mapped as outlined in Stage one. The strengths and weaknesses of the Canadian and Belgian approaches to VAD will then inform the design of an optimal regulatory framework for Australia.'* **[73]**

This project makes no mention of any jurisdiction in the United States. It is clear that the aim of researchers in ACHLR is not to curb practice in Australia to bring it closer to that in the United States, but is to further expand practice so that it emulates the regulatory regimes in Canada and Belgium, at least in some respects.

A recent output of this ACHLR project, co-authored by White and Willmott, is an analysis of interviews with Belgian euthanasia providers. Under the first heading 'Theme 1a: The Act is valuable for allowing euthanasia' they note the following:

> *'One participant expressly referred to the importance of the Act for permitting euthanasia for patients with mental disorder. While they observed that euthanasia was performed prior to the enactment of the law (albeit in secret as it was illegal), this was only in acute situations where the patient was terminally ill. Accordingly, the Act has been essential for providing access to euthanasia for patients with mental disorder.'* **[74]**

This view of euthanasia for mental disorder is reported without demur or qualification. There was some discussion of how euthanasia for this reason should be regulated but no critique of the very idea of providing death to alleviate mental distress, or death for people who might be incapable of giving informed consent. Euthanasia for this reason is simply mentioned as an expression of the reiterated opinion of providers that *'the Act is a valuable, boundary-setting instrument*'. **[75]**

This study is also illustrative of much of the evidence being put forward in pursuit of expansion of the law. This study is not a systematic review or a meta-analysis of quantitative data, nor an analysis of physiological evidence of cases of misdiagnosis or of the mechanism of the action of lethal drugs. It is an example of small scale qualitative research with people who are strongly in favour of euthanasia or assisted suicide. What can be concluded from the preferences of euthanasia providers other than this is what they prefer? The widespread harm of premature death requested on the basis of psychological or social issues that could be addressed, not least the feeling of being a burden to others, is notable by its absence.

During the debate of the Second Reading of the Terminally Ill Adults (End of Life) Bill, David Davis MP expressed the view that:

> *'If on Third Reading I think that the outcome we are heading towards is Belgium, I will vote against; and if the outcome is Canada, I will probably vote against. If it is Australia, I will vote in favour. That is what the next stage of this process is about.'* **[76]**

This statement is helpful for its clarity but it rests on a mistake, for there is clear evidence of a slippery slope in Australia and it is equally clear where this slope leads. If we follow Australia then the outcome we are heading towards is Canada, and if we follow Canada then the outcome we are heading towards is Belgium.

'Too many safeguards'?

In oral evidence to the Health, Social Care and Sport Committee, White warned against what he saw as '*a temptation for parliamentarians to focus so heavily on safety that we sometimes forget about access*'. **[77]** Similarly in written evidence to the Public Bill Committee, White and Willmott argued that '[w]*hile a continued focus on safety is essential, work is needed to ensure assisted dying systems can be effectively accessed…* [thus] *caution is needed when considering the addition of numerous extra safeguards to a proposed assisted dying law*'. **[78]**

A similar concern was expressed by Mewett and Fellingham in oral evidence to the Public BillCommittee:

> Mewett: '… *many of those things, such as the gag clause and the waiting period, are really up for challenge. They have been shown not to be safeguards but, in fact, impediments and barriers to equitable and compassionate access to the scheme.*'
>
> Fellingham: '*I agree with Dr Mewett. They seem like a good idea, but they do tend to be barriers more than safeguards.*' **[79]**

Again, in oral evidence Blake repeated the recommendation that '*voluntary assisted dying is treated like any other treatment option*'. **[80]** However, if VAD is like 'any other treatment option' then all safeguards should be regarded as 'barriers to access'. What other treatments options are there that can be self-administered but are never permitted to be administered by a medical professional? Or can be offered to those who can consent but cannot be provided, on the basis of a best interest decision, to people who are unable to consent? **[81]** Treating VAD as 'any other treatment option' leads to the pattern of practice found in Belgium or the Netherlands including the tacit acceptance of '*life terminating acts without explicit request*'. **[82]**

A consistent preference for 'access' over 'safety' has driven the expansion of Australian legislation from that of Victoria to that of Queensland and from that of Queensland to that of ACT (noting that Victoria already represents a major departure from the model in Oregon). For example, White and Willmott state that they '*do not favour having a specific timeframe until death*' as '*not including a timeframe is unlikely to make a difference in practice*.' **[83]** However, it is difficult to assess this claim as the only jurisdiction in the world with a law that provides euthanasia and / or assisted suicide for people whose natural death is expected, but without specifying a timeframe, is ACT, and this law has not yet come into force. **[84]**

In 2015 Colombia restricted euthanasia to people in the 'terminal phase' of illness **[85]** and in 2016 Canada restricted 'medical assistance in dying' to people whose death was 'reasonably foreseeable' **[86]**, in both cases without specifying a timeframe. However in 2021 both these countries expanded their laws to include people whose death was not reasonably foreseeable. Furthermore, the language of the Canadian law was already interpreted very broadly and it seems likely that the same will occur with the ACT legislation. It is thus very likely that abandoning any timeframe will 'make a difference in practice' and the difference is likely to be in the direction of increased numbers and of use by those who are not terminally ill.

The concern to remove so-called 'barriers to access', which is clearly at work in the expansion of VAD in Australia, tends to lead to increasing disregard of any social or professional obligation to offer those suffering any alternative other than death. This is evident in discussion of people who feel that, on account of their ill health, they are a burden to relatives or carers. This is known to be a very common reason for requesting death **[87]**, including in Western Australia where it motivates over 35% of VAD requests. **[88]** Rather than acknowledge that this is a problem, and that the problem is made worse as access to the means of death is made easier, it is held not to be a problem because such feelings are compatible with 'capacity'.

Professor Blake thus stated that:

> *'If there are people who are saying they are a burden, that does not mean that their decision is not voluntary. That does not mean that they do not have the capacity. It simply is an expression of how they feel.'* **[89]**

However, the fact that someone has 'capacity' and their action is 'voluntary' does not mean that no harm is done by encouraging or assisting their actions. If someone seeks death because their care needs are not being met, or because of social isolation, or because of financial concerns, the obvious question is why this situation has been allowed to occur. Why are their needs not being met? How can they have been helped to live? In this context we should seek to address the root cause of the wish to die rather than simply facilitate it.

The need to rely on something more than simply an assessment of 'capacity' (as set out in the Mental Capacity Act 2007) in this context led Sarah Olney MP to propose an amendment to the Leadbeater Bill. **[90]** This amendment would have set the bar higher than mere 'capacity' in the case of those in danger of prematurely ending their lives. The rejection of this amendment by the Public Bill Committee **[91]** showed an unwillingness to compromise access for the sake of providing greater safety.

Another striking example of this attitude is the decision to abandon what had been trumpeted as a unique safeguard in the Bill, the requirement of prior approval by a High Court judge. **[92]** The judge is now to be replaced by a panel involving a social worker and a psychiatrist. **[93]** The reason for this change is clearly not to improve safety but to enable access, as doubts were raised in Committee about the capacity of the Courts to deal with the number of cases that might occur. Similar concerns have since been raised about the availability of psychiatrists, with mental health services already struggling **[94]**, and of social workers with the care sector in crisis. **[95]** It may be that the proposed alternative will be watered down further. In any case, this *volte-face* is a clear example of a Bill being made less safe and requests being subject to less scrutiny out of a concern to ensure increased access.

When defending the abandonment of this key safeguard, Kim Leadbeater said that:

> *'… some would say the bill now had "too many safeguards"'*. **[96]**

The argument that there can be 'too many safeguards' has been heard repeatedly in Australia and has been responsible for eroding the safeguards in the VAD legislation in Victoria, such as they are. The weakening of the Terminally Ill Adults (End of Life) Bill, even before it has completed the Committee stage, illustrates the dangers of hearing disproportionately from Australian witnesses who consistently prioritise access over safety.

Hearing for other voices

The over-reliance by these Parliamentary Committees on evidence from Australia is thus of grave concern, not only because of the one-sidedness of the evidence received, the fact that practice is so recent as to provide little evidence, and the fact that law and practice in Australia is distinct in important ways from the laws proposed in Scotland and in England and Wales. Most troubling is the clear evidence of a slippery slope in Australia and the direction of travel away from PAS in Oregon and towards MAiD in Canada.

It is not possible to un-hear what has been said, but it is possible to balance what has been said with critical voices who are familiar with the situation in Australia. One of the first acts of the Public Bill Committee was to reject a proposal to hear from Dr John Daffy, previously head of infectious disease at St Vincent’s Hospital in Melbourne or from Dr Stephen Parnis, previous vice-president of the Australian Medical Association. **[97]** They might otherwise have provided just such a counterweight.

It is still possible, nevertheless, to gain an alternative perspective about what is happening in Australia from the written evidence. There are hundreds of pages of this evidence, and is easy to miss the wood for the trees, but three submissions are worth highlighting. These should be read by any MP who has heard a little of the evidence from Australia and wants to put it in context.

First is the submission TIAB27 from Associate Professor Xavier Symons and Dr Bernadette Tobin AO of the Plunkett Centre for Ethics. **[98]**

Second is the submission TIAB245 from Robert Clark, former Attorney-General and MP in Victoria. **[99]** Some of this repeats what he has recently written in the *BMJ Supportive & Palliative Care Forum*. **[100]**

Third, and most insightful, is TIAB245(a), further written evidence from Clark in which he critically assesses some of the claims made by witnesses from Australia in the oral evidence sessions. **[101]**

These taken together may offer an antidote to many misleading claims purportedly supported by evidence from Australia.

Getting Help

If the issues discussed here affect you or someone close to you, you can call Samaritans on 116 123 (UK and ROI), visit their website https://www.samaritans.org/ or contact them on jo@samaritans.org.

If you are reporting or writing about a case of death by suicide, whether assisted or non-assisted, please consult media guidelines https://www.samaritans.org/about-samaritans/media-guidelines/ on how to do so responsibly.

Endnotes

Cover picture: Adaptation of ‘Legality of Assisted Dying in Australia’, by Jdee4, Wikipedia (used under Creative Commons Attribution-Share Alike 4.0 International Licence).

[1] On the ambiguity of the term ‘assisted dying’ see Jones DA, ‘Defining the Terms of the Debate: Euthanasia and Euphemism’, The Anscombe Bioethics Centre 2021; Jones DA ‘How (not) to define ‘assisted dying’, *Journal of Medical Ethics*, published Online First: 29 January 2025, doi: 10.1136/jme-2024-110415; Jones DA ‘Assisted dying’ is assisted suicide and / or euthanasia’ *JME Forum*, 31 January 2025.

[2] The Assisted Dying for Terminally Ill Adults (Scotland) Bill and the Terminally Ill Adults (End of Life) Bill. The latter includes a reasonable expectation of death within 6 months (s. 2(1)(b)), but the former does not include any timeframe (s. 2).

[3] Victoria, Voluntary Assisted Dying Act 2017, effective 19 June 2019; Western Australia, Voluntary Assisted Dying Act 2019, effective 1 July 2021; Tasmania, End-of-life Choices (Voluntary Assisted Dying) Act 2021, effective 23 October 2022; South Australia, Voluntary Assisted Dying Act 2021, effective 31 January 2023; Queensland, Voluntary Assisted Dying Act 2021, effective 1 January 2023; New South Wales, Voluntary Assisted Dying Act 2022, effective 28 November 2023; ACT (Australian Capital Territory), Voluntary Assisted Dying Act 2024, effective 3 November 2025.

[4] New Zealand, End of Life Choice Act 2019, effective 6 November 2021.

[5] Health, Social Care and Sport Committee Meeting, Tuesday 5 November 2024. Official Report.

[6] Dr Ramona Coelho and Dr Stefanie Green, see Health, Social Care and Sport Committee Meeting, Monday 11 November 11 2024. Official Report.

[7] Health, Social Care and Sport Committee Meeting, Tuesday 4 February 2025. Official Report (col. 25).

[8] Public Bill Committee, Terminally Ill Adults (End of Life) Bill, Fourth sitting (Wednesday 29 January 2025) and Sixth sitting (Thursday 30 January 2025).

[9] Dr Ryan Spielvogel and Dr Jessica Kaan, see Public Bill Committee, Terminally Ill Adults (End of Life) Bill (Third sitting), Tuesday 28 January 2025.

[10] Public Bill Committee, Terminally Ill Adults (End of Life) Bill (Seventh sitting), Thursday 30 January 2025.

[11] Voluntary Assisted Dying Review Board: Members.

[12] Australian Centre for Health Law Research.

[13] Public Bill Committee (Seventh sitting) col. 225.

[14] Friends at the End: Our position on assisted dying.

[15] My Death My Decision: What We Stand For.

[16] Voluntary Assisted Dying Review Board: Members.

[17] Public Bill Committee (Fourth sitting) col. 124, see also VADANZ.

[18] *Ibid*., col. 123.

[19] *Ibid*., see also VADANZ: Governance.

[20] *Ibid*., VADANZ: Governance.

[21] In their submission to the Public Bill Committee (TIAB 48) Prof Ben White and Prof Lindy Willmott state that they have 'been part of teams which have received over $A65 million for our end-of-life research and training programs'.

[22] Go Gentle Australia.

[23] VADCON24.

[24] See, for example, McLaren CJ and Mewett G 'Update on voluntary assisted dying in Australia.' *The Medical Journal of Australia* 215.3 (2021): 115-116. McLaren CJ and Mewett G 'Participating doctors' perspectives on the regulation of voluntary assisted dying in Victoria: a qualitative study', *Medical Journal of Australia*, 10.5694/mja2.51419, 216, 4, (210–210), (2022).

[25] *Op. cit*., Public Bill Committee (Sixth sitting) col. 212.

[26] Jones DA, 'Did the Voluntary Assisted Dying Act 2017 prevent "at least one suicide every week"?', *Journal of Ethics in Mental Health*, Open Volume 11: 1-20.

[27] In Victoria there were 129 VAD deaths in the first year out of approximately 41,400 deaths across the State, i.e. 0.3% whereas in Queensland there were 1.6%.

[28] *Op. cit*., Fellingham speaking to the Public Bill Committee (Fourth sitting), col. 127.

[29] *Ibid*., Fellingham speaking to the Public Bill Committee (Fourth sitting) col. 124.

[30] House of Commons Health and Social Care Committee, Report on Assisted Dying / Assisted Suicide, Second Report of Session 2023–24 HC 321, 29 February 2024, para. 70; see also Figure 2 (page 25).

[31] Oregon Health Division. 1999. Oregon's Death with Dignity Act: The First Year's Experience, p. 1.

[32] Oregon, 1997: 'Death with Dignity Act', effective 27 October 1997; Washington, 2009: 'Death with Dignity Act', effective 5 March 2009; Vermont, 2013: Act 39, 'Patient Choice and Control End of Life Act', 31 May 2013; Colorado, 2015: 'End of Life Options Act', effective 16 December 2016; California, 2015: 'End of Life Option Act', effective 9 June 2016; D.C., 2017: D.C. Law 21-182 District of Columbia, 'Death with Dignity Act', effective 18 February 2017; Hawaii, 2019: 'Our Care, Our Choice Act', effective 1 January 2019; New Jersey, 2019: 'Medical Aid in Dying for the Terminally Ill Act', effective 1 August 2019; Maine, 2019: 'Death with Dignity Act', effective 19 September 2019; New Mexico, 2021: 'End-of-Life Options Act', effective 18 June 2021.

[33] Op. cit., Terminally Ill Adults (End of Life) Bill, s. 18 and s. 2(1)(b)).

[34] *Op. cit*., Assisted Dying for Terminally Ill Adults (Scotland) Bill, s. 15 but not s. 2.

[35] Western Australia (p. 6) 94.9%, Tasmania (p. 25), 81.8%, Queensland (p. 10) 67%, New South Wales (p.6) 79.1%. The exceptions to this pattern are Victoria and South Australia, which restrict euthanasia to those not physically capable of self-administering, but the Victoria Government has just signalled that this safeguard is due to be abandoned – see below.

[36] In Victoria, Western Australia, South Australia and New South Wales 12 months for patients with neurodegenerative conditions. In Queensland, 12 months for all patients.

[37] Which has the pattern of 6 months and 12 for patients with neurodegenerative conditions.

[38] Which has no time frame for expectation of death (see below).

[39] Sources for this data are provided in the submission to the Public Bill Committee by Associate Professor Xavier Symons and Dr Bernadette Tobin AO of the Plunkett Centre for Ethics TIAB 27, para. 3.2.

[40] Oregon, 1997: 127.885 §4.01, (4) and (5); Vermont 2013: § 5286, Health care facility exception; Colorado, 2015: 25-48-118; California, 2015: 443.15; D.C., 2017: Law 21-182., section 11 c and d; Hawaii, 2019, §327L-19 b and c; New Jersey, 2019: 26b 2; Maine, 2019: § 2140. 22 B and C; New Mexico, 2021 (amended 2023): 24-7C-2, E.

[41] *Op. cit.*, ACT VAD Act 2024, part 7.

[42] BMA: Physician-assisted dying legislation around the world.

[43] As cited, for example, by Healthcare Professionals for Assisted Dying, p. 8.

[44] Oregon 2019, California 2021, Vermont 2022, Hawaii 2023, New Mexico 2023, Oregon 2023, Washington 2023, Vermont 2023, and Colorado 2024 see Jones, DA 'A Different Slippery Slope', *The American journal of bioethics*, 2024) 24.2: W1-W1, doi: 10.1080/15265161.2023.2296406. Of these, only New Mexico 2023 represented a tightening up of the law.

[45] Regnard C, Worthington A, Finlay I, Oregon Death with Dignity Act access: 25 year analysis, *BMJ Supportive & Palliative Care* 2024;14:455-461.

[46] *Op. cit.*, Victoria VAS Act 2017, s. 46(c)(i).

[47] *Op. cit.*, Queensland VAD Act 2021, s. 50(2).

[48] *Op. cit.*, ACT VAD Act 2024, s. 42(1), 43(1).

[49] *Op. cit.*, Victoria VAS Act 2017, s. 9 (4).

[50] *Op. cit.*, Queensland VAD Act 2021, s. 10(1)(a)(ii).

[51] *Op. cit.*, ACT VAD Act 2024, s. 11 (6).

[52] That is, to the Law in Canada as it was in 2016, when there was an eligibility requirement that natural death be 'reasonably foreseeable' but without specifying a timeframe.

[53] HC Health and Social Care Committee 2023, para. 120, pp. 45-46 citing oral evidence from 16 May 2023, Q91.

[54] Health, Social Care and Sport Committee Meeting, Tuesday November 5 2024, col. 18.

[55] *Ibid.*, col. 18.

[56] See for example: Go Gentle Australia, State of VAD 2024, p. 40.

[57] VADANZ, Submission to Review of the operation of the Voluntary Assisted Dying Act 2017 (Victoria), February 2024.

[58] Victoria VADRB, Voluntary Assisted Dying Review Board Annual Report July 2023 to June 2024, Victoria Department of Health, pp. 34-36.

[59] *Op. cit.*, Public Bill Committee (Fourth sitting), col. 129.

[60] Centre for Evaluation and Research, Evidence Review of the Operation of Victoria's Voluntary Assisted Dying Act 2017, October 2024, p. 6.

[61] *Ibid.*, p. 90.

[62] *Ibid.*, Appendix 6: Addendum to Review of the Operation of Victoria's Voluntary Assisted Dying Act 2017 – Stakeholder feedback regarding legislation, pp. 90–97.

[63] Minister for Health Mary-Anne Thomas Media release Thursday, 20 February 2025. Voluntary Assisted Dying Laws Still The Compassionate Choice. It is noteworthy that in this statement the Minister refers to VAD as a choice for people with 'a life limiting illness', rather than a terminal illness.

[64] *Ibid.*

[65] Australian Government Department of Health and Aged Care: What is Palliative Care?

[66] *Op. cit.*, Review of VAD Act 2017, p. 97.

[67] *Ibid.*, p. 93.

[68] Roberts, R 'Doctor who asked dementia patient's family to hold her down while she gave lethal injection cleared', *Independent*, 5 February 2017.

[69] Ministry of Health, 2024: Review of the End of Life Choice Act 2019, Wellington: Ministry of Health, pp. 10–22.

[70] Government of Western Australia, Department of Health News, 2 December 2024: Review of the Voluntary Assisted Dying Act 2019.

[71] Western Australia VADRB, Voluntary Assisted Dying Board Western Australia Annual Report 2023–24, pp. 53–55.

[72] Public Bill Committee, Terminally Ill Adults (End of Life) Bill: Written evidence submitted by Professors Ben White and Lindy Willmott, Australian Centre for Health Law Research, Queensland University of Technology, Australia (TIAB 48).

[73] Enhancing End-of-Life Decision-Making: Optimal Regulation of Voluntary Assisted Dying.

[74] Archer M, Willmott L, Chambaere K, Deliens L and White BP, 'How does regulation influence euthanasia practice in Belgium? A qualitative exploration of involved doctors' and nurses' perspectives', *Medical Law Review*, (2025) 33., p.fwaf003, at p. 8.

[75] *Ibid.*, pp. 1, 7, 20, 24.

[76] Hansard Volume 757, Terminally Ill Adults (End of Life) Bill: debated on Friday 29 November 2024, col. 1053.

[77] Health, Social Care and Sport Committee Meeting, Tuesday 5 November 2024, col. 21.

[78] *Op. cit.*, Public Bill Committee, Written evidence TIAB 48.

[79] *Op. cit.*, Public Bill Committee (Fourth sitting), col. 129.

[80] *Op. cit.*, Public Bill Committee (Sixth sitting) col. 214.

[81] On the implications of construing assisted suicide or euthanasia as a treatment option see Public Bill Committee written evidence submitted by Professor David Albert Jones (TIAB 258) see also Jones DA 'Is there a logical slippery slope from voluntary to nonvoluntary euthanasia?'. *Kennedy Institute of Ethics Journal* (2011) 21.4: 379-404.

[82] Pijnenborg L, *et al* 'Life-terminating acts without explicit request of patient'. *The Lancet* (1993) 341 (8854), 1196–1199.

[83] *Op. cit.*, Public Bill Committee, Written evidence, TIAB 48.

[84] Scheduled to come into effect, 3 November 2025.

[85] Columbia Ministry of Health 2015 Resolution 1216, article 2: '*Enfermo en fase terminal*'.

[86] Government of Canada: Canada's medical assistance in dying (MAiD) law.

[87] In the most recent reports it was cited in Canada by 45.1% of those whose death was reasonably foreseeable and 49.2% of those whose death was not reasonably foreseeable. in Oregon by 43.3% in 2023 (and 47.1% in total) and in Washington by 51%. In Oregon and Washington this fear of being a burden to others seems to have increased significantly since the law was in force. For exploration of the phenomenon of fear of being a burden to others among dying patients see Chochinov HM *et al*, 'Burden to others and the terminally ill', *Journal of Pain and Symptom Management* 34.5 (2007): 463-471.

[88] Western Australia VADRB, Voluntary Assisted Dying Board Western Australia Annual Report 2023–24, p. 22, fig. 5.

[89] *Op. cit*., Public Bill Committee (Sixth sitting) col. 222.

[90] Amendment 34 and consequent amendments, Public Bill Committee, Terminally Ill Adults (End of Life) Bill (Ninth sitting), Tuesday 11 February 2025, official report cols. 325–348.

[91] *Ibid*.

[92] See, for example, Hansard, Terminally Ill Adults (End of Life) Bill: cols, 1012, 1019, 1033, 1065.

[93] Elgot J, 'Kim Leadbeater: assisted dying bill will still have world's strongest safeguards', *Guardian,* 11 February 2025.

[94] Eastham J, '"Not enough psychiatrists" to make assisted dying Bill work', *Telegraph,* 17 February 2025.

[95] Holl-Allen G, 'Social workers too busy for assisted dying panels, Leadbeater told', *Telegraph,* 20 February 2025.

[96] Farley H, 'Replacing judge with experts strengthens assisted dying bill, MP says', *BBC News*, 10 February 2025.

[97] *Op. cit*., Public Bill Committee, Terminally Ill Adults (End of Life) Bill (First sitting), Tuesday 21 January 2025, col. 24.

[98] *Op. cit*., Public Bill Committee, Written Evidence, TIAB 27.

[99] *Ibid*., Public Bill Committee, Written Evidence, TIAB 245.

[100] Clark R, 'The Victorian assisted suicide experience and its implications', *BMJ Supportive & Palliative Care Forum*, 31 January 2025. Author: Hon. Robert Clark, former Attorney-General and MP, Victoria, Australia.

[101] Public Bill Committee, Written Evidence, TIAB 245(a).

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