JOURNAL OF APPLIED SCIENCE AND SOCIAL SCIENCE

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

A Comparative Analysis of Voluntary Assisted Dying Legislation: Perspectives from Australia and the Netherlands

Dr. Evelyn R. Chen

Department of Bioethics and Health Law, University of Melbourne, Melbourne, Australia

Prof. Julian P. Vander

Faculty of Social Sciences, Leiden University, Leiden, Netherlands

Abstract: Background: The legal and ethical debate surrounding voluntary assisted dying (VAD) is a pressing global issue. This practice presents a profound challenge for policymakers seeking to balance individual autonomy in end-of-life decisions with the protection of vulnerable populations. This study addresses a gap in the literature by providing a detailed comparative analysis of the legislative and implementation frameworks for VAD in Australia and the Netherlands, two jurisdictions with distinct approaches to this complex issue.

Methods: This article is based on a qualitative, desk-based review and comparative legislative and policy analysis. Primary data sources include legislative documents from both jurisdictions, official government reports, and a select body of academic literature. The analysis was structured around key regulatory components, including eligibility criteria, assessment processes, and oversight mechanisms, to identify and compare the similarities and differences between the two models.

Results: The Netherlands, a pioneer in this field, operates under a national legal framework emphasizing "due care criteria" and a well-established system of oversight by euthanasia review committees. Its implementation has been supported by specialized consultation services. Australia, in contrast, has adopted a state-by-state approach with highly specific eligibility criteria, such as defined prognoses for terminal illness, and a multi-layered assessment process. Both models incorporate distinct safeguards aimed at preventing abuse, but their practical application and cultural contexts differ significantly.

Discussion: The comparative analysis reveals that while both countries share a goal of providing compassionate end-of-life care, their divergent legislative and implementation models offer unique lessons. The Dutch experience highlights the importance of robust, long-standing consultation services, while the Australian approach demonstrates the challenges and opportunities of a more

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

prescriptive, state-specific legislative process. Navigating the delicate balance between autonomy and safeguarding vulnerable individuals remains central to both systems.

Conclusion: A deep understanding of the complexities of VAD regulation is essential for navigating end-of-life care. The comparative insights from Australia and the Netherlands provide a valuable roadmap for policymakers, healthcare professionals, and societies worldwide grappling with these profound ethical and legal questions.

Keywords: Voluntary Assisted Dying, Euthanasia, Comparative Law, End-of-Life Care, Australia, Netherlands, Bioethics.

INTRODUCTION

1.1 Background and Context

The global discourse surrounding end-of-life care has undergone a profound transformation in recent decades. As medical technology advances and societies grapple with aging populations, the ethical, legal, and social complexities of a "good death" have come to the forefront of public and political debate. At the heart of this conversation is voluntary assisted dying (VAD), a practice that allows a person with a terminal illness to receive medical assistance to end their life on their own terms. This practice, often distinguished from passive euthanasia or withdrawing life support, raises fundamental questions about individual autonomy, the role of physicians, and a society's responsibility to protect its most vulnerable members. The legalization of VAD represents a delicate and often contentious legislative act, one that requires a careful balancing of competing values: compassion for those suffering unbearably, respect for a person's right to self-determination, and the imperative to safeguard against coercion, abuse, or misdiagnosis. This paper explores these intricate challenges by undertaking a comparative analysis of two distinct VAD frameworks: the pioneering model of the Netherlands and the more recent, state-by-state approach of Australia.

1.2 Historical Overview of VAD Legislation

The Netherlands holds a unique and long-standing position in the history of legalized euthanasia and physician-assisted suicide. While the country's penal code criminalized these acts, a series of court decisions in the 1970s and 1980s led to the establishment of "due care criteria," which, if followed, provided a legal defense for physicians. This de facto decriminalization was codified into law in 2002 with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, making the Netherlands the first country in the world to officially legalize these practices under strict conditions. This legislative evolution was not a sudden event but a gradual process shaped by judicial precedent, medical practice, and a culture of open discussion about end-of-life care (Onwuteaka-Philipsen et al. [5]).

In stark contrast, Australia's journey toward VAD legislation has been a protracted and often politically fraught process. Despite early legislative attempts in various states, notably the short-lived Rights of the

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

Terminally Ill Act in the Northern Territory in 1995, widespread reform stalled for over two decades (Willmott et al. [1]). The landscape shifted dramatically with the passage of the Voluntary Assisted Dying Act 2017 in Victoria, which took effect in June 2019. This landmark legislation created a new and distinct model for VAD in Australia, one that has since been followed by other states. This state-by-state approach has resulted in a patchwork of similar but not identical laws, reflecting the country's federal system and a cautious, incremental approach to reform (White & Willmott [2]). The contrast between the Netherlands' national, long-established model and Australia's nascent, state-specific framework provides a unique opportunity for comparative study.

1.3 Rationale and Gaps in Existing Literature

While a significant body of literature exists on VAD and euthanasia, much of it is focused on ethical debates or single-jurisdiction legal analyses. There is a discernible gap in comprehensive, comparative analyses that not only describe the legislative frameworks but also delve into their practical implementation, including the roles of specific consultation services, oversight bodies, and the lived experiences of patients and their families. Existing studies may touch upon these aspects but often fail to provide a holistic, side-by-side comparison that draws out the practical lessons and implications of different regulatory choices. This article aims to fill this gap by conducting a detailed, comparative analysis of the legislative frameworks and implementation processes in Australia (specifically Victoria as the first state to pass the law) and the Netherlands. By examining the distinct approaches to eligibility, assessment, and oversight, this study seeks to provide valuable perspectives and lessons for policymakers and healthcare professionals worldwide.

1.4 Research Questions

This study is guided by the following research questions:

1. What are the key differences and similarities in the legislative frameworks for VAD in Australia and the Netherlands, particularly concerning eligibility criteria and safeguards?

2. How do their respective implementation processes, including consultation and oversight mechanisms, affect the practical application of VAD?

3. What are the broader implications of these different approaches for patient autonomy, compassionate care, and the protection of vulnerable individuals?

METHODS

2.1 Research Design

This study employs a qualitative, desk-based research design centered on comparative legislative and policy analysis. The goal is not to present a new empirical data set but rather to synthesize and analyze existing information from two different jurisdictions. This approach is well-suited to the topic, as it allows

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

for a deep dive into the legal and policy documents that form the foundation of VAD practice in both countries, while also incorporating insights from scholarly literature and official reports.

2.2 Data Sources

The primary sources of information for this analysis include:

- Legislative Documents: The Victorian Voluntary Assisted Dying Act 2017 and the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 serve as the foundational legal texts.

- Official Government and Committee Reports: This includes reports from the Dutch Regional Euthanasia Review Committees and media releases from government bodies, such as the statement by Premier Daniel Andrews on the establishment of the VAD model in Victoria (Premier Daniel Andrews [3], Regional Euthanasia Review Committees [4]).

- Academic Literature: The analysis draws heavily on the provided reference list, which includes scholarly articles that critically examine the legal and social aspects of VAD in both jurisdictions (e.g., Willmott et al. [1], White & Willmott [2], Onwuteaka-Philipsen et al. [5], Glare et al. [8]). This literature provides critical context and analysis of the legislative and practical dimensions of VAD.

2.3 Analytical Framework

The analysis follows a thematic approach, with a focus on several key regulatory components that are central to VAD legislation. These themes are:

1. Eligibility Criteria: A comparison of the conditions a person must meet to be considered for VAD, such as the nature of their illness, prognosis, and capacity.

2. Assessment and Request Process: An examination of the steps required for a patient to make a VAD request, including the number of medical opinions needed and the role of different healthcare professionals.

3. Safeguards and Oversight Mechanisms: A review of the measures in place to prevent misuse, coercion, or abuse, including the role of dedicated review bodies.

4. Role of Consultation and Support Services: An investigation into how specialized services support both patients and physicians throughout the process.

This framework allows for a structured, point-by-point comparison, enabling the identification of both commonalities and critical divergences between the Australian and Dutch models.

2.4 Ethical Considerations

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

As this is a desk-based study of publicly available legislative and scholarly materials, formal ethical clearance was not required. However, the analysis is conducted with a strong commitment to ethical principles, including a balanced and non-judgmental tone, respect for the sensitivity of the subject matter, and a focus on presenting findings in an objective manner. The aim is not to take a particular stance on the morality of VAD but rather to analyze how different societies have codified their approaches to it.

RESULTS

3.1 The Netherlands Model

3.1.1 Legislative Framework

The Dutch legal framework is governed by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. The law provides a legal defense for a physician who performs euthanasia or physician-assisted suicide, provided they meet a set of six "due care criteria." These criteria are the cornerstone of the Dutch system:

- The patient's suffering is unbearable and has no prospect of improvement.
- The patient's request is voluntary and well-considered.
- The patient is fully informed about their situation and prognosis.
- There is no reasonable alternative to alleviate the suffering.
- The physician consults with at least one other independent physician who has seen the patient.
- The physician exercises due medical care in performing the procedure.

Crucially, the Dutch law does not impose a specific life expectancy requirement. The focus is on the patient's subjective experience of "unbearable suffering," which is not limited to physical pain but can also include psychological suffering. This flexible approach contrasts sharply with the more prescriptive frameworks seen elsewhere (Onwuteaka-Philipsen et al. [5]).

3.1.2 Implementation and Practice

The Dutch system is notable for its well-established infrastructure that supports physicians and patients. A critical component is the Support and Consultation on Euthanasia in the Netherlands (SCEN) network. This network consists of experienced physicians who specialize in providing mandatory second opinions. The SCEN consultant's role is not just to check for compliance with the due care criteria but also to provide advice and support to the attending physician, ensuring the process is thorough and well-considered (Van Wesemael et al. [10]).

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

The process itself is a multi-step, often prolonged, one. The physician and patient engage in multiple discussions over time, and a second opinion is obtained. Once the procedure is completed, the case is reported to one of five Regional Euthanasia Review Committees (RTE). The RTEs are composed of a lawyer, a physician, and an ethicist. They review each case to determine whether the physician acted in accordance with the due care criteria. The RTEs' role is a form of post-facto oversight, providing transparency and accountability to the process. Their reports, which are publicly available, offer valuable insights into the practice of VAD in the Netherlands (Regional Euthanasia Review Committees [4]).

3.1.3 Key Findings and Public Discourse

Decades of legalized VAD in the Netherlands have generated a wealth of empirical data and social analysis. Studies show that the most common reason for a VAD request is cancer, followed by diseases of the nervous and cardiovascular systems (Onwuteaka-Philipsen et al. [5]). Research has also investigated the perspectives of relatives of patients who died after VAD. One study found that most relatives had positive feelings about the patient's choice and the process, though a small percentage expressed concerns about the decision or the procedure (Georges et al. [6]).

A significant finding from Dutch research is that a substantial number of VAD requests are either refused or withdrawn. One study reported that of all requests, only about one-third were granted, while a similar number were either undecided or withdrawn by the patient. The primary reasons for refusal included non-compliance with the due care criteria, particularly the lack of "unbearable suffering," and issues with the patient's capacity or voluntariness (Jansen-van der Weide et al. [7]). This finding underscores the rigor of the Dutch system's safeguards and the fact that a request for VAD does not guarantee access. It is a process of thorough evaluation, not a simple right to a procedure.

3.2 The Australian Model (with a focus on Victoria)

3.2.1 Legislative Framework

Australia's approach, starting with Victoria's Voluntary Assisted Dying Act 2017, is characterized by its strict, prescriptive, and multi-layered nature. The law is not a national one; rather, each state has passed its own legislation, with Victoria's serving as the foundational model. Key eligibility criteria under the Victorian Act include:

- The person must be 18 years of age or older.
- They must be an Australian citizen or permanent resident, and have been a resident of Victoria for at least 12 months.
- They must have an incurable, advanced, and progressive disease that is causing unbearable suffering.

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

- The disease must be expected to cause death within 6 months, or within 12 months for neurodegenerative diseases (White & Willmott [2]).

This strict prognosis requirement is a major point of divergence from the Dutch model, where the focus is on suffering rather than a specific life expectancy. The Australian law also explicitly excludes mental illness as a sole reason for VAD and specifies that a person's disability is not a criterion for eligibility.

3.2.2 Implementation and Policy Development

The implementation of the Victorian Act was a meticulously planned process. Ahead of the law's commencement in June 2019, the Victorian government announced the establishment of a VAD model, including training for healthcare professionals and the creation of a dedicated VAD Review Board (Premier Daniel Andrews [3]). The state-level nature of the law means that each state is responsible for its own implementation and oversight, leading to variations in practice and policy across the country (Willmott et al. [1]).

The process itself is designed to be highly deliberate and involve multiple checks. A person must make three separate requests for VAD: an initial request, followed by a formal written request, and a final request. At least two different doctors must assess the patient. The first is a coordinating doctor, who must have extensive experience in the patient’s condition. This doctor conducts an initial assessment and, if satisfied with the eligibility, refers the patient for a second opinion from a consulting doctor. Both doctors must be trained in the VAD process and be independent of each other. The law also requires a final review by a third party, often a specialist, to confirm the patient’s capacity and voluntariness (White & Willmott [2]).

3.2.3 Challenges and Safeguards

A central challenge in the Australian model, stemming from its strict prognosis requirement, is the difficulty of accurately predicting a patient's survival time. Research has shown that even experienced oncologists can have a wide range of accuracy in their survival predictions for terminally ill cancer patients, with many predictions being overly optimistic (Glare et al. [8]). This raises questions about whether the 6- or 12-month requirement is a clinically reliable or ethically sound barrier to access.

To address concerns about coercion and vulnerability, the Australian model includes a number of safeguards. The patient must have decision-making capacity throughout the entire process. The request must be entirely voluntary and free from any pressure. The role of the two independent medical practitioners is paramount in ensuring these criteria are met. Additionally, the law establishes the Voluntary Assisted Dying Review Board, which oversees every single case to ensure compliance. This board has the power to refer cases to other bodies if it finds evidence of non-compliance, providing a robust system of oversight (White & Willmott [2]). The state-level nature of the laws allows for a more tailored approach to addressing local concerns and cultural contexts, but it also creates the potential for legal inconsistencies across the country.

JOURNAL OF APPLIED SCIENCE AND SOCIAL SCIENCE

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

3.3 The Clinical and Ethical Dilemma of Prognostication in VAD

The Australian legislative model's reliance on a time-based prognosis—specifically, a life expectancy of six months, or twelve months for neurodegenerative diseases—is a distinguishing feature that sets it apart from the more flexible, suffering-based criteria of the Netherlands. This prescriptive approach, while intended as a clear and objective safeguard, introduces a significant and often overlooked clinical and ethical dilemma for healthcare professionals. The challenge lies in the inherent imprecision of prognostication, particularly in the context of end-of-life care.

3.3.1 The Inaccuracy of Medical Prognosis

Medical literature, long before the advent of VAD legislation, has consistently documented the unreliability of survival predictions for terminally ill patients. A landmark systematic review by Glare et al. [8] examined physicians' survival predictions in terminally ill cancer patients and found a consistent pattern: a significant overestimation of life expectancy. The review revealed that physicians' predictions were accurate in only a small percentage of cases, with a strong tendency to be overly optimistic. This finding is not an indictment of clinical skill but rather a recognition of the complex and unpredictable nature of disease progression. Numerous factors, including comorbidities, patient resilience, and unforeseen complications, can influence a patient's trajectory in ways that are difficult, if not impossible, to foresee with certainty.

For a law to hinge on a medical prognosis that is scientifically and statistically unreliable creates a fundamental tension. It places the clinician in a precarious position. A doctor who is ethically committed to honesty and transparency with their patient must also navigate a legal requirement that demands a degree of certainty that clinical science cannot provide. This can lead to a dilemma where a physician may have a strong sense that a patient is approaching the end of their life but cannot in good faith attest to a specific timeline. This is not merely a technical problem; it has profound ethical implications. A physician who is hesitant to make a definitive prognosis for fear of legal repercussions may inadvertently deny a suffering patient access to a compassionate end-of-life option. The very safeguard designed to protect the vulnerable may, in this case, serve as an unintentional barrier.

3.3.2 The "Unbearable Suffering" vs. "Time-Based" Criterion

The Dutch model's focus on "unbearable suffering" offers a compelling counterpoint to Australia's time-based approach. The Dutch legal framework acknowledges that a person's suffering is not solely a function of their remaining time on earth. It recognizes that profound, irremediable suffering can be present for a period longer than six or twelve months and that this suffering, not an arbitrary timeline, should be the primary criterion for VAD eligibility. The Dutch system trusts the physician's clinical judgment, in consultation with a second opinion, to determine if the patient's suffering meets the due care criteria (Onwuteaka-Philipsen et al. [5]). This approach aligns more closely with the principles of patient-centered care, where the patient's subjective experience of their illness is given paramount importance.

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

In contrast, the Australian model's reliance on a specific life expectancy can lead to ethically problematic situations. Consider a person with a severe and progressive neurodegenerative disease, such as motor neurone disease, who is experiencing profound suffering and has a clear wish for VAD but whose doctor believes they will live for 14 months. Under the Australian law, this person would be deemed ineligible. They would be forced to endure months of additional suffering before they could reapply, if they are still able to. This creates a system where a person's suffering is acknowledged, but their ability to act on their wishes is dictated by a legal clock that is itself based on an often-inaccurate prediction. The safeguard, in this instance, does not protect the person but instead prolongs their suffering.

3.3.3 The Impact on Patient and Physician Autonomy

The time-based prognosis requirement also impacts both patient autonomy and physician autonomy. For the patient, it can erode their ability to choose the timing of their death. A person may wish to access VAD at a point where they still have sufficient capacity and quality of life to say goodbye to loved ones and complete their affairs. However, if their prognosis is just outside the legal window, they must wait until their condition deteriorates further. This waiting period can lead to a loss of capacity, making them ineligible for VAD entirely, or it can force them to endure a period of prolonged and undignified decline, contrary to their wishes. This subverts the very principle of autonomy that VAD is intended to uphold.

For the physician, the legal requirement can constrain their clinical judgment. A doctor who believes a patient is suffering unbearably may feel ethically compelled to assist them, but they are legally bound by a prognosis that may not align with their clinical intuition. This can lead to moral distress for the clinician, forcing them to choose between their professional and ethical obligations to their patient and their legal obligations under the VAD Act. In a system built on trust and a physician-patient relationship, introducing an inflexible, legally mandated timeline can damage this trust and create a significant source of professional conflict.

DISCUSSION

4.1 Comparative Analysis: Commonalities and Divergences

While both the Australian and Dutch models for VAD aim to provide compassionate options for people with unbearable suffering at the end of life, their frameworks reflect distinct philosophical and cultural approaches.

4.1.1 Eligibility and Assessment

The most significant divergence lies in the eligibility criteria. The Dutch model is built on the principle of "unbearable suffering," which is a subjective and flexible criterion. While this allows for greater individual autonomy and can encompass psychological suffering, it also requires a high degree of physician judgment and professional trust. The Australian model, by contrast, is far more prescriptive. By mandating a specific, and short, prognosis (6 to 12 months), it creates a clear but rigid boundary. This approach is arguably

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

designed to be more palatable to a cautious public and to provide a more easily verifiable standard, but it may also exclude some individuals with chronic, progressive, and irremediable suffering who may not meet the strict life-expectancy criteria.

Similarly, the assessment processes differ in their structure. The Netherlands relies on a single mandatory second opinion from a SCEN consultant, a system that has been in place for years and is integrated into medical practice (Jansen-van der Weide et al. [9]). The Australian model requires two independent medical practitioners to conduct the assessments, with additional reviews by a third party to ensure capacity and voluntariness. The multi-step, multi-practitioner approach in Australia is a clear reflection of a legislative intent to build multiple "circuit breakers" into the process, ensuring that the decision is deliberated over a longer period and is not made in haste (Willmott et al. [1]).

4.1.2 Safeguards and Oversight

Both systems recognize the critical importance of safeguards to protect vulnerable individuals. The Dutch model's primary oversight is the post-procedure review by the Regional Euthanasia Review Committees (RTE). The RTEs serve as an external, independent body that can refer cases for prosecution if the due care criteria were not met (Regional Euthanasia Review Committees [4]). This system provides transparency and accountability, ensuring that the law is being applied correctly.

The Australian model, however, embeds a high degree of oversight within the process itself. The VAD Review Board, which is also an independent body, provides continuous oversight of every case, from request to administration. This "front-end" oversight, combined with the multiple layers of medical assessment and the deliberative waiting periods, is a central feature of the Australian approach. While this may provide a high level of reassurance to the public, it also creates a complex and potentially burdensome administrative process for both patients and healthcare providers.

4.1.3 The Prognosis Paradox: A Case Study in Legislative Philosophy

The most profound divergence between the Australian and Dutch VAD models is the way each framework addresses the fundamental question of who is eligible for VAD. This difference is not merely a technicality but a reflection of a deeper legislative philosophy. The Dutch model, forged over decades of legal precedent and societal consensus, is fundamentally an autonomy-driven model. Its focus on "unbearable suffering" places the patient’s subjective experience at the center of the decision-making process. The law respects the patient's capacity to define their own suffering as intolerable, and it trusts the clinical and ethical judgment of physicians to confirm that this suffering is irremediable (Jansen-van der Weide et al. [7]). The safeguards in the Dutch system are designed to confirm voluntariness and provide robust clinical oversight, but they do not impose an arbitrary medical timeline on the process. This approach is a clear expression of a society that has, over time, moved towards a greater acceptance of the individual’s right to self-determination in matters of life and death.

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

In contrast, the Australian model is a safeguard-driven model first and foremost. The strict prognosis requirement is a direct response to a cautious political and public climate (Willmott et al. [1], White & Willmott [2]). The legislators' goal was to create a framework that was demonstrably safe, a system with multiple "circuit breakers" to prevent misuse and reassure a skeptical public. The prognosis requirement serves as the ultimate circuit breaker—a seemingly objective, measurable criterion that limits access to a very small, defined group of people whose end of life is imminent. The logic is that by narrowing the window of eligibility to the demonstrably dying, the law minimizes the risk of error, such as a patient recovering or living for many years.

However, this legislative philosophy, while well-intentioned, creates a paradox. While it aims to prevent harm by limiting access, it can also cause harm by denying a compassionate end-of-life option to individuals who are suffering but do not meet the strict legal criteria. The paradox is that the very safeguard designed to protect the vulnerable can inadvertently prolong their suffering and undermine their autonomy. The Australian model's reliance on a prognosis is a clear example of a well-meaning legislative effort that has created a significant clinical and ethical challenge for the very people it is meant to serve. The contrast with the Dutch model, which prioritizes the patient's experience over a doctor's prediction, highlights the critical difference in the two nations' legislative philosophies.

4.2 Lessons Learned and Policy Implications

The comparative analysis of these two models, particularly through the lens of prognostication, yields several important lessons for policymakers. The Dutch experience demonstrates the value of a national, long-standing framework built on a foundation of professional trust and supported by specialized services like SCEN. These services, which offer expert consultation and support, are crucial for navigating the ethical and practical complexities of VAD (Van Wesemael et al. [10]). The Dutch system's focus on "unbearable suffering" rather than prognosis highlights an approach that prioritizes a patient's lived experience of their illness. It shows that a system can be both compassionate and safe, provided it is supported by robust clinical consultation and a culture of open dialogue.

In contrast, the Australian model demonstrates how a more cautious, prescriptive approach can be legislated and implemented. The state-by-state reform process, while leading to some inconsistencies, has allowed for a more tailored and incremental approach. The strict prognosis requirement and multi-step assessment process are clear safeguards, designed to build public confidence and prevent hasty decisions. However, the analysis of the prognosis paradox reveals the limitations of this approach. It shows that over-reliance on a rigid, medical criterion can create unintended negative consequences, such as ethical dilemmas for physicians and the potential for prolonged suffering for patients. The key takeaway for other jurisdictions is that while legislative safeguards are essential, they must be flexible enough to accommodate the complexities and realities of medical practice and the patient's individual experience.

Ultimately, understanding the complexities of VAD is essential for navigating the delicate balance between autonomy, compassion, and safeguarding vulnerable individuals. Both the Australian and Dutch

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

systems offer a pathway to a dignified death, but they do so through different means, reflecting differing levels of trust in physician judgment, public readiness, and legislative intent.

4.3 Limitations and Future Research

This study, as a comparative legislative and policy analysis, has inherent limitations. It is based on publicly available documents and scholarly reports and does not include new empirical data from interviews with patients, families, or healthcare providers. As such, it cannot fully capture the on-the-ground, day-to-day experiences of VAD in either country. Additionally, the Australian system is still in its infancy compared to the decades-long experience of the Netherlands, meaning that long-term data on its impact is not yet available.

Future research should focus on longitudinal studies to assess the long-term impact of the Australian VAD legislation on end-of-life care, physician attitudes, and patient outcomes. It would also be valuable to conduct a more in-depth comparative study of the patient journey in both countries to understand how the different procedural requirements affect access and experience. Specifically, research could examine the experiences of individuals who request VAD in Australia but are deemed ineligible due to the prognosis requirement. This would provide critical insight into the real-world implications of this legislative choice. Given the challenges identified regarding prognostic accuracy, further empirical research is needed to quantify the number of patients who are denied access to VAD in Australia based on this criterion and to explore the ethical and personal consequences of these denials. This would provide a critical foundation for any future legislative review.

CONCLUSION

The comparative analysis of voluntary assisted dying legislation in Australia and the Netherlands provides a rich and valuable perspective on one of the most pressing bioethical challenges of our time. The Netherlands, with its pioneering national framework and emphasis on "due care criteria," offers a model of a long-established, physician-led process. Australia, with its more recent and prescriptive state-by-state approach, provides a case study in cautious, incremental reform built on multiple layers of safeguards. While both systems share a foundational commitment to providing a dignified and compassionate end to life, their divergent approaches to eligibility, assessment, and oversight demonstrate the complex and context-specific nature of this issue. Understanding these differences is crucial for policymakers and societies worldwide as they continue to navigate the profound ethical, legal, and social questions posed by end-of-life care. The analysis of the "prognosis paradox" in the Australian model highlights a key tension: how to create a safe system without creating unintended barriers that can prolong suffering and undermine patient autonomy. It underscores the essential need for a nuanced approach to VAD legislation that is grounded in both compassion and a realistic understanding of clinical practice.

REFERENCES

Volume15 Issue10, October-2025, pg. 1-13

E-ISSN: 2229-3213
P-ISSN: 2229-3205
SJIF 2019: 4.679 2020: 5.015 2021: 5.436

Published Date: - 01-10-2025

1. Willmott L, White B, Stackpoole C, et al. (Failed) Voluntary euthanasia law reform in Australia: two decades of trends, models and politics. UNSW Law J 2016; 39: 1–46.

2. White B, Willmott L. The future of assisted dying reform in Australia. Aust Health Rev 2018; 42: 616–620.

3. Premier Daniel Andrews. Voluntary assisted dying model established ahead of vote in Parliament [media release]. https://www.premier.vic.gov.au/voluntary-assisted-dying-model-established-ahead-of-vote-in-parliament/ (viewed Apr 2019).

4. Regional Euthanasia Review Committees. Euthanasia Code 2018. Review procedures in practice. The Hague: RTE, 2018. https://www.google.com/search?q=https://english.euthanasiecommissie.nl/the-committees/code-of-practice(viewed July 2019).

5. Onwuteaka-Philipsen BD, Legemaate J, van der Heide A, et al. Third evaluation: Termination of life on request and assisted suicide [Dutch; English summary, pp. 19-25]. The Hague: ZonMw, 2017.

6. Georges JJ, Onwuteaka-Philipsen BD, Muller MT, et al. Relatives' perspective on the terminally ill patients who died after euthanasia or physician-assisted suicide: a retrospective cross-sectional interview study in the Netherlands. Death Stud2007; 31: 1–15.

7. Jansen-van der Weide MC, Onwuteaka-Philipsen BD, van der Wal G. Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide. Arch Intern Med 2005; 165: 1698–1704.

8. Glare P, Virik K, Jones M, et al. A systematic review of physicians' survival predictions in terminally ill cancer patients. BMJ 2003; 327: 195–198.

9. Jansen-van der Weide MC, Onwuteaka-Philipsen BD, van der Wal G. Quality of consultation and the project 'Support and Consultation on Euthanasia in the Netherlands' (SCEN). Health Policy 2007; 80: 97–106.

10. Van Wesemael Y, Cohen J, Onwuteaka-Philipsen BD, et al. Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium. BMC Health Serv Res 2009; 9: 220.