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David Albert Jones

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# Slippery slopes down under: the progressive loosening of requirements for voluntary assisted dying in Australia and New Zealand

DAVID ALBERT JONES 

*School of Theology and the Arts, St Mary's University, Twickenham, UK*

Between November 2017 and June 2024 eight jurisdictions in Australia and New Zealand passed laws to legalise some form of euthanasia and/or assisted suicide. Like the United States, Australia has a federal constitution and ‘voluntary assisted dying’ (VAD) in Australia has been legalised at the state level. However, unlike the United States, Australia and New Zealand both permit practitioner administration of the lethal drug (euthanasia) as well as self-administration (assisted suicide). Another difference is that physician-assisted suicide, at first, spread very slowly in the United States, and new laws were based closely on the requirements of the original legislation in Oregon. In contrast, in Australia and New Zealand, the spread of VAD has been rapid from the outset, and there is a discernible pattern of successive weakening of safeguards in more recent legislation. The Australian model has increasingly come to resemble that of Canada.

**KEYWORDS** Assisted dying, assisted suicide, euthanasia, slippery slope, Australia

## Australia invoked in the English debate over assisted dying

In its survey of different models of ‘Assisted Dying/Assisted Suicide’ (AD/AS), the UK House of Commons Health and Social Care Committee grouped together New Zealand, states within Australia, and states within the United States as jurisdictions ‘where AD/AS is legal on the basis of a person receiving a terminal diagnosis’ (HCHSC 2024, para. 70). These jurisdictions were regarded as having the strongest safeguards. The House of Commons Committee also noted that, whereas the practice in Canada was frequently cited as an unfavourable example

by people who responded to the Committee's consultation, New Zealand and Australia were frequently cited as favourable examples (HCHSC 2024, para. 115).

Australia was also invoked favourably in the House of Commons in the debate which preceded the successful Second Reading of the Terminally-Ill Adults (End of Life) Bill. One MP stated that:

Arguments that this legislation would be the beginning of a slippery slope are not reflected by the majority of legislators, such as Australia and across multiple states in the USA, where such policies have not been expanded. Again, the Health and Social Care Committee has told us that where terminal illness was the basis—not suffering—as for this Bill, the law has not changed (Hansard 2024, Column 1058).

Another MP went so far as to say that his support for the legislation would depend on whether the final form of the Bill followed the Australian model as opposed to that of Belgium or Canada.

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 (Hansard 2024, Column 1053).

The source of this favourable impression is often some statement by an Australian clinician, academic or politician who is a supporter of the Australian legislation. For example, the House of Commons Committee quoted with approval the statement of Kyam Maher MLC, a Minister in the Government of South Australia:

We have a model, which Victoria started, that is now, with some degrees of variation, the Australian model, where someone has a terminal illness, is usually in the last six or 12 months of their life and is in insufferable pain. All states have adopted that. Personally, 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 (HCHSC 2024, para. 115).

This account was not challenged by the Committee. However, a close examination of the legislation that has been passed in New Zealand, in the six Australian states and in the Australian Capital Territory reveals a rather different picture. The evidence suggests that the safeguards in the legislation introduced in Victoria have progressively been weakened in subsequent legislation. The evolution of 'voluntary assisted dying' (VAD) laws in Australia and New Zealand presents a very clear example of a 'slippery slope' in action.<sup>1</sup>

## The development of the Oregon model

As background it is useful to begin with an overview of the law in Oregon and other jurisdictions in the United States. One notable feature of the Oregon model is the

<sup>1</sup> On the validity of slippery slope arguments more generally see Williams (1995), Lode (1999), and Volokh (2003).

stability of this legislation for a considerable period after its initial implementation, at least in law though not necessarily in practice (Finegan 2024, Regnard *et al.* 2024). In 2020, it could be stated that ‘the assisted dying law in Oregon has remained unchanged for over 20 years. There has been ... no widening of its initial, limited scope’ (HPAD 2020, p. 6). Not only did the Oregon law not change, but subsequent legislation in other US states that followed Oregon adopted all the safeguards present in the Oregon law. The example of Oregon was thus thought to provide reassurance to legislators in other countries that there was no slippery slope of inevitable expansion after such a law was passed: ‘the law you enact is the law you get’ (HPAD 2020, p. 6).

This reassuring picture was maintained until 2020.<sup>2</sup> However, since that year, there has been a noticeable shift in the United States, from no amendments for more than 20 years to a rapid succession of amendments (Jones 2024b). In the last six years, seven states have enacted nine such amendments. Eight out of nine of these amendments have aimed to expand provision or weaken requirements: either removing residence requirements (Oregon 2023, Vermont 2023); permitting nurse practitioners a role in assessing or prescribing (Hawaii 2023, Washington 2023, Colorado 2024); reducing or waiving waiting times (Oregon 2019, California 2021, Vermont 2022, Hawaii 2023, Washington 2023, Colorado 2024); requiring non-participating institutions to post their policies on the provision of assisted suicide (California 2021, Washington 2023); or imposing additional duties on doctors with a conscientious objection (California 2021). The one exception to this expansion of provision and weakening of safeguards was New Mexico. In 2023 the state amended its law to strengthen the conscience provisions, exempting doctors from having to provide information on physician-assisted suicide and from having to refer patients to a doctor who does not have an objection (New Mexico 2023). Nevertheless, it is also noteworthy that New Mexico, which is the only state to have legalised physician-assisted suicide since 2020, incorporates some features from amendments in other US jurisdictions; for example, it permits nurse practitioners to prescribe the lethal drug (New Mexico 2021, pp. 24–7C-2. D(3)).

This recent weakening of the requirements set out in 1997 in Oregon is striking, but the two most characteristic safeguards of the Oregon model have not yet been breached. All jurisdictions in the United States where the practice is legal still require self-administration and all restrict eligibility to people with an illness that is expected to cause death within six months.

It is illuminating to compare the Oregon model with that in Canada, which offers both self-administration (assisted suicide) and practitioner administration (euthanasia) and which, between 2016 and 2021, required that death was ‘reasonably foreseeable’ but without specifying a required timeframe (Criminal Code 241.2(2)(d)). Since 2016 the number of ‘medical assistance in dying’ (MAID) deaths in Canada has risen more quickly than any other jurisdiction and Canada now has the highest number of such deaths of any jurisdiction in the world. It is noteworthy that Canada and California introduced some form of euthanasia or

<sup>2</sup> Among US jurisdictions that have legalised physician-assisted suicide, the first to amend its law was Oregon. That amendment was passed in August 2019 and came into force in January 2020.

assisted suicide in 2016 and they have very similar sized populations. However, in the period 2016–2021, whereas there were 2,422 deaths under the law in California (CDPH 2022, p. 3), which followed the Oregon model, there were 31,664 deaths in Canada (Health Canada 2022, p. 18, 3.1). At the same time, serious concerns have been raised about the dangers of the practice in Canada (Coelho *et al.* 2023, Kotalik and Shannon 2023, Lyon *et al.* 2025). Euthanasia and/or assisted suicide expand in numbers and in scope in every jurisdiction where they are introduced. Nevertheless, the Oregon model with its two key safeguards of self-administration (assisted suicide) and an expectation of death within six months, is associated with a significantly lower rate of expansion of the practice (Gamondi *et al.* 2014, Borasio *et al.* 2019, Jones 2024a, p. 10). The Oregon model has been described as ‘slowing the slide down the slippery slope’ (Pullman 2023).

## Victoria departs from the Oregon model

The first Australian state to pass a law legalising euthanasia or assisted suicide was Victoria in 2017. This was influenced by ‘assisted dying frameworks’ that were in place in Oregon, the Netherlands, Québec, and the federal law in Canada.

Although there are many differences between the frameworks, the Committee saw benefits in aspects of each. The framework recommended in this Report is based on those elements which the Committee considered best practice as well as an appropriate cultural fit in the context of Victoria’s medical and legal systems and culture (VLSIC 2016, p. 14, 1.4.5).

The resultant legislation (Victoria 2017) followed Oregon in certain respects but departed from that model in the two key requirements identified above. Those drafting the law accepted that an expectation of death within six months might be applicable to diseases such as cancer, but regarded this as more difficult to apply to neurodegenerative diseases. This was in part because it could be more difficult to predict death within six months in these conditions, and in part because neurodegenerative conditions may carry some risk of loss of decision-making capacity before that point. Similarly, lawmakers in Victoria considered that, while the requirement for self-administration was a useful safeguard in general, it discriminated against people who were physically incapable of administering the lethal drug themselves.

Eligibility in the Voluntary Assisted Dying Act 2017 was thus set at the expectation of death within six months for most conditions, but this was extended to 12 months for people with neurodegenerative conditions (S. 9(4)). Again, self-administration was to be the norm for most patients, but practitioner administration was permitted for those who were not physically capable of self-administration (S. 46(c)(i)).

A note on terminology: in Victoria, the term ‘voluntary assisted dying’ (VAD) was used to cover both self-administration (assisted suicide) and practitioner administration (euthanasia). The term VAD was subsequently adopted in all Australian jurisdictions (Western Australia 2019, Queensland 2021, South Australia 2021,

Tasmania 2021, NSW 2022, ACT 2024).<sup>3</sup> In New Zealand, which passed a similar law in 2019 (similar in that it legalised assisted suicide and euthanasia for people with a terminal illness), the term used was ‘assisted dying’ (New Zealand 2019, S. 4). This paper will use the term ‘assisted dying’ when referring specifically to New Zealand but, for convenience, will use the term VAD when referring to New Zealand together with Australian jurisdictions.

These departures from the safeguards in the Oregon model are significant for different reasons. The requirement of expectation of death within six months is clearly arbitrary. Why should the law include someone expected to die in five months but exclude someone expected to die in seven months? The criterion has also been attacked because of the inherent uncertainty of prognosis (Treleven *et al.* 2023). Nevertheless, while time limits may be arbitrary and uncertain, if there is no timeframe given for when death is expected then in practice eligibility can easily be extended to chronic conditions. This has been the experience in Canada (Shannon 2023). The figure of six months, precisely because it is arbitrary, relies on precedence for its strength. It has remained in place in the United States for more than 25 years. Once a well-established limit is broken it is difficult to defend alternative limits. The expansion invites consideration of further expansion.

The second breach by Victoria of Oregon’s key requirements is not of an arbitrary time limit but is a matter of principle. There is an inherent difference between a patient taking their own life and their life being taken by another (Jones 2024a). Even in countries where both acts are illegal, they typically fall under different laws and directly taking someone else’s life is the more serious offence.<sup>4</sup>

It is important to recognize that, even when done at the patient’s request, lethal injection by a healthcare practitioner (euthanasia) is not itself the action of the patient. Actions speak louder than words and in euthanasia the ‘last word’ is that of the practitioner, not that of the patient. Given the choice, most people prefer to hand over responsibility to the doctor and, where only self-administration is offered, far fewer people use it (Pullman 2023, Jones 2024a). This implies that euthanasia practitioners are taking the lives of people who would have chosen to live if the alternative involved self-administering the lethal drug. This reluctance to be the instrument of one’s own death could be construed as an ambivalence about choosing to die. Euthanasia also places ultimate power in the hands of the healthcare professional, and so has the potential for abuse of this power, and in particular of voluntary euthanasia leading to non-voluntary euthanasia, also known as LAWER ‘life-terminating acts without explicit request of patient’ (Pijnenborg *et al.* 1993, Chambaere *et al.* 2014, Jones 2017, Keown 2022). This is not to deny that LAWER can happen in jurisdictions without legal euthanasia, but legal euthanasia gives legitimacy, in principle, to the use of medical power to end life. For a variety of reasons, then, legalising euthanasia is widely regarded as more dangerous than

<sup>3</sup> The dates given here are the dates the Bills passed and reflects the title of the respective law notwithstanding that there may be a delay between the law passing and its implementation. The date each law took/takes effect is given in the bibliography.

<sup>4</sup> For example, in England and Wales, assisted suicide is prohibited by the Suicide Act 1961 and carries a maximum sentence of 14 years, whereas euthanasia is prohibited by the common law on murder and the Homicide Act 1957 and carries a mandatory life sentence (murder) or a maximum sentence of life (manslaughter).

legalising assisted suicide. In permitting euthanasia, even for a narrowly defined group of people (those physically incapable of suicide), Victoria removed what was a key safeguard in Oregon legislation.

## The rapid expansion of VAD in Australia and New Zealand

Oregon legalised physician-assisted suicide in 1997, and after 10 years no other state in the United States had followed its lead. Even after 25 years there were only nine out of 50 states that have enacted such laws (Oregon 1997, Washington 2009, Vermont 2013, California 2015; Colorado 2015; Hawaii 2019, Maine 2019, New Jersey 2019, New Mexico 2021) plus one state where assisted dying was legalised by case law (*Baxter v. Montana*, 354 Mont. 234 (2009)) i.e. 20% of states, plus one non-state jurisdiction (District of Columbia 2016).

In contrast, Victoria legalised VAD (euthanasia and physician-assisted suicide) in 2017, and within five years, 100% of the Australian states (Victoria 2017, Western Australia 2019, Queensland 2021, South Australia 2021, Tasmania 2021, NSW 2022) and New Zealand (2019) had passed similar laws; and within a further two years, the Australian Capital Territory had also passed a law (ACT 2024), leaving only the Northern Territory, where these practices are illegal in Australia.<sup>5</sup>

In the United States between 1997 and 2020, all states that enacted assisted suicide legislation followed Oregon closely in regard to eligibility criteria and other requirements. In contrast, in Australia and New Zealand, no jurisdiction followed Victoria in all its requirements, and in general, the later that a state changed its law, the weaker its requirements for VAD. This can be seen clearly in relation to the two key requirements of the timeframe for terminal illness and the conditions for inclusion of practitioner administration (euthanasia).

In Victoria in November 2017 eligibility for VAD was restricted to expectation of death within six months or 12 months for neurodegenerative conditions (S. 9(4)) and practitioner administration was restricted to those physically incapable of self-administration (S. 46(c)(i)).

In New Zealand in November 2019, eligibility for ‘assisted dying’ was restricted to six months for all conditions (S. 5(1)(c)), but practitioner administration was offered to all patients (S. 19(2)).

In Western Australia, in December 2019, eligibility for VAD was restricted to the expectation of death within six months or 12 months for neurodegenerative conditions (S. 16(1)(c)(ii)), but doctors were given latitude to offer practitioner administration if this was more suitable for the patient (S. 56(2)).

In Tasmania in March 2021 eligibility for VAD was generally restricted to expectation of death within six months or 12 months for neurodegenerative conditions (S. 6(1)(c)), but exceptions could be made to this based on medical considerations (S. 6(3), 6(4)), Doctors were also given latitude to offer practitioner administration if this was more suitable for the patient (S. 86(5)).

<sup>5</sup> It is noteworthy that the Northern Territory previously legalised euthanasia by the Rights of the Terminally Ill Act 1995 (NT) which was then overturned at federal level by the Euthanasia Laws Act 1997. However, now it is the only jurisdiction in mainland Australia not to have enacted such legislation.

South Australia in June 2021 followed Victoria in its requirements, restricting eligibility for VAD to expectation of death within six months or 12 months for neurodegenerative conditions (S. 26(1)(d)(iii), 26(4)) and restricting practitioner administration to those physically incapable of self-administration (S. 64(c)(i)).

Queensland, in September 2021, abandoned the six-month requirement, setting eligibility for VAD at 12 months for all conditions (S. 10(1)(a)(ii)), and doctors were again given latitude to offer practitioner administration if this was more suitable for the patient (S. 50.2).

The law passed in New South Wales in May 2022 set eligibility for VAD at six months for most conditions and 12 months for neurodegenerative conditions (S. 16(1)(d)(ii)) and gave doctors latitude to offer practitioner administration to patients, but unlike other Australian states, did not set out any criteria for why practitioner administration should or should not be offered (S. 57(1)).

Australian Capital Territory (ACT) in June 2024 deemed patients eligible for VAD if they had a condition that was ‘advanced, progressive and expected to cause death’ (S. 11(1)(b)), but did not specify any timeframe. The law expressly stated that patients may be eligible for VAD ‘even if it is uncertain whether their relevant conditions will cause death within the next 12 months’ (S. 11(6)). As with New Zealand, but alone among Australian jurisdictions, practitioner administration was provided as an option for all patients (S. 82(3)(c)). In these respects the law in ACT is much closer to the Canadian law of 2016 than it is to the Oregon model.

An unusual feature of the ACT legislation is that it specifies that a person is eligible for VAD if they have a condition that ‘either on its own or in combination with 1 or more other diagnosed conditions’ is expected to cause death (S. 11(1)(b)). This will include conditions that are progressive but not in themselves terminal. The phrase echoes practice in Belgium where people are eligible for euthanasia if they have ‘poly pathology’, a term often used to refer to the common ailments of old age, such as arthritis, hearing loss, cognitive impairment, and general frailty (Raus *et al.* 2021, pp. 88–89. See also Van Wijngaarden *et al.* 2018, Haekens 2021, Van Den Noortgate and Van Humbeek 2021). It is difficult in such cases to point to any one condition as terminal or to provide a timeframe for death, but in a broad sense, the person might be ‘approaching the end of their life’ (S. 11(3)(c)) and hence be eligible for euthanasia or assisted suicide in ACT.

## Changes in the legislative model in Australia and New Zealand

Victoria’s VAD Act 2017 required that for eligibility for VAD a person’s condition must be ‘incurable’ (S. 9(1)(d)(i)) and South Australia followed Victoria in this (S. 26(1)(d)(i)).<sup>6</sup> Tasmania used the language of a condition being ‘incurable’, but

<sup>6</sup> This section, and indeed the paper more generally, has benefited from the analysis of Waller *et al.* (2023) who provide a helpful comparison of the relevant legislation in the six Australian states. The current paper differs from that article in that it includes New Zealand and ACT, in that it does not attempt to be a comprehensive comparison but focuses on prominent safeguards that differ between states, and in that it gives more attention to progressive change over time. The present paper is also more critical of the aim of maximizing ‘access’ to VAD, as will be discussed in later sections.

made clear that this was a subjective judgement, related to what treatments the patient deemed acceptable rather than the potential for treatment (S. 6(2)(a)). New Zealand, Western Australia, Queensland, New South Wales and ACT dropped reference to conditions having to be ‘incurable’ for eligibility.

Victoria had robust citizenship and residency requirements, requiring that someone either be an Australian citizen or have the official status of ‘permanent resident,’ and that they be ordinarily resident in Victoria (S. 9(1)(b)). There were similar requirements in the VAD laws of New Zealand (S. 5(1)(b)), Western Australia (S. 16(1)(b)), and South Australia (S. 26(1)(b)). However, these requirements have been loosened in Tasmania (S. 11(1)(a)(iii)), Queensland (S. 10(1)(e)), New South Wales (S. 16(1)(b)(iii)), and ACT (S. 11(1)(f)) so that someone could be eligible for VAD who was neither an Australian citizen nor a permanent resident of the state.

Another safeguard in the Victoria law was a waiting period of at least nine days between the first and final request, though this could be reduced to one day if death was likely within the nine-day period (S. 38). This requirement was maintained by Western Australia (S.48), South Australia (S. 56), and Queensland (S. 43(3)) but Tasmania reduced this to 48 h before the second request (S. 30(2)) and a further 48 h before the final request (S. 53(2)) and New South Wales reduced it to five days in total (Schedule 1 Dictionary: designated period). Western Australia (S. 48(3)(a)), Tasmania (S. 30(2)(b), 53(2)(b)), Queensland (S. 43(2)(a)), and New South Wales (S. 49(2)(a)) also added a second reason for waiving the waiting period – where there was a danger of the person losing capacity within the timeframe. New Zealand and ACT abandoned the waiting period altogether.

One safeguard that was original to Victoria was the prohibition on doctors initiating discussion of VAD (S. 8(1)). The rationale for this safeguard was to prevent healthcare professionals from exerting indirect influence that might encourage a patient to end their life. The healthcare relationship is an unequal one and it is the doctor who frames the medical options for the patient to consider. The Victoria legislation is in stark contrast with regulation in Canada, where doctors ‘must take reasonable steps to ensure persons are informed of the full range of treatment options available to relieve suffering’ including the option of MAID (Health Canada 2023, p. 6.1). Doctors in Canada have an obligation to inform patients proactively if they are eligible for MAID, except where this would not be ‘consistent with the person’s values and goals of care’ (Health Canada 2023, p. 6.3). In practice, patients in Canada have often been upset by practitioners raising this possibility before it has been raised by the patient (Kirkey 2022). Victoria’s safeguard was included in legislation in New Zealand (S. 10) and South Australia (S. 12) but was dropped in all other Australian states and in ACT.

Victoria required that assessments, prescriptions and administration of VAD be conducted by a qualified medical professional (S. 10). South Australia followed Victoria in this requirement (S. 27) but New Zealand (S. 4), Western Australia (S. 54(a)(ii)) and New South Wales (S. 55(a)(iv)) allowed nurse practitioners to deliver VAD and Tasmania (S. 62(2)), Queensland (S. 83(a)(iii)) and ACT (S. 89(2)) also allowed registered nurses some role in the delivery of VAD.

Victoria required that either the co-ordinating medical practitioner or the consulting medical practitioner ‘must have relevant expertise and experience’ (S. 10(3)) in the condition expected to cause death. South Australia followed this rule (S. 27(3)) and Tasmania added to it – requiring that both practitioners had relevant experience (S. 9(c)). However New Zealand and all other Australia jurisdictions dropped the requirement of expertise in the condition. This meant that neither the co-ordinating practitioner nor the consulting practitioner necessarily had specific expertise in the trajectory of the illness, nor in the medical options relevant to the person requesting VAD.

New Zealand and all Australian jurisdictions provided at least a limited right of conscientious objection for healthcare professionals: against participating in assessment for VAD and against prescribing or administering the lethal drugs. Victoria also allowed a right not to provide patients with information about VAD (S. 7(a)). This right was upheld in South Australia (S. 10(a)) and implicitly in New South Wales (S. 21(5)), but expressly not in New Zealand (S. 9(2)), Western Australia (S. 20(5)(b)), Tasmania (S. 18(1)) or Queensland (S. 16(3)). ACT not only required provision of information about VAD but made conscientious refusal to provide this a criminal offence (S. 100(2), 100(3)).

Unlike Oregon (Oregon 1997, Ch. 127.885 §4.01. (4) and (5)) or other states in the United States, Victoria did not include any overt protection for institutions such as hospices, hospitals or nursing homes, from having to participate in VAD. On the other hand, Victoria did not impose obligations on institutions to participate nor did it lay down specific legal obligations on non-participating institutions. It allowed institutions to develop their own policies. A similar approach was taken in New Zealand, Western Australia and Tasmania. However, South Australia set down requirements for non-participating institutions. Residential facilities, including nursing homes were required not to hinder access to information and to allow access to practitioners for assessment and administering of VAD (S. 17). Health service establishments, such as hospitals or hospices, could refuse to give information or allow VAD activities onsite, but had to advise patients that the facility did not participate in the VAD process, and had to arrange to transfer the patient to a facility where VAD could be provided (Section 11). New South Wales followed broadly the same requirements as South Australia (S. 90–99). Queensland expanded the obligations on non-residential facilities by requiring access for assessments and, where the doctor providing VAD did not think transfer was reasonable, requiring facilities to allow VAD onsite (S. 90–97). ACT went further still, making no distinction between the obligations on residential facilities and health service establishments and creating several criminal offences which the operator of a facility or establishment might commit if they did not facilitate access to VAD in specified ways (S. 104–109).

## **A demonstrable erosion of safeguards over time**

This paper has compared requirements for provision of VAD in legislation in Australia and New Zealand across nine domains: timeframe for expected death;



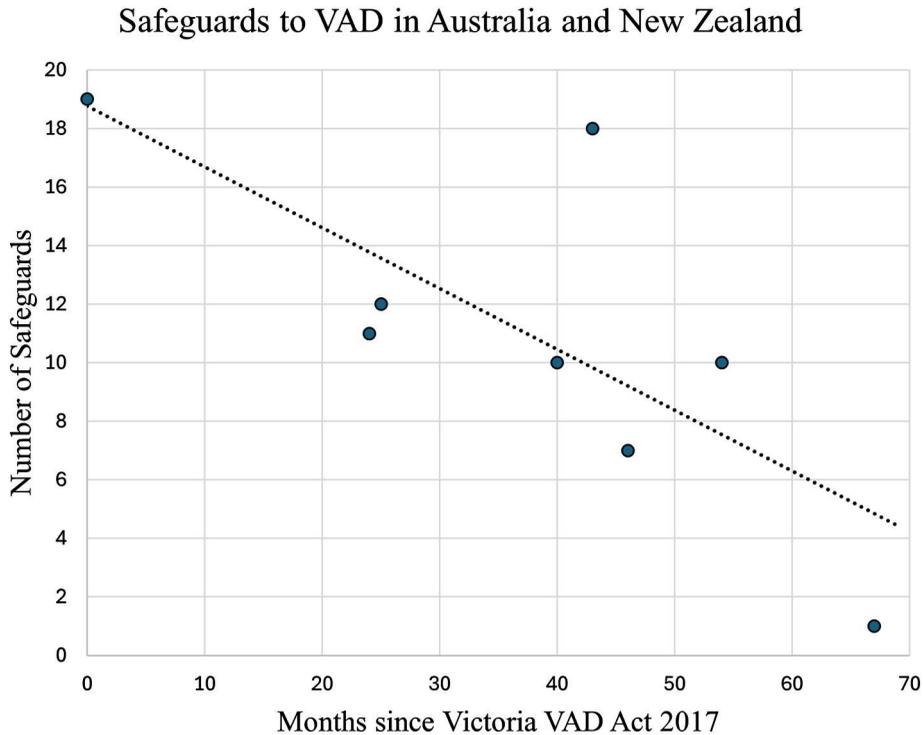


FIGURE 1. Safeguards in VAD legislation in Australia and New Zealand identified in this paper plotted against number of months between the passing of the respective legislation and the passing of Victoria’s VAD Act 2017.

exceptions that buck the trend somewhat, as South Australia followed Victoria more closely than New Zealand, Western Australia or Tasmania did, and New South Wales was more restrictive than Queensland. Nevertheless, there does seem to be a trend over time and as is shown by [Figure 1](#).

### Impact of these differences

In relation to the limits on offering euthanasia, it is clear that the requirement in Victoria and South Australia that patients be physically incapable of self-administering had a major impact on practice. These were the only jurisdictions where most VAD deaths were self-administered. In the first full year of operation 83.7% of VAD in Victoria was self-administered (108 out of 129, see [VADRBV 2023](#), p. 5) and in South Australia 90.4% was self administer (141 out of 156, [SAVADRB 2024](#), p. 9). Indeed these remain the only jurisdictions in the world which permit both assisted suicide and euthanasia where most such deaths are by assisted suicide ([Jones 2024a](#)). There is also evidence that giving doctors discretion about whether to offer euthanasia had a real, though lesser, impact on practice. Around one in five VAD deaths were self-administered in Western Australia

(22.6% (43 out of 190), VADRBWA 2022, p. 25), Tasmania (18%, VADCT 2024, p. 25) and New South Wales (20.9% (83 out of 398), NSWVADB 2024, p. 6). In Queensland, the figure was 40% (VADRBQ 2024, p. 1). In all cases this was clearly less than Victoria or South Australia but clearly more than New Zealand, which offered patients a free choice of means of administration and saw less than one in ten of assisted deaths self-administered (6.7% (22 out of 328), Ministry of Health 2023, p. 10).

One demonstrable impact of lessening the number and/or rigour of requirements is an increase in VAD deaths. When physician-assisted suicide was introduced in Oregon in 1997 there were 16 such deaths in the first year, which was less than 0.1% of deaths in Oregon that year (OHD 2000, p. 6). Similarly when Washington introduced the practice there were 51 such deaths in 2010, the first full year (WSDH 2011), again less than 0.1% of deaths in that state that year (56,995 deaths see PRB 2021). In contrast Canada experienced 2,838 MAID deaths in 2017, its first full year of operation (Health Canada 2022, p. 18). This was 1.0% of deaths in Canada that year (276,689 deaths, see Statistics Canada 2019).

In Victoria there were 129 VAD deaths in the first year of activity (VADRBV 2023, p. 5), which was approximately 0.3% of deaths in that state that year (41,373 deaths between September 2019 and August 2020, see BDMV 2024). This was perhaps as expected as Victoria departed from key safeguards in Oregon but did not go as far as Canada. Jurisdictions which followed Victoria but had progressively fewer or weaker safeguards had progressively higher rates of VAD death in their first full year: New Zealand 328 (0.9% of 38,574 deaths in 2022, see Ministry of Health 2023, p. 10, SNZ 2023); Western Australia 190 (1.1% of all deaths, VADRBWA 2022, p. 5); Tasmania 60 (1.2% of all deaths VADCT 2024, p. 4); South Australia 156 (1.0% of all deaths, SAVADRB 2024, p. 9); and Queensland 598 (1.6% of all deaths VADRBQ 2024). New South Wales does not have a full year of data but for the first 7 months had 398 deaths which was 1.2% of all deaths (33,997 deaths between December 2023 and June 2024, see NSWVADB 2024, p. 6, ABS 2024). The law in ACT comes into operation in November 2025. Note that while, in general, VAD mortality has increased in successive legislation, South Australia, which was later than Western Australia and Tasmania but had more safeguards, had a lower rate of VAD death. Note also that NSW which was later than Queensland but had more safeguards, had a lower rate of VAD death than Queensland (at least on data thus far).

Note also that Western Australia, Tasmania, and Queensland all had higher rates of assisted suicide or euthanasia in their first full year than Canada did in its first full year. This is striking as Canada was hitherto the jurisdiction that with the highest initial rate of death under such laws and Canada has seen the fastest increase in such deaths anywhere in the world. It will be instructive to follow how fast VAD deaths increase in these Australian states in the coming years.

A challenge for assessing the impact of changes in successive legislation is that the jurisdictions that have weakened the requirements most are those that have passed laws most recently, and thus have least data. This creates a misleading impression of practice in Australia as reporting tends to focus on Victoria, which alone has five years of data. Analysis has also tended to focus on official reporting, which presents

select data from providers within an official narrative frame. There is limited independent qualitative research on Australian practice, but such as there is raises concerns and impact on palliative care (Michael *et al.* 2024) and impact on professionals (McDougall *et al.* 2022, Kirchhoffer *et al.* 2023, Rutherford *et al.* 2023).

We also know that many of the safeguards in Victoria, such as they are, have been abandoned by other jurisdictions in Australia, and we can already see that this has had an impact on practice. For example, the number of VAD deaths in Queensland in its first year, as a proportion of deaths in that state, was more than five times higher than the equivalent figure in Victoria (1.6% compared to 0.3%). Victoria is simply not a reliable guide to what will happen in other states and issues raised in Victoria may reasonably be expected to be present on a much larger scale in other Australian jurisdictions. Furthermore, the law recently passed in ACT, which is by far the most radical in Australia to date, will only come into force in November 2025, so it will not be until 2027 that data on its first year of operation will be available for an initial assessment of the impact of that law.

### Safeguards abandoned as ‘barriers to access’

A key reason that these requirements have progressively been loosened across New Zealand and Australia is because they have been construed as ‘barriers to access’ (White *et al.* 2023). If euthanasia and assisted suicide are regarded as beneficial healthcare treatments that provide an effective remedy for intractable suffering then there would seem to be a duty to offer these to anyone who could benefit. Not to do so would require a strong reason, such as a demonstrable risk of coercion or of other abuses.

After Victoria gave access to euthanasia to people who were physically unable to self-administer the lethal drug, it was asked why people who were physically able to self-administer, but reluctant to do so, should be denied it. There is no conventional medical treatment that is confined to self-administration. Similarly, there is no conventional medical treatment where the doctor cannot proactively let patients know about this option. Indeed, in other contexts, not to inform patients of their full range of options would be regarded as a failure of care. Hence, the restriction on medical professionals initiating discussion of VAD has been referred to pejoratively as the ‘gag’ clause.<sup>7</sup> Again, if it can be offered to those expected to die within 12 months from a neurodegenerative disease (as in Victoria), it would seem unfair to exclude those expected to die within the same timeframe but from a different kind of disease (hence the expansion from Victoria to Queensland). Again if it could be offered to someone expected to die within 12 months (as in Queensland), it would seem unfair to exclude people who are approaching the end of their life but without a clear timeframe (hence the expansion from Queensland to ACT).

The argument commonly used against maintaining safeguards in VAD legislation in Australia and New Zealand has been framed as one of ‘balancing safety with

<sup>7</sup> Moore *et al.* (2020), though it should be noted that this ‘gag’ was put in place to prevent professionals proactively pushing VAD on patients and was never a ‘gag’ to responding to patients who asked about it.

access' (McDougall and Pratt 2020, Downar *et al.* 2024). However, the onus has been placed on those defending safeguards to show what specific abuses would occur if this or that safeguard were not in place. This may be difficult to demonstrate as abuses such as coercion are underreported (Burgess 2019). Similarly, VAD does not require investigation of cause of death by post mortem, so there is no data on the extent of misdiagnosis or inappropriate medical advice by doctors who provided VAD but who did not have expertise in the medical condition of the patient.

The argument against maintaining safeguards also fails to recognise that the intentional taking of life within healthcare is not conventional medical treatment but, in every jurisdiction where it is legal, is a legal exception to a more general legal prohibition against taking life. This legal prohibition is deeply rooted in the Common Law, in human rights law and in traditional medical ethics (Pellegrino 2001, Gorsuch 2009, Keown 2018). It is the exception to the prohibition that stands in need of justification, not the safeguards that limit the exception that require special justification.<sup>8</sup>

Finally, it should be notice that all eligibility criteria are barriers to access. This argument against safeguards, if successful, would demand the inclusion of a much wider group of people than are currently included in Australian or New Zealand legislation. It would extend to children, for if a treatment is beneficial in adults, and could be beneficial for children, there is an onus to offer it to minors, as occurs in the Netherlands and Belgium. The argument would also imply that VAD should be provided as a remedy to other forms of suffering related to ill health, such as chronic physical illness or mental illness, as also occurs in the Netherlands and Belgium.

## A clear example of expansion

It is not the aim of this paper to provide a critique to the argument that has led to the progressive weakening or removal of safeguards from VAD legislation in Australia and New Zealand. The paper aims simply to show that there has been such a process and, in this context, notes that the above argument has been an important driver for the rapid erosion of safeguards that has occurred. Insofar as the process has been driven by the logic of this argument it could be termed a 'logical slippery slope' (see Jones 2011, Keown 2022).

Thus far the erosion of requirements has been seen in successive legislation but groups and individuals who successfully campaigned for these progressively weaker laws are now campaigning for jurisdictions such as Victoria, New

<sup>8</sup> The present paper has focused on safeguards in the respective state and territorial laws, but similar considerations apply to federal law. In November 2023 a court decision clarified that 'the term "suicide"', as used in ss 474.29A and 474.29B of the Criminal Code Act 1995 (Cth), does apply to the ending of a person's life in accordance with, and by the means authorised by, the Voluntary Assisted Dying Act 2017 (Vic)' (Carr v Attorney-General (Cth) [2023] FCA 1500, 74). It is an offence to use a 'carriage service' (such as telephone or email) to provide 'instruction on a particular method of committing suicide' (474.29B (1)(b)) and this applies to VAD. This court judgement has been presented as a barrier to accessing VAD (Davey and Kolovos 2023) but with little or no discussion of the added risks of electronic communication when counselling or facilitating the intentional ending of life.

Zealand and Western Australia to amend their laws to increase access (Dexter 2024, May and Ittimani 2024, Ore 2024, Go Gentle Australia 2024a). The legislation passed in ACT is being cited as the model for others to follow, even though it has not yet come into force itself (Go Gentle Australia 2024b, p. 31, 40). No jurisdiction in Australia or New Zealand has yet amended its law, but those jurisdictions that took the lead in passing VAD legislation are already considering relaxing their laws ‘to bring them in line with other states’ (Thomas 2025).

In September 2024 the VAD Review Board for Victoria, in its annual report argued that ‘opportunities to realise the goal of providing compassionate care do require amendments to the Act’. The recommendations were all in the direction of weakening safeguards in order to ‘reduce barriers to accessing the program’ (VADRbv 2024, pp. 34–36).

In November 2024, the New Zealand Ministry of Health completed the first Review of the End of Life Choice Act 2019. This Review recommended, among other things, that the law be amended to permit healthcare professionals to initiate discussion of ‘assisted dying’ (Ministry of Health 2024, p. 10, Recommendation 1). The Review also recommended that the law be amended to reduce the protection given to healthcare professionals (Ministry of Health 2024, p. 15, Recommendations 13 and 14) and healthcare institutions (Ministry of Health 2024, p. 16, Recommendation 15) not to have to participate in the practice. These changes reflect the erosion of safeguards that has occurred between the VAD legislation in Victoria and the legislation in Queensland. It also demonstrates that including a statutory review within the law, rather than being a safeguard, can be a mechanism to promote further expansion of the law.

In December 2024, the Victoria Coroner recommended that legislators consider amending the law in Victoria, ‘widening the eligibility criteria to capture those suffering an irreversible decline in their health or a greatly reduced quality of life, but who may not have a specific disease expected to cause death within six months’ (Evans 2024). This was in response to eight cases of suicide thought to have been prompted, in part, by VAD requests being turned down because the applicants were ineligible under the current law. This is not the first evidence of conventional suicide or suicide attempts in the context of refusal or delay in accessing assisted suicide or euthanasia (Thienpont *et al.* 2015, p. 5, Isenberg-Grzeda *et al.* 2020). However, the Victoria Coroner failed to acknowledge that there is no evidence that giving access to VAD reduces conventional suicide (Nanner 2021, Doherty *et al.* 2022, Girma and Paton 2022, Güth *et al.* 2023). Indeed in Victoria the change in the law was followed by a 50% increase in conventional suicide among people over 65, the cohort who make most use of VAD (Jones 2023). The Coroner also failed to acknowledge that if eligibility criteria are to be meaningful then, wherever the line is drawn, some people will not be eligible and could thus be prompted to consider conventional suicide. Shifting the line simply shifts the problem.

In February 2025 the five-year review of the implementation of the law in Victoria was published (VSG 2025). While the Review did not make any recommendations for changes in the law, it reported the views of stakeholders (such as the VAD Review Board for Victoria) who had urged that the law should be expanded/loosening in the following ways:

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 which would take the legislation further than any existing legislation in Australia: In addition to these nine, the Review mentions a further proposal 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]. (Jones 2025, pp. 8–9, citing CERE 2024, pp. 90–97)

In Response to the Review, the Government of Victoria announced its intent to ‘bring forward legislation to Parliament in 2025 that will respond to lessons from the review and seek to bring Victoria’s voluntary assisted dying legislation more in line with other Australian jurisdictions’.

There will be people who prefer the model of legislation found in Canada or Belgium and view the rapid movement of the Australia/New Zealand model in that direction as something positive. They will regard this not as a slippery slope to disaster but as progressive ‘improvements’ to access (e.g. Waller *et al.* 2023, pp. 1465–1469). What cannot be denied is that significant change has taken place in the Australian approach to assisted suicide and euthanasia over a short time period. VAD in Australia and New Zealand is emphatically not an example of stable, durable, cautious or unchanging legislation. The approached has

changed rapidly, is continuing to change and further changes are very much on the horizon.

Even as Kyam Maher was telling British Parliamentarians ‘I do not think we are going to see much change one way or another any time soon’ (HCHSC 2024, para. 115), the Australia Capital Territory was debating a further significant expansion of the Australian model. That law, which passed in June 2024, contained no time-frame for expectation of death, had no waiting period between requests, criminalised doctors who conscientiously objected to providing information on VAD, and imposed criminal sanctions on those operating hospices who failed to facilitate VAD. It even included provisions very like the Belgian concept of euthanasia for ‘poly pathology’.

The Australian model at first appeared to be similar to the Oregon model but over seven short years Australia has come to resemble, and in some respects even to surpass, Canada as the epitome of ‘apparently inexorable expansion of legal eligibility criteria’ (Lyon *et al.* 2025, p. 18). The progressive loosening of requirements for voluntary assisted dying in Australia and New Zealand is an archetypal example of how passing a law which seemed to have rigorous safeguards could be the beginning of a ‘slippery slope’.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Notes on contributor

*David Albert Jones* is a Professor in Bioethics at St. Mary’s University, Twickenham and a Research Fellow at Blackfriars Hall, Oxford. He previously served as Director of the Anscombe Bioethics Centre in Oxford (2010 to 2025) and as Vice-chair of the Ministry of Defence Research Ethics Committee (2009 to 2024).

## ORCID

*David Albert Jones*  <http://orcid.org/0000-0001-7268-6353>

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