**Language**

There are many important conversations that Western Australians need to have in relation to voluntary assisted dying.

It will be critical that these conversations take place respectfully and with clarity about what is being said. Having a common, easy-to-understand approach to the meanings of key words and phrases will help with clarity and to avoid the misunderstandings that can sometimes derail helpful discussion.

Various different terms and definitions have been used in Australia and around the world in relation to voluntary assisted dying. The approach taken by the Panel is to use words and definitions that are consistent with the key principles of choice and keeping the person who is at the end of their life at the centre of all considerations.

**Voluntary assisted dying**

The term ‘voluntary assisted dying’ is used by the Joint Select Committee and the Panel. It emphasises the voluntary nature of the choice of the person who has capacity to make this decision. It reflects a person-centred approach focussed on those who are eligible to access assisted dying. Voluntary assisted dying involves a process to access medication and to enable a person to legally choose the manner and timing of their death.

**Person**

Throughout this discussion paper the Panel uses the word ‘person’ to refer to *the person* *who is approaching the end of their life*. ‘Person’ is preferred over the terms ‘patient’ or ‘client’. This emphasises the key principles of autonomy and choice in voluntary assisted dying.

**Person-centred**

Like the Joint Select Committee, the Panel recognises that end-of-life care needs to be person-centred. Person-centred care is a philosophical approach to clinical care and service delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for them.

**Terms not used**

The following terms are not used by the Panel because they are not an accurate description of the process, who is in control of the process, or because of the value judgements implicit in these terms. These have been well described in the *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report* (from the Department of Health and Human Services, State of Victoria, July 2017) and are reproduced with amendment following.

**Euthanasia**

“Euthanasia refers to the situation when death is induced to relieve suffering. The term derives from the Greek for ‘good death’. The term, however, can carry connotations of something bad as well as something good, because of its historic abuse in involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. Many people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. […] When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient.”

**Assisted suicide**

Suicide involves the tragic loss of life of a person who is otherwise not dying, whereas voluntary assisted dying involves a person’s choice about their mode of death when they are already dying. Suicide is usually undertaken alone as an act of desperation, whereas voluntary assisted dying is a pathway involving medical and family support. Suicides are potentially avoidable; “every effort should be made to prevent these deaths” and there is a “range of critical work being undertaken to prevent suicide”. By contrast, the people “who are the focus of voluntary assisted dying face an inevitable death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe” their choice about the circumstances of their impending death. For these reasons, the Panel believes the word ‘suicide’ should not be used in relation to voluntary assisted dying. It is wrong to confuse these two very different kinds of deaths.

**Other terms**

Voluntary assisted dying is one element of a broader range of end of life choices. It sits within the context of a person exercising a number of choices as they approach the end of their life from a terminal disease or terminal illness. Some of the other terms associated with end of life are outlined below. These definitions have been chosen by the Panel for their use of simple, person-centred language.

**End-of-life care**

End-of-life care is care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness. During this period, people may experience rapid changes and fluctuations in their condition and require support from a range of people, including health services, as well as family and carers.

**Palliative care**

Palliative care helps people with any life-limiting or terminal condition to live their lives as fully and as comfortably as possible. It is not just for people with cancer. Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social. It also provides practical and emotional support to family and carers.

**Glossary**

A more detailed glossary of other terms used in this discussion paper is provided below.

**Advance Health Directive**

An Advance Health Directive (AHD) is a legal document that enables you to make decisions now about the treatment you would want – or would not want - to receive if you ever became sick or injured and were incapable of communicating your wishes. In such circumstances, your AHD would effectively become your voice.

**Capacity**

Also known as decision-making capacity, this refers to the ability of a person to make a decision. Capacity is decision specific – a person can have the ability to make one type of decision but not another. A person may have a disease, illness, brain injury or disability that impacts the ability to make some decisions but not all decisions – it can’t be assumed that someone does not have capacity just because they have one of these conditions. Capacity can fluctuate or vary depending on other factors such as stress, medication or infection.

**Chronic disease / illness**

Chronic disease is defined on the basis of the biomedical disease classification, and includes diabetes, asthma, organ failure and depression. Chronic illness is the personal experience of living with chronic disease.

**Controlled drugs**

These are substances which require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence. Also known as Schedule 8 (or S8) drugs.

**Departmental approval**

This means approval by a government department or someone acting on behalf of a government department.

**End of life**

End of life is the timeframe during which a person lives with, and is impaired by, a life-limiting or fatal condition, even if the prognosis is ambiguous or unknown. Those approaching end of life will be considered likely to die during the next 12 months.

**Grievous**

(Of something bad) very severe or serious.

**Irremediable**

Impossible to cure or put right.

**Joint Select Committee**

The Joint Select Committee refers to a parliamentary committee that was established on 23 August 2017 to look into End of Life Choices in Western Australia. The Joint Select Committee was chaired by Ms Amber-Jade Sanderson MLA and consisted of four members of the Legislative Council and four members of the Legislative Assembly. The Joint Select Committee tabled its report, *My Life, My Choice*, on 23 August 2018.

**Medical practitioner**

Medical practitioner refers to a medical doctor who is registered with the Australian Health Practitioner Regulation Agency. In this discussion paper it usually refers to general practitioners or medical specialists.

**Navigator**

A navigator is a person who helps and supports another person to understand their way through a system (such as the health system).

**Neurodegenerative conditions**

Resulting in, or characterised by degeneration of the nervous system, especially the neurons in the brain. Examples include: motor neurone disease, Parkinson’s disease, Huntington’s disease and dementia.

**Nurse practitioner**

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. A nurse practitioner must be registered with the Australian Health Practitioner Regulation Agency to practice.

**Registered health practitioner**

Registered health practitioner refers to a person registered under the Health Practitioner Regulation National Law (Western Australia) to practice a health profession (other than as a student).

This includes: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, dental practitioners, medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists and psychologists.

(It should also be acknowledged that a term such as Allied Health Professional would more broadly include self-regulated professions such as social work and speech pathology, but that these professions are not registered).

**Terminal**

(Of a disease) predicted to lead to death, especially slowly; incurable. Terminal care is care of the dying in the last days or hours of life.

**The Panel**

The Panel refers to the Ministerial Expert Panel on Voluntary Assisted Dying established by the Minister for Health, the Honourable Roger Cook MLA. Refer to Appendix 1 for details of the panel members.

**Victoria**

References to Victoria in this discussion paper refer to the state of Victoria in Australia and not Victoria the capital city of British Columbia in Canada.