IN THE STATE OF VICTORIA

IN RE PROPOSED LEGISLATION	**DECLARATION OF WILLIAM TOFFLER, MD**

I, WILLIAM TOFFLER, declare the following under penalty of perjury.

1. I am a professor of Family Medicine and a practicing physician in Oregon USA for more than 35 years. I write to provide some insight on the issue of physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in Victoria.

2. Oregon's law applies to persons with a terminal disease who are predicted to have less than six months to live. Our law states:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

ORS 127.800 s.101(12), attached hereto at page A-1.

3. In practice, this definition is interpreted to include chronic conditions such as chronic lower respiratory disease and diabetes mellitus, better known as "diabetes."

4. Attached hereto are excerpts from the most recent Oregon government statistical report regarding our law.[1] The excerpt at A-3 lists "chronic lower respiratory disease" and "other illnesses" as "underlying illnesses" sufficient to justify assisted suicide.

5. The other illnesses referenced at A-3 are described in more detail in endnote 2, which is attached hereto at A-4. They include "diabetes mellitus."

6. In Oregon, people with chronic conditions such as diabetes mellitus are eligible for assisted suicide, if, without treatment such as insulin, they have less than six months to live. This is significant when you consider that, without insulin, a typical insulin-dependent 20 year-old will live less than a month.

7. Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar.

8. I have also been provided with an excerpt of the Victoria bill and two proposed amendments, which are attached hereto at A-5 through A-7. These materials also have a six months to live criteria, *i.e.*, except in the case of a neurodegenerative disease, illness or medical condition.

9. The bill, with the proposed amendments, has the following

---

[1] The full report can be read at this link: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

objective medical criteria to determine eligibility:

> [T]he person must be diagnosed with a disease, illness or medical condition that -
>
> (i) is incurable; and
> (ii) is advanced, progressive and will cause death; and
> (iii) is expected to cause death within weeks or months, not exceeding ~~12~~ 6 months [except in the case of a neurodegenerative disease, illness or medical condition.]

9. In my professional judgment, these objective criteria include a person with insulin dependent diabetes, because: (1) diabetes is not a neurodegenerative disease, illness or medical condition; and (2) the final stage of the disease itself is a failure to produce insulin, such that the affected person is dependent on insulin to live. The disease at that point is incurable, advanced, progressive and will cause death within 6 months without treatment.

10. In short, if Victoria follows Oregon practice to determine eligibility without treatment, the bill, as amended, will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live.

Signed under penalty of perjury, this 15th day of November 2017, at Portland Oregon USA.

William L Toffler MD

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR USA 97239

(http://www.oregon.gov)

Death with Dignity Act

(/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/)

Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or download the statute (/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf) for printing - (*or read the statute at* https://www.oregonlegislature.gov (https://www.oregonlegislature.gov/bills_laws/ors/ors127.html))

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

Page A-1

(/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx#top)(Section 2)

Oregon Death with Dignity Act

Data summary 2016

Oregon Health Authority
PUBLIC HEALTH DIVISION

Characteristics	2016 (N=133)		1998–2015 (N=994)		Total (N=1,127)	
Residence						
Metro counties (Clackamas, Multnomah, Washington) (%)	54	(40.9)	427	(43.3)	481	(43.0)
Coastal counties (%)	10	(7.6)	70	(7.1)	80	(7.1)
Other western counties (%)	57	(43.2)	413	(41.8)	470	(42.0)
East of the Cascades (%)	11	(8.3)	77	(7.8)	88	(7.9)
Unknown	*1*		*7*		*8*	
End of life care						
Hospice						
Enrolled (%)	118	(88.7)	868	(90.4)	986	(90.2)
Not enrolled (%)	15	(11.3)	92	(9.6)	107	(9.8)
Unknown	*0*		*34*		*34*	
Insurance						
Private (%)	35	(29.7)	534	(57.1)	569	(54.0)
Medicare, Medicaid or other governmental (%)	82	(69.5)	388	(41.5)	470	(44.6)
None (%)	1	(0.8)	13	(1.4)	14	(1.3)
Unknown	15		59		74	
Underlying illness						
Malignant neoplasms (%)	**105**	**(78.9)**	**767**	**(77.2)**	**872**	**(77.4)**
Lung and bronchus (%)	16	(12.0)	177	(17.8)	193	(17.1)
Breast (%)	12	(9.0)	74	(7.4)	86	(7.6)
Colon (%)	12	(9.0)	61	(6.1)	73	(6.5)
Pancreas (%)	9	(6.8)	64	(6.4)	73	(6.5)
Prostate (%)	6	(4.5)	41	(4.1)	47	(4.2)
Ovary (%)	3	(2.3)	37	(3.7)	40	(3.5)
Other (%)	47	(35.3)	313	(31.5)	360	(31.9)
Amyotrophic lateral sclerosis (%)	**9**	**(6.8)**	**80**	**(8.0)**	**89**	**(7.9)**
Chronic lower respiratory disease (%)	**2**	**(1.5)**	**44**	**(4.4)**	**46**	**(4.1)**
Heart disease (%)	**9**	**(6.8)**	**26**	**(2.6)**	**35**	**(3.1)**
HIV/AIDS (%)	**0**	**(0.0)**	**10**	**(1.0)**	**10**	**(0.9)**
Other illnesses (%)[2]	**8**	**(6.0)**	**67**	**(6.7)**	**75**	**(6.7)**
DWDA process						
Referred for psychiatric evaluation (%)	5	(3.8)	52	(5.3)	57	(5.1)
Patient informed family of decision (%)[3]	119	(89.5)	858	(93.6)	977	(93.0)
Patient died at						
Home (patient, family or friend) (%)	117	(88.6)	931	(94.0)	1,048	(93.4)
Long term care, assisted living or foster care facility (%)	9	(6.8)	46	(4.6)	55	(4.9)
Hospital (%)	3	(2.3)	1	(0.1)	4	(0.4)
Other (%)	3	(2.3)	12	(1.2)	15	(1.3)
Unknown	*1*		*4*		*5*	

Characteristics	2016 (N=133)	1998–2015 (N=994)	Total (N=1,127)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	18	12	13
Range	1–1,484	0–1,905	0–1,905
Number of patients with information available	*132*	*992*	*1,124*
Number of patients with information unknown	*1*	*2*	*3*
Duration (days) between first request and death			
Median	56	46	48
Range	15–539	14–1,009	14–1,009
Number of patients with information available	*133*	*994*	*1,127*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness			
Median	4	5	5
Range	1–60	1–38	1–60
Number of patients with information available	*24*	*532*	*556*
Number of patients with information unknown	*109*	*462*	*571*
Minutes between ingestion and death			
Median	27	25	25
Range	7min–9hrs	1min–104hrs	1min–104hrs
Number of patients with information available	*25*	*537*	*562*
Number of patients with information unknown	*108*	*457*	*565*

1 Unknowns are excluded when calculating percentages.

2 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.

3 First recorded beginning in 2001. Since then, 52 patients (4.9%) have chosen not to inform their families, and 21 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.

4 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

5 First asked in 2003. Data available for 133 patients in 2016, 863 patients between 1998–2015, and 996 patients for all years.

6 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

7 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

Part 2—Criteria for access to voluntary assisted dying

9 Eligibility criteria for access to voluntary assisted dying

(1) For a person to be eligible for access to voluntary assisted dying—

(a) the person must be aged 18 years or more; and

(b) the person must be—

(i) an Australian citizen or permanent resident; and

(ii) ordinarily resident in Victoria; and

(c) the person must have decision-making capacity in relation to voluntary assisted dying; and

(d) the person must be diagnosed with a disease, illness or medical condition that—

(i) is incurable; and

(ii) is advanced, progressive and will cause death; and

(iii) is expected to cause death within weeks or months, not exceeding 12 months; and

(iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

(2) A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the **Mental Health Act 2014**.

LEGISLATIVE COUNCIL

VOLUNTARY ASSISTED DYING BILL 2017

(Amendments and New Clause to be proposed in Committee by Mr RAMSAY)

1. Clause 3, page 6, after line 4, insert—

"***mental illness*** has the same meaning as in the **Mental Health Act 2014**;".

2. Clause 3, page 7, after line 3 insert—

"***psychiatrist*** means a person who is registered under the Health Practitioner Regulation National Law as a medical practitioner in the speciality of psychiatry (other than as a student);".

3. Clause 5, page 12, line 25 omit "characteristics." and insert "characteristics;".

4. Clause 5, page 12, after line 25 insert—

"( ) all relevant clinical guidelines, and a plan in respect of the self-administration of a voluntary assisted dying substance for the purpose of causing death, should be fully explained to a person's family before the supply, prescribing or administration of a voluntary assisted dying substance to the person.".

5. Clause 9, line 22, omit "12 months" and insert "6 months or, in the case of a neurodegenerative disease, illness or medical condition, not exceeding 12 months".

6. Clause 10, after line 24 insert—

"( ) If the person being assessed has a history of mental illness, either the co-ordinating medical practitioner or each consulting medical practitioner must be a psychiatrist or must refer the person to a psychiatrist under section 18(1).".

7. Clause 18, line 19 after "criteria," insert "or if section 10(4) applies,".

8. Clause 19, line 31 omit "process." and insert "process;".

9. Clause 19, page 21, after line 31 insert—

"( ) that the person is encouraged to inform any registered health practitioner who is currently providing health services to the person of the person's request to access voluntary assisted dying.".

NEW CLAUSE

10. Insert the following New Clause to follow clause 115—

"A Board to record, retain and make public statistical information

(1) The Board must record and retain statistical information about—

(a) persons who have been issued with a voluntary assisted dying permit; and

LEGISLATIVE COUNCIL

VOLUNTARY ASSISTED DYING BILL 2017

(Amendments and New Clause to be proposed in Committee by Mr JENNINGS)

1. Clause 9, line 9, omit "be".

2. Clause 9, line 10, before "an" insert "be".

3. Clause 9, line 12, omit all words and expressions on this line and insert—

"(ii) be ordinarily resident in Victoria; and

(iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months; and".

4. Clause 9, line 22, omit "12 months" and insert "6 months".

5. Clause 9, page 16, after line 4 insert—

"( ) Despite subsection (1)(d)(iii), if the person is diagnosed with a disease, illness or medical condition that is neurodegenerative, that disease, illness or medical condition must be expected to cause death within weeks or months, not exceeding 12 months.".

6. Clause 18, page 21, after line 7, insert—

"( ) If the co-ordinating medical practitioner is able to determine that the person has a disease, illness or medical condition that is neurodegenerative in accordance with section 9(4) that—

(a) will cause death; and

(b) is expected to cause death between 6 and 12 months—

the co-ordinating medical practitioner must refer the person to a specialist registered medical practitioner who has appropriate skills and training in that particular disease, illness or medical condition that is neurodegenerative, whether or not the co-ordinating medical practitioner had also made a referral under subsection (2).

( ) The specialist registered medical practitioner referred to in subsection (4) must—

(a) determine whether the person has a disease, illness or medical condition that is neurodegenerative that—

(i) will cause death; and

(ii) is expected to cause death between 6 and 12 months; and

(b) provide a clinical report to the co-ordinating medical practitioner that sets out the specialist registered medical practitioner's determination.