

A background paper

How should Australia regulate voluntary euthanasia and assisted suicide?

November 2012

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This paper has been prepared as input to a high-level roundtable discussion that will be held under the collaborative sponsorship of Australia 21 and the Queensland University of Technology in Brisbane in January 2013.

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Executive Summary

The purpose of this paper is to provide a basis from which to start an informed and rational dialogue in Australia about voluntary euthanasia (VE) and assisted suicide (AS). It does this by seeking to chart the broad landscape of issues that can be raised as relevant to how this conduct should be regulated by the law. It is not our purpose to persuade. Rather, we have attempted to address the issues as neutrally as possible and to canvass both sides of the argument in an even-handed manner. We hope that this exercise places the reader in a position to consider the question posed by this paper:

How should Australia regulate voluntary euthanasia and assisted suicide?

In line with the approach taken in the paper, this question does not take sides in the debate. It simply asks how VE and AS should be regulated, acknowledging that both prohibition and legalisation of such conduct involve regulation.

We begin by considering the wider legal framework that governs end of life decision-making. Decisions to withhold or withdraw life-sustaining treatment that result in a person's death can be lawful. This could be because, for example, a competent adult refuses such treatment. Alternatively, stopping or not providing treatment can be lawful when it is no longer in a person's best interests to receive it. The law also recognises that appropriate palliative care should not attract criminal responsibility. By contrast, VE and AS are unlawful in Australia and could lead to prosecution for crimes such as murder, manslaughter or aiding and abetting suicide. But this is not to say that such conduct does not occur in practice. Indeed, there is a body of evidence that VE and AS occur in Australia, despite them being unlawful.

There have been repeated efforts to change the law in this country, mainly by the minor political parties. However, apart from a brief period when VE and AS was lawful in the Northern Territory, these attempts to reform the law have been unsuccessful. The position is different in a small but increasing number of jurisdictions overseas where such conduct is lawful. The most well known is the Netherlands but there are also statutory regimes that regulate VE and/or AS in Belgium and Luxembourg in Europe, and Oregon and Washington in the United States. A feature of these legislative models is that they incorporate review or oversight processes that enable the collection of data about how the law is being used. As a result, there is a significant body of evidence that is available for consideration to assess the operation of the law in these jurisdictions and some of this is considered briefly here. Assisting a suicide, if done for selfless motives, is also legal in Switzerland, and this has resulted in what has been referred to as 'euthanasia tourism'. This model is also considered.

The paper also identifies the major arguments in favour of, and against, legalisation of VE and AS. Arguments often advanced in favour of law reform include respect for autonomy, that public opinion favours reform, and that the current law is incoherent and discriminatory. Key arguments against legalising VE and AS point to the sanctity of life, concerns about the adequacy and effectiveness of safeguards, and a 'slippery slope' that will allow euthanasia to occur for minors or for adults where it is not voluntary. We have also attempted to step beyond these well trodden and often rehearsed cases 'for and against'. To this end, we have identified some ethical values that might span both sides of the debate and perhaps be the subject of wider consensus.

We then outline a framework for considering the issue of how Australia should regulate VE and AS. We begin by asking whether such conduct should be criminal acts (as they presently are). If VE and AS should continue to attract criminal responsibility, the next step is to enquire whether the law should punish such conduct more or less than is presently the case, or whether the law should stay the same. If a change is favoured as to how the criminal law punishes VE and AS, options considered include sentencing reform, creating context-specific offences or developing prosecutorial guidelines for how the criminal justice system deals with these issues.

If VE and AS should not be criminal acts, then questions arise as to how and when they should be permitted and regulated. Possible elements of any reform model include: ensuring decision-making is competent and voluntary; ascertaining a person's eligibility to utilise the regime, for example, whether it depends on him or her having a terminal illness or experiencing pain and suffering; and setting out processes for how any decision must be made and evidenced. Options to bring about decriminalisation include challenging the validity of laws that make VE and AS unlawful, recognising a defence to criminal prosecution, or creating a statutory framework to regulate the practice.

We conclude the paper where we started: with a call for rational and informed consideration of a difficult and sensitive issue. *How should Australia regulate voluntary euthanasia and assisted suicide?*

1. Introduction

Voluntary euthanasia (VE) and assisted suicide (AS) are important yet ethically challenging issues in contemporary Australian society. They are issues about which public opinion tends to be polarised as individuals can and do have thoroughly researched and considered, yet different positions. The stakes in this debate are also very high. Those against legalising VE and AS argue that it represents societal endorsement of the intentional ending of another person's life while those in favour argue reform is necessary for people to be able to choose to die with dignity. Agitation for law reform has been an ongoing phenomenon in this debate. While reform is occurring in an increasing number of overseas jurisdictions, attempts to reform the law in Australia have been unsuccessful to date.¹ This is despite a large number of bills being put forward over a sustained period of time, with legislative efforts occurring in every Australian State and Territory except for Queensland.² There is no indication that such attempts will cease. At the time of writing this paper, there are plans for bills dealing with the issue of euthanasia to be introduced into the New South Wales³ and Tasmanian⁴ Parliaments. Questions about how the law regulates these issues have also been raised by the criminal prosecution of individuals who have ended the lives of others or assisted others to end their own lives.⁵

The issue of how we, as a society, regulate VE and AS arises in a particular social, demographic and medical context. For example, Australia has an ageing population and the baby boomer generation is now (and will increasingly be) involved in medical decisions as they come to the end of their lives. This generation will not be passive recipients of paternalistic medical practices, and will insist on greater input in and control over their dying process. At the same time, VE and AS are issues that are of significant interest to the public and, as considered in this paper, are issues about which there is majority public support for reform.⁶ Further, this debate occurs in the context of ongoing advances in medicine. Lives can be sustained in circumstances that have never previously been contemplated, and decisions need to be made about whether to give life-sustaining medical treatment, or allow the

¹ Note, however, the Northern Territory legislation, *Rights of the Terminally Ill Act 1995*, which operated until its repeal by the *Euthanasia Laws Act 1997* (Cth).

² See, for example, Voluntary Euthanasia Bill 2012 (SA); Rights of the Terminally Ill Bill 2011 (NSW); Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011 (SA); Voluntary Euthanasia Bill 2010 (SA); Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA); Voluntary Euthanasia Bill 2010 (WA). For further discussion, see below in Section 4 Legislative reform attempts in Australia.

³ In the New South Wales Legislative Council on 23 October, Cate Faehrmann (Australian Greens) signalled the introduction of the Rights of the Terminally Ill Bill into Parliament in 2013.

⁴ According to media reports, a voluntary euthanasia bill will be introduced by Lara Giddings (Tasmanian Premier) and Nick McKim (leader of the Australian Greens in Tasmania) into Tasmanian Parliament this year: D Arndt, 'Assisted death debate reignited', *The Examiner*, 4 July 2012.

⁵ Recent prosecutions that have attracted attention include those of Shirley Justins and Caren Jenning (*Justins v Regina* [2010] NSWCCA 242; *R v Justins* [2011] NSWSC 568); David Mathers ('Mercy killer escapes jail over "agonising conflict"', *Sydney Morning Herald*, 28 April 2011, available at: <http://www.smh.com.au/nsw/mercy-killer-escapes-jail-over-agonising-conflict-20110428-1dxst.html> (accessed 16 August 2012)); Victor Rijn ('Husband's suicide push driven "by love"', *The Age*, 23 May 2011, available at: <http://www.theage.com.au/victoria/husbands-suicide-push-driven-by-love-20110523-1f00m.html> (accessed 16 August 2012)); and Merin Nielsen (*R v Nielsen* [2012] QSC 29; Brooke Baskin, 'Queensland teacher Merin Nielsen jailed for aiding suicide of man, 76', *The Courier Mail*, 17 February 2012, available at: <http://www.couriermail.com.au/news/queensland/familys-despair-at-suicide-jailing/story-e6freoof-1226273271906> (accessed 16 August 2012)).

⁶ See below in Section 6.2 Key arguments in favour of legalising VS and AS: 'Public opinion is in favour of legalising VE and AS'.

individual to die. There have also been significant improvements in palliative care which have enabled pain in dying patients to be managed to the extent that has not been possible in the past.

Australia21 wishes to advance the debate on VE and AS in an evidence-based and rational way. This paper is the first step in that process and addresses the question:

How should Australia regulate voluntary euthanasia and assisted suicide?

The above question does not imply a view as to whether the existing law should remain the same, or be amended. VE and AS are currently regulated (by the criminal law) and would also be the subject of regulation (in varying ways) under proposals to legalise these practices.

2. Definitions and scope of paper

It is important to be clear about the meaning of the terms used in this paper and the scope of issues it is considering. A failure to define terms and articulate clearly the issues being discussed can lead to confusion through people talking at cross-purposes as well as generating conflict where in fact none exists. In this paper, we adopt the following definitions.

Table 1: Terminology used in the paper

Term	Meaning	Example
euthanasia	For the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person	A doctor injects a patient with a lethal substance to relieve that person from unbearable physical pain
voluntary euthanasia	Euthanasia is performed at the request of the person whose life is ended, and that person is competent	A doctor injects a competent patient, at their request, with a lethal substance to relieve that person from unbearable physical pain
competent	A person is competent if he or she is able to understand the nature and consequences of a decision, and can retain, believe, evaluate, and weigh relevant information in making that decision	
non-voluntary euthanasia	Euthanasia is performed and the person is not competent	A doctor injects a patient in a post-coma unresponsive state (sometimes referred to as a persistent vegetative state) with a lethal substance
involuntary euthanasia	Euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she not die	A doctor injects a competent patient who is in the terminal stage of a terminal illness such as cancer with a lethal substance without that person's request

Term	Meaning	Example
withholding or withdrawing life-sustaining treatment ⁷	Treatment that is necessary to keep a person alive is not provided or is stopped	<p><i>Withdrawing</i> treatment: A patient with profound brain damage as a result of a heart attack is in intensive care and breathing with the assistance of a ventilator, and a decision is made to take him or her off the ventilator because there is no prospect of recovery</p> <p><i>Withholding</i> treatment: A decision is made not to provide nutrition and hydration artificially (such as through a tube inserted into the stomach) to a person with advanced dementia who is no longer able to take food or hydration orally</p>
assisted suicide	A competent person dies after being provided by another with the means or knowledge to kill him- or herself	A friend or relative obtains a lethal substance (such as Nembutal) and provides it to another to take
physician-assisted suicide	Assisted suicide where a doctor acts as the assistant	A doctor provides a person with a prescription to obtain a lethal dose of a substance

We also clarify the scope of this paper. It will consider only the arguments that relate to VE and AS, which deal only with *requests from a competent adult* for death or assistance to die. There are two main reasons for limiting the paper in this way. Firstly, different (and possibly even more ethically problematic) issues arise where the person is competent and does not request euthanasia, is incompetent so unable to express a view, or is a minor. Secondly, all of the attempts to reform the law in Australia have been limited to VE and AS, as has the vast majority of public debate. Accordingly, although some may argue that euthanasia and AS should extend to other situations, such issues are not explored here. As such, this paper will *not* consider euthanasia and AS for:

- Adults who are competent and do not want to end their lives;
- Adults who were competent at some point and completed an advance directive requesting euthanasia or assistance to die at a later time when he or she has lost competence;
- Individuals who are not competent (adults or minors) and therefore unable to make an informed choice about whether to end their lives; and
- Competent minors who seek euthanasia or assistance to die.

⁷ This is sometimes referred to as 'passive euthanasia' as the death arises from not giving life-sustaining treatment.

3. Current Australian legal landscape at the end of life

3.1 VE and AS are unlawful

VE and AS are unlawful in all States and Territories in Australia.⁸ Ending another person's life is murder or manslaughter under the criminal law. Assisting a person to end their own life is also a criminal offence and is described in different jurisdictions in terms such as aiding and abetting suicide.⁹ (It is not unlawful, however, for a person to end, or attempt to end, their own life.) A person will still be criminally responsible for his or her actions even if he or she is motivated by compassion or if the deceased consented to his or her own death.¹⁰

3.2 Withholding or withdrawing life-sustaining treatment can be lawful

While taking active steps to end a person's life (or assisting them to do so themselves) is unlawful, the law does permit life-sustaining treatment to be withheld or withdrawn in certain circumstances.¹¹ One situation is where a person who is competent to make his or her own decisions refuses that treatment. This right to refuse medical treatment is underpinned by respect for bodily integrity. The law protects a person from interference with their body – including by way of medical treatment – unless there is some recognised legal justification for doing so. A person's decision to not receive treatment must be respected even if that treatment is necessary to stay alive and even if the refusal of treatment is contrary to medical opinion.¹²

Decisions to withhold or withdraw life-sustaining treatment can also be made by and for a person who lacks decision-making competence. One way this can be done is through an advance directive. This is where a person makes decisions while they are competent about what medical treatment they want or do not want when they lose their ability to decide for themselves. Most Australian jurisdictions have enshrined this common law right into legislation.¹³ A second way to make decisions when a person lacks competence is through substitute decision-making. Adult guardianship legislation throughout Australia establishes mechanisms for people (generally those close to the patient) to be empowered to make decisions about health care when a patient cannot decide for themselves.¹⁴ The criteria substitute decision-makers need to consider when making decisions to withhold or withdraw life-sustaining treatment vary across Australia but the patient's best interests is generally an integral factor.¹⁵ Thirdly, parents can make this decision for their

⁸ See generally C Stewart, 'Euthanasia and assisted suicide' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [12.10]-[12.200].

⁹ B Murphy, 'Human Rights, human dignity and the right to die: Lessons from Europe of assisted suicide' (2009) 33 *Criminal Law Journal* 341, 347-8.

¹⁰ M Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, 1997) 21-2.

¹¹ See generally L Willmott, B White and S-N Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010).

¹² L Willmott, B White and S-N Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [13.30]-[13.40].

¹³ L Willmott, 'Advance Directives and the Promotion of Autonomy: a Comparative Australian Statutory Analysis' (2010) 17 *Journal of Law and Medicine* 556.

¹⁴ See generally B White, L Willmott and S-N Then, 'Adults who Lack Capacity: Substitute Decision-Making' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010).

¹⁵ L Willmott, B White and S-N Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [13.130], [13.180]-[13.230].

children who do not yet have decision-making competence. The relevant criterion for such a decision is the child's best interests.¹⁶

In addition to patients, substitute decision-makers and parents being able to refuse life-sustaining treatment in certain circumstances, it is also possible for doctors to make this decision to withhold or withdraw treatment. The law generally does not impose a duty on doctors to provide treatment that will not benefit a patient. Where a doctor determines that treatment is not in a patient's best interests, he or she is not required to provide it even if it is needed for the patient to stay alive.¹⁷ Sometimes this decision is framed in terms of treatment being 'futile'.

Although the person dies both when life-sustaining treatment is withheld or withdrawn and when VE occurs, the law distinguishes between them. Withholding and withdrawing is lawful because it involves a *failure to treat* where there is no duty to provide that treatment. The absence of a duty is due either to the refusal of treatment by the patient or his or her substitute decision-maker, or because the treatment is not in the patient's best interests and so need not be provided. By contrast, VE involves taking *active steps* to end another's life and so is in breach of the criminal law.

3.3 Provision of appropriate palliative care is lawful

Australian law is also very likely to recognise that the provision of appropriate palliative care is lawful, even if it might hasten death.¹⁸ This is despite the fact that providing this treatment could be seen as taking active steps to end a patient's life and therefore be in breach of the criminal law. This legal protection arose in response to concerns that otherwise appropriate palliative care could accelerate death (for example, opioids suppressing respiration) although many argue that properly administered palliative care does not do this.¹⁹

Of greatest significance for Australian law is a health professional's intention. To be lawful, palliative care must be provided with the intention to relieve pain and not to cause or hasten death, although that death may be foreseen. In the three States that have enshrined this protection in statute, regard must also be had to other factors such as good medical practice.²⁰

The central role of intention raises questions for how the law operates in this area. A doctor's intentions when providing certain treatment are easy to obscure or can be ambiguous. It is possible for the same act to be done, namely hastening a patient's death, with different intentions. For example, a doctor may provide medication with the intention of hastening death, or instead with the intention of relieving pain and only foreseeing (rather than intending) the likely death.²¹ While the statement of law may be clear, its operation in practice is not.²²

¹⁶ L Willmott, B White and S-N Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [13.280]-[13.290].

¹⁷ L Willmott, B White and S-N Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [13.70]-[13.80].

¹⁸ See generally B White and L Willmott, 'The Doctrine of Double Effect' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010).

¹⁹ B White, L Willmott and M Ashby, 'Palliative care, double effect and the law in Australia' (2011) 41 *Internal Medicine Journal* 485.

²⁰ B White, L Willmott and M Ashby, 'Palliative care, double effect and the law in Australia' (2011) 41 *Internal Medicine Journal* 485.

²¹ CD Douglas, IH Kerridge and R Ankeny, 'Managing intentions: the end-of-life administration of analgesics and sedatives, and the possibility of slow euthanasia' (2008) 22 *Bioethics* 388.

²² See below in Section 6.2 Key arguments in favour of legalising VE and AS: 'Current regulatory framework does not work: VE and AS currently occurs'.

4. Legislative reform attempts in Australia

Australia has witnessed continual and numerous attempts to reform the law governing VE and AS. These attempts have occurred in all Australian States and Territories except Queensland. In the past, most bills have been introduced by members of the Australian Greens, Australian Democrats and Independent members, although some recent attempts since 2010 have come from an ALP member of parliament. In the table that appears as Appendix A to this Paper, we have listed legislative attempts to reform the law regarding VE and/or AS of which we are aware, along with details of who introduced the bill and when, and in which house of parliament this occurred. While the vast majority of these bills sought to effect change in the substantive law governing VE and AS, there were also bills dealing with other issues in this area such as seeking a referendum on the topic and restoring the powers of Territories to legislate on the issue.

The history of failed attempts at legislative reform suggests that despite strong public opinion in favour of VE and AS, there is not majority support from politicians as a group for changing the law. Understanding politicians' perspectives and motivations for this position is important but there is only limited empirical evidence as to politicians' role in this debate. One study examined how federal politicians voted in a conscience vote to overturn the Northern Territory euthanasia legislation (and two other sensitive conscience votes).²³ Three key factors that were significant in how the politicians voted were party alliances, gender and religious affiliation.²⁴ The most significant correlation was religious affiliation, with all Catholics voting in favour of overturning the Northern Territory legislation and all but one of the politicians from other Christian religions doing the same. Another study surveyed Queensland politicians as to their personal views on these issues and found that 55% of respondents favoured euthanasia reform.²⁵ However, the study suggested that these personal views may not be followed in a public vote where concerns about party lines and re-election intrude.

Given the critical role that politicians play in this debate and the apparent disconnect between public opinion and politicians' opinions, it may be instructive to analyse the public record (for example, hansard and the reports of review committees) to distil the arguments that politicians identify as important when supporting or opposing reform. Such an analysis may be helpful in better understanding the VE and AS debate, particularly if politicians are granted a conscience vote as is often the case for topics such as these.

5. Legislative schemes that permit VE and/or AS

Although reform has not occurred in Australia (except for a brief period in the Northern Territory), legislation permits VE and/or AS in the Netherlands, Belgium, Luxembourg, Oregon, Washington and Switzerland. In the first five jurisdictions (Netherlands, Belgium, Luxembourg, Oregon and Washington), reform occurred through specific legislation. In Switzerland, AS is permitted in some circumstances because of the narrower reach of the crime of AS in that country, and this is explained further below. In this section, we will provide a brief overview of the legislative models that currently operate, as well as the legislation that was enacted and operated (albeit briefly) in the

²³ J Warhurst, 'Conscience Voting in the Australian Federal Parliament' (2008) 54 *Australian Journal of Politics and History* 579.

²⁴ Religious affiliation was included where the relevant politician had identified his or her affiliation and where this information was in the public domain.

²⁵ L Willmott and B White, 'Private Thoughts of Public Representatives: Assisted Death, Voluntary Euthanasia and Politicians' (2003) 11 *Journal of Law and Medicine* 77.

Northern Territory prior to its repeal by the Commonwealth Parliament. As our focus here is on the more detailed regulation that occurs through legislative reform, we will not examine where reform has occurred through judicial means (for example in Montana), although this is considered later in the paper.²⁶

5.1 Netherlands, Belgium, Luxembourg, Oregon, Washington (and the Northern Territory)

The statutes enacted in these jurisdictions are set out in Table 2 below.

Table 2: VE and AS legislation by jurisdiction

Jurisdiction	Legislation
Netherlands ²⁷	<i>Termination of Life on Request and Assisted Suicide Act 2000</i>
Belgium	<i>Act on Euthanasia 2002</i>
Luxembourg	<i>Law of 16 March 2009 on Euthanasia and Assisted Suicide</i>
Oregon ²⁸	<i>Death with Dignity Act 1994</i>
Washington ²⁹	<i>Washington Death with Dignity Act</i>
Northern Territory	<i>Rights of the Terminally Ill Act 1995 (now repealed)</i>

The table that appears as Appendix B to this paper provides some further detail about aspects of the above six statutes and facilitates comparisons across jurisdictions. We also make some observations here about key features of these legislative regimes. Firstly, the statutes differ in relation to the kind of activity which is regulated – either VE or AS or both. VE and AS are permitted in the Netherlands, Belgium³⁰ and Luxembourg, and were permitted under the Northern Territory regime. Only assisting a suicide can be lawful in Oregon and Washington.

Secondly, there is significant divergence in terms of eligibility requirements, that is, what must be present before a person will qualify for VE or AS under the particular regime. Such requirements relate to the person's competence, age, medical condition as well as whether there are any residence requirements that must be satisfied. In Oregon and Washington (and the Northern Territory), the person must be competent at the time he or she is making the request to end his or her life, while in the Netherlands, Belgium and Luxembourg, a person's advance statement

²⁶ See below in Section 8 A framework for considering regulatory options for VE and AS. We note too that judicial reform also occurred in Colombia in 1997, although a recent media article has reported that a bill has been passed in Colombia that regulates the practice of euthanasia in some circumstances: J O'Gorman, 'Colombian Senate Approves Regulation of Euthanasia', *Colombia Reports*, 9 August 2012, available at: <http://www.colombiareports.com/colombia-news/news/25483-colombian-senate-approves-regulation-of-euthanasia.html> (accessed 17 August 2012).

²⁷ Note that prior to legislative reform in the Netherlands, case law in that country had recognised the defence of necessity for a doctor in some cases where he or she was confronted with a request by a patient to die, and providing assistance was the only way to end the patient's suffering.

²⁸ In Oregon, the legislation resulted from a voter-initiated referendum. For a discussion of the legal challenges to this legislation, see C Stewart, 'Euthanasia and assisted suicide' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) [12.210].

²⁹ The Washington legislation was also enacted as a result of a referendum at the 2008 general election.

³⁰ It should be noted that the Belgian legislation does not expressly permit AS. However, there appears to be general acceptance, including by the Federal Control and Evaluation Commission, the body established to oversee the implementation of the euthanasia law, that provided the safeguards of the euthanasia legislation are complied with, a doctor who assisted a suicide would also be protected by the legislation: G Lewy, *Assisted Death in Europe and America, Four Regimes and Their Lessons* (Oxford Scholarship Online, 2011) 77 (accessed 20 August 2012).

requesting euthanasia can also be acted upon. In most jurisdictions (Luxembourg, Oregon, Washington and the Northern Territory), there is a requirement that the person be suffering from a terminal illness. Although there is no such requirement in the Netherlands or Belgium, in those jurisdictions, the person's suffering must be 'lasting and unbearable' (Netherlands) or the person must be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated (Belgium). In most jurisdictions, the person must be an adult, although the Belgian legislation extends to 'emancipated minors' and in the Netherlands, such practices can occur for minors as young as 12.³¹ The legislation in Oregon and Washington contain residence requirements, but that is not the case in the other jurisdictions (and was not the case for the Northern Territory regime).

All statutes contain safeguards although there are significant variations between jurisdictions. These safeguards include ensuring that the consent of the person was given voluntarily, requiring information to be provided to the person, involving more than one doctor, and observing cooling off periods between making the initial request for assistance and the person dying. Details of the safeguards in the various jurisdictions are contained in Appendix B.

Finally, all statutes have provisions facilitating oversight of the practice of VE and/or AS.

5.2 Switzerland

Over recent years, Switzerland has become a destination for individuals who come from jurisdictions in which VE and AS is unlawful, but who want assistance to end their lives. Ironically, Switzerland has not passed legislation to make either VE or AS lawful. The law in Switzerland is governed by their *Criminal Code*, and under that Code, both VE and AS are unlawful. The relevant provisions are set out below:³²

Article 114

Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person's own genuine and insistent request shall be liable to a custodial sentence not exceeding three years or to a monetary penalty.

Article 115

Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.

Article 114 deals with VE as it involves a person who 'causes' the death of another, while article 115 is about assisting another to bring about his or her own death. The effect of article 114 is that VE is unlawful and the person performing the act commits a crime, even if the act is done for 'commendable motives' at the other's request. On the other hand, not all cases of AS will be illegal. Assisting a suicide is only an offence if it is done for 'selfish' motives. Article 115 is unlikely to apply to a case where a person has a medical condition which causes unbearable pain and suffering, forms a desire to end his or her life to relieve that pain and suffering, and seeks assistance to achieve that goal.

³¹ Euthanasia can be performed at a minor's request if the minor is aged between 16 and 18, the minor has a reasonable understanding of his or her own interests, and the parents or guardians have been involved in the decision-making process. This is also the case for a minor aged between 12 and 16 who has a reasonable understanding of his or her own interests, and where the parents or guardians agree with the decision.

³² <http://www.admin.ch/ch/e/rs/3/311.0.en.pdf> (accessed 20 July 2012). This source is an English translation of the Swiss *Criminal Code*, and is not an official source.

There are a number of consequences that flow from the fact that the permissive Swiss law arose from the interpretation given to an offence provision in its *Criminal Code*, rather than a comprehensive statutory regime designed to regulate AS. Most significantly, there are no express eligibility criteria to be satisfied for the person seeking assistance to die, and few safeguards. Provided the person assisting another to die is not motivated by selfish motives, an offence has not been committed. It also means that assistance can be provided by friends and relatives, and is not limited to doctors as in the other jurisdictions. Further, again unlike the other jurisdictions, this also means there is less governmental oversight in terms of the practices which are occurring. The absence of a regulatory regime also means that there is not scope to impose a residence requirement as in Oregon and Washington. Because providing assistance is lawful if it is done with selfless motives, this test can be met both when assisting Swiss residents to die and those who visit Switzerland specifically seeking this assistance.³³

6. Arguments for and against reform

This section considers briefly the arguments that are generally espoused to support or oppose legalising VE and AS. There is not scope in this paper to exhaustively summarise the vast literature in this field, or to outline the nuances that are relevant to each argument. Nevertheless, we examine briefly the critical issues that are important to the different perspectives in the debate.

6.1 Finding a consensus of ethical values

Before rehearsing the arguments for and against VE and AS, we will attempt to identify some ethical or moral positions about which consensus as to their relevance to this debate may be possible. This exercise is undertaken in the hope that agreement about these positions may provide a touchstone in discussions about whether or not the current regulatory environment should remain or, if reform is proposed, the nature of such reform.

1. *The inherent value of human life*: There is general, although not universal, consensus that special status should be afforded to human beings over and above other species.
2. *The need to respect a person's autonomy*: The right of a competent person to self-determination is a fundamental principle in a liberal democracy, and should be respected.³⁴
3. *The need to protect vulnerable members of society*: As a society, we value all individuals and want to protect those who are vulnerable and in need of protection.
4. *The need to alleviate pain and suffering from individuals who are unwell*: As a compassionate society, we seek to minimise or completely ameliorate pain or suffering endured by individuals who are unwell.

³³ Since 2003, Dignitas states that it has assisted 15 Australians to end their lives in Switzerland: Dignitas, 'Accompaniments to suicide per year and residence', available at: <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2011.pdf> (accessed 17 August 2012).

³⁴ The authors acknowledge that differing views exist about what constitutes autonomy for the purpose of medical decision-making, but it is beyond the scope of this paper to explore those contrasting views.

5. *The need for the law to be coherent and transparent:* For a liberal democracy to function effectively, individuals should respect the prevailing legal framework. For this to occur, the law must be coherent, and operate in a transparent fashion.
6. *The need for the law to be followed:* For a liberal democracy to function effectively, individuals need to follow the law.

As mentioned above, the goal in attempting to articulate ethical principles that are shared by the majority of the community, is to identify points of possible consensus for all individuals regardless of their perspective in the euthanasia debate. We acknowledge, however, that despite the potential for agreement on some core ethical principles, the different weight afforded to these principles by individuals may, and probably will, lead to different conclusions in terms of desired regulatory models.

6.2 Key arguments in favour of legalising VE and AS

1. *Autonomy (sometimes referred to as the right to self-determination) demands that a competent person has the right to choose how he or she dies*

The right of a competent person to make decisions that affect his or her own life is seen as fundamental in a liberal democracy such as Australia. This is sometimes referred to as a right to self-determination or a right to act in an autonomous way. This right of self-determination should entitle a competent person who is informed of his or her medical diagnosis, prognosis, treatment options and consequences of those options to choose the manner in which he or she dies. This right includes the right to ask for someone else to end his or her life, or to receive assistance to die.

Illnesses and diseases have different medical trajectories. Some illnesses or diseases may mean that a person is deprived of independence because he or she needs assistance from others for all aspects of living. Some individuals may find it undignified to continue to live in circumstances where they must rely on others to, for example, feed them, bathe them and assist them with toileting, and may prefer to end their lives rather than continue to live in this fashion.³⁵ A competent person who forms that view should have the right to end his or her life.

2. *VE or AS is necessary for the relief of pain in some situations*

Great improvements have been made in palliative care over the past decade. Nevertheless, not all pain can be alleviated by medicine: both existential³⁶ and some physical pain cannot be alleviated and may result in a request from an individual for his or her life to end. As a society, we should not prevent a competent person, who is experiencing unrelenting pain or suffering, from ending his or her life.³⁷

³⁵ See, for example, the views expressed by Dr John Elliot, an Australian doctor suffering from various illnesses including multiple myeloma, who travelled to Switzerland to receive assistance to die. He chose to take this course as he considered that death from natural causes in Australia would involve 'pain and the loss of his dignity': A Rothschild, 'Just When you Thought the Euthanasia Debate had Died' (2008) 5 *Bioethical Inquiry* 69, 69-70.

³⁶ By existential pain, we mean pain which is not necessarily connected with physical pain. The term refers to emotional or psychological pain and/or suffering.

³⁷ Campbell has described the ability to choose to die to avoid extreme pain and suffering which cannot be alleviated by medicine as a human right: T Campbell, 'Euthanasia as a Human Right' in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, 2008) 455.

3. Current regulatory framework does not work: VE and AS currently occurs

*Evidence that lives are ended unlawfully*³⁸

There is a clear body of evidence that demonstrates that VE and AS occur despite being unlawful.³⁹ This includes research that examines doctors' intentions when administering pain relieving medication and whether the provision of this treatment always complies with the law. As discussed above, an act done with an intention to relieve pain is lawful (even if death is foreseen), but the same act done with an intention to kill is not lawful.⁴⁰ Despite this, some doctors who are treating terminally ill patients intend to kill when they administer pain relieving medication, and so will be acting unlawfully.⁴¹ Further, the palliative practice of 'terminal sedation'⁴² – where a patient is kept under deep continuous sedation to manage pain, while artificial nutrition and hydrating is withdrawn or withheld ultimately leading to death – can give rise to legal ambiguity and has sometimes been equated to 'slow euthanasia'.⁴³

Consequences of unlawfulness

Two adverse consequences flow from the fact that unlawful practices occur. The first is that as these practices are unlawful, they are unregulated. Regulation promotes good practice and, conversely, there are dangers inherent in unregulated practices, particularly where they lead to people's lives being ended. For example, for which patients is it acceptable for doctors to assist to die? What practices are acceptable to achieve this purpose? Are doctors covertly making quality of life assessments which result in a decision to end a person's life? Legalisation and regulation of VE and AS allows for the creation of appropriate safeguards and oversight to ensure, for example, that a decision to end one's life is made only by a competent adult.

The second consequence of the existence of unlawful practices is that the ongoing occurrence of such practices in defiance of the law brings the law into disrepute.

4. The current law is incoherent

As considered earlier in the paper, some decisions are lawful even though they result in a person's death.⁴⁴ Withholding and withdrawing life-sustaining treatment can be lawful, for example, when doing so is judged to be in a person's best interests. Providing pain relief that causes the death of a person will be lawful if the doctor's intention is to relieve pain rather than to kill the patient. This is the case even if the doctor foresees that the medication will end the patient's life. The law is incoherent if some deliberate acts (or omissions) which occur in the knowledge that a person will die

³⁸ Evidence of unlawful conduct in Australia relating to VE and AS is discussed further below in Section 7.1 What happens in Australia?

³⁹ See, for example, H Kuhse et al, 'End-of-life decision-making in Australian medical practice' (1997) 166 *Medical Journal of Australia* 191; R Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (Melbourne University Press, 2002); R Syme, *A Good Death: an Argument for Voluntary Euthanasia* (Melbourne University Press, 2008).

⁴⁰ See above in Section 3.3 Provision of appropriate palliative care is lawful.

⁴¹ CD Douglas et al, 'The intention to hasten death: a survey of attitudes and practices of surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511.

⁴² CD Douglas, IH Kerridge and RA Ankeny, 'Narratives of "Terminal Sedation", and the Importance of the Intention-Foresight Distinction in Palliative Care Practice' (2011) *Bioethics*, DOI: 10.1111/j.1467-8519.2011.01895.x (early view).

⁴³ The lawfulness of this practice is likely to depend on the precise circumstances of the case, particularly the reasons for the provision of the sedation and the cessation or withholding of artificial nutrition and hydration.

⁴⁴ See above in Section 3 Current legal landscape at the end of life.

as a result are lawful, yet others (namely VE and AS) are not.⁴⁵ There is no moral distinction to warrant treating these situations differently.

Another argument concerning incoherence of the law also arises in this context. For many years, suicide has been a lawful act, yet assisting in a suicide is not. It is odd if it is unlawful to assist someone to do something that is lawful.

5. Public opinion is in favour of legalising VE and AS

There is a long standing history of strong public support for the legalisation of VE and AS in certain circumstances. A recent illustration is a survey conducted in November 2010 by the Australia Institute which found that 75% of respondents thought a doctor should be allowed to assist a terminally ill person experiencing unrelievable suffering to die at their request.⁴⁶

6. The current law is discriminatory

The prohibition on VE and AS operates differently on individuals, depending on factors such as the nature of their illness and (possibly) their financial circumstances. Some individuals have the physical ability to commit suicide, while the physical circumstances of others may prevent them from doing so. Some individuals may have the financial resources to travel overseas to jurisdictions such as Switzerland where AS is lawful, while others may not.

Legalising VE and AS will expand options for individuals who want to die, but currently are unable to end their own lives or access assistance to die.

6.3 Key arguments against legalising VE and AS

1. Sanctity of life

Human life is paramount and it should always be illegal to commit an act with the intention of ending another person's life, or assisting a person to end his or her own life. Such arguments tend to be grounded in religious ideology. As suggested by one commentator:

For years the Catholic Church and most mainstream Protestant Churches have opposed any form of euthanasia on the grounds that decisions about life and death should be reserved for divine agency.⁴⁷

The Catholic Church's Declaration of Euthanasia states that the practice of VE and AS is a:

⁴⁵ A Rothschild, 'Just When you Thought the Euthanasia Debate had Died' (2008) 5 *Bioethical Inquiry* 69, 73-74; L Doyal, 'The Futility of Opposing the Legislation of Non-voluntary and Voluntary Euthanasia' in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, 2008) 470.

⁴⁶ The Australia Institute, 'Survey results – attitudes to voluntary euthanasia' (2011), available at: <https://www.tai.org.au/index.php?q=node%2F19&pubid=822&act=display> (accessed 19 August 2012). The question asked was:

'This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?' Responses were:

- Yes, voluntary euthanasia should be legal (75%)
- No, voluntary euthanasia should be against the law (13%)
- Not sure (12%).

For a wider discussion of Australian attitudes in this area, see J Sikora and F Lewins, 'Attitudes concerning euthanasia: Australia at the turn of the 21st Century' (2007) 16 *Health Sociology Review* 68.

⁴⁷ J Sikora, 'Religion and attitudes concerning euthanasia' (2009) 45 *Journal of Sociology* 31, 33.

*violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.*⁴⁸

The importance of human life is also recognised by our common law. In the landmark English case of *Bland*, the House of Lords recognised that it would be lawful to withdraw life-sustaining medical treatment from a man in a persistent vegetative state but accepted that the ‘sanctity of life’ formed part of the English legal system.⁴⁹ The Australian courts have also recognised the State’s interest in preserving human life.⁵⁰

The sanctity of life means that the deliberate ending of life can never be justified.

2. *If VE or AS is legalised, it is impossible to construct safeguards that will ensure an individual who falls outside the regime is not killed*

As can be seen from Appendix B, all statutes that have provided for VE or AS contain safeguards that are designed to ensure that the only people whose lives are ended or to whom assistance to die is provided are those who are (or were) competent and made their decision voluntarily, and who have particular medical conditions. In all of those jurisdictions, there is also oversight of the relevant legislation. However, it would be difficult, if not impossible, to ensure all of the legislative requirements relating to eligibility are satisfied in all cases. Of particular concern may be the ability to ensure that the request to die was given voluntarily. A person approaching the end of his or her life who relies heavily on others for all aspects of living may be pressured to end his or her life. Such pressure may not necessarily be overt, and may be exerted in subtle ways. Nevertheless, this may result in the fact that the request to die cannot be regarded as having been made voluntarily.

This inability to ensure that safeguards are observed means there is potential for abuse in that a person who does not fall within the ambit of the legislation may be killed. Vulnerable individuals in our society, such as the sick, the elderly and those living with disabilities, will be at risk.

3. *If VE or AS for competent adults is legalised, the regime will be broadened to include involuntary and non-voluntary euthanasia, and euthanasia for minors (the ‘slippery slope’ argument)*

Pursuant to the slippery slope argument, safeguards that the community agrees on to underpin legislative reform (for example, that only competent adults should be able to receive assistance to die) would, in time, be eroded, and the regime would ultimately extend to individuals who lack competence or to minors. Such extensions of the regime would be morally unacceptable, yet difficult to resist once VE and AS are available to some members of our society.

⁴⁸ F Cardinal Seper, ‘Declaration on Euthanasia’ 72 Acta Apostolicae Sedis 542, 1980, Congregation for the Doctrine of the Faith, available at: http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html (accessed 30 July 2012). See also Pope John Paul II, ‘Evangelium Vitae’, 25 March 1995, available at: http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html (accessed 19 August 2012).

⁴⁹ *Airedale NHS Trust v Bland* [1993] AC 789, 859.

⁵⁰ See, for example, *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, [5]-[16], and most recently a reference by the majority of the High Court in *Patel v The Queen* to ‘the value the law places on human life’: [2012] HCA 29, [87].

4. *The improvements in palliative care make the need for VE and AS obsolete*

The advances in medical knowledge over the past decade, particularly in the field of palliative care, mean that the debate about VE and AS is no longer necessary. Palliative care has improved to such an extent that individuals do not have to endure physical pain throughout the dying process. As such, the need to consider a legal regime of VE or AS is now obsolete.

5. *It is the role of doctors (and health professionals generally) to save lives and protect unwell people, not to kill them*

Medical and other health professionals are trained to save and protect human life, and improve the quality of the life of their patients. It would be contrary to their fundamental role in society for these professionals to be asked to kill their patients, or assist their patients to end their own lives. A separate, but related, point is that doctors should not be forced to act in a way that is contrary to their conscience. Even if a legislative regime does not *require* them to provide assistance, such a regime may require a doctor to refer the patient to someone who may be able to assist to end his or her life. An obligation to make such a referral may also be contrary to their beliefs and they should not be required to act in a way that is contrary to their conscience.

6. *If VE or AS were legalised, sick and other vulnerable people may feel coerced to end their lives*

Countries can and do have different cultures. Variations occur in countries in relation to how they care for the aged, sick and disabled. Some people may be concerned that the introduction of laws that enable us to kill the vulnerable within our community may result in a culture where there is an expectation that people within this group will take steps to end their lives when they reach a certain stage of deterioration. Indeed, there may be a concern that vulnerable people may be subject to pressure, subtle or otherwise, to take such steps.

A shift in existing culture of caring for the sick in our community may also lead to a reluctance of sick individuals to seek medical help when it is needed. These individuals may be concerned that rather than be provided with assistance to manage their condition, they may be encouraged by their doctor to seek assistance to end their lives.

6.4 The role of human dignity in this debate

Before leaving this discussion of the arguments in favour of and against VE and AS, a note about 'human dignity' is necessary. Views are likely to differ regarding precisely what is encompassed by this term.⁵¹ Nevertheless, it is frequently cited as a reason that VE or AS should be allowed. Relevant to this argument is that illness and disease can result in individuals having to rely on others for all aspects of their lives, and living in a way that they regard as abhorrent. The loss of dignity may be a significant factor in deciding that life has become unacceptable, and VE or AS would enable such a person to bring life to an end, and should be permitted. On the other hand, some argue that human dignity, which is inherent in all individuals, is incompatible with the practice of VE and AS. Accordingly, neither VE nor AS should be permitted. An argument of this kind appears to link concepts of human dignity and the sanctity of life.

Because human dignity is a concept which is potentially relevant to both sides of this debate, it has not been included in the above outline of arguments for and against VE and AS. Instead, in the

⁵¹ The use of the term 'dignity' in the context of the euthanasia debate was explored in some detail in U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 S1 *Bioethics* 1,38-45.

arguments supporting reform, dignity is considered in the narrower context as part of the justification for allowing individual choice in decision-making at the end of life. On the other side, dignity is relevant in advancing the argument concerning the sanctity of life, and the need to protect human life.

7. What happens in practice?

Some of the arguments discussed in the previous section are primarily moral or ethical ones. But other arguments make claims about likely future practice or draw on empirical evidence as to what is currently happening both in Australia and overseas (particularly those jurisdictions where VE and/or AS is lawful). This section considers the evidence that is available in relation to current practice, and does so in light of two important propositions about the implications of legalising VE and AS.

The first proposition is that making VE and AS illegal is an effective deterrent to them occurring. In this section, we refer to some of the available evidence of current practice regarding VE and AS in Australia, namely that the unlawful practices of VE and AS currently occur. We do not conclude from this that the law should change to reflect (and regulate) current practice. It could equally be argued that increased emphasis needs to be placed on enforcing the current laws.⁵² Rather we put forward this information about the extent of compliance or not with the law as relevant evidence to inform deliberations of how VE and AS should be regulated.

The second proposition is that in jurisdictions where VE and AS are legal, there will be a slide into other (unacceptable) practices such as involuntary and non-voluntary euthanasia, or VE and AS in circumstances where the safeguards in the legislation are not complied with. If this occurs, the vulnerable individuals within our society will be particularly at risk.⁵³ In this section, we consider some of the data regarding the practice of VE and/or AS in the Netherlands, Belgium, Switzerland and Oregon to see the extent to which these concerns have been realised. (We will not examine the situation in Luxembourg or Washington due to the relatively limited time that their regimes have been in operation.)

7.1 What happens in Australia?

As the practice of VE and AS is illegal, there are significant impediments to accurately quantifying the extent to which these practices occur in Australia. However, there have been a few studies that have sought to examine this issue empirically. One is a study by Kuhse and others which concluded that in 1995-1996, 1.8% of all deaths in Australia occurred due to VE and 0.1% were due to physician AS.⁵⁴ As outlined in the next section, these statistics are broadly comparable with the position in permissive jurisdictions. A noteworthy difference existed though in relation to the rate of death due

⁵² J Keown, 'Defending the Council of Europe's Opposition to Euthanasia' in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, 2008) 483.

⁵³ See above in Section 6.3 Key arguments against legalising VE and AS: 'If VE or AS is legalised, it is impossible to construct safeguards that will ensure an individual who falls outside the regime is not killed' and 'If VE or AS for competent adults is legalised, the regime will be broadened to include involuntary and non-voluntary euthanasia, and euthanasia for minors (the 'slippery slope' argument)'.

⁵⁴ H Kuhse et al, 'End-of-life decision-making in Australian medical practice' (1997) 166 *Medical Journal of Australia* 191.

to 'ending life without patient's explicit request': Kuhse and her colleagues noted it was significantly higher in Australia (3.5%) than in the Netherlands (0.7%, at the comparable time of 1995).⁵⁵

A qualitative study by Magnusson has also documented sustained unlawful conduct relating to VE and AS. His book, entitled 'The Euthanasia Underground', details the involvement of 49 people in deaths through euthanasia (voluntary and otherwise) and AS.⁵⁶ There is also a body of work that has been done on intention when providing pain relieving medication. Some doctors who treat terminally ill patients intend to kill (rather than only relieve pain) when they administer palliative care, and so will be acting unlawfully.⁵⁷

In addition to this empirical research, there is a body of anecdotal evidence that VE and AS occurs in Australia. For example, seven Melbourne doctors published an open letter to the then Victorian Premier that appeared on the front page of 'The Age' newspaper, admitting to having performed euthanasia.⁵⁸ The letter formed part of a campaign to legalise AS. Dr Rodney Syme was one of those doctors, and he has also published a book which revealed his involvement in assisting patients to end their lives.⁵⁹

While there is not comprehensive evidence in relation to the extent to which VE and AS occurs in Australia, there is clear evidence that such practices do take place despite being unlawful, giving rise to potential for those involved to be prosecuted.⁶⁰

7.2 What happens in the Netherlands, Belgium, Switzerland and Oregon?

A vast body of literature exists about current practices in jurisdictions that permit VE and/or AS. This literature includes official reports that are legislatively mandated as part of government oversight of these practices, as well as publications resulting from formal and comprehensive reviews of law and practice that are conducted from time to time.⁶¹ However, the bulk of the literature is comprised of papers published in scholarly journals, frequently by commentators who have an entrenched view, one way or the other, about whether such practices should be lawful. Some of this literature reports

⁵⁵ H Kuhse et al, 'End-of-life decision-making in Australian medical practice' (1997) 166 *Medical Journal of Australia* 191 at 195-196.

⁵⁶ R Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (Melbourne University Press, 2002).

⁵⁷ CD Douglas et al, 'The intention to hasten death: a survey of attitudes and practices of surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511.

⁵⁸ R Syme, D Russell, P Scrivener, N Roth, A Buchanan, D Bernshaw, S Benwell, 'An Open Letter to the State Premier of Victoria', *The Age*, 24 March 1995.

⁵⁹ R Syme, *A Good Death: an Argument for Voluntary Euthanasia* (Melbourne University Press, 2008).

⁶⁰ See, for example, the prosecution of Daryl Stephens, urologist in Western Australia. He was ultimately acquitted of murder (a charge which was pursued by the Director of Public Prosecutions despite a magistrate initially finding there was insufficient evidence to warrant taking the matter to trial): D Weber, 'Doctor releases book on woman's death', *PM*, 8 October 2002, available at: <http://www.abc.net.au/pm/stories/s696378.htm> (accessed 19 August 2012).

⁶¹ Recently, for example, reviews of the law and medical practice at the end of life were undertaken in both the United Kingdom and Canada resulting in two comprehensive reports: see Report of the Commission on Assisted Dying, *The current legal status of assisted dying is inadequate and incoherent...* (2011), available at: <http://www.demos.co.uk/publications/thecommissiononassisteddying> (accessed 20 August 2012) and U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 *S1 Bioethics* 1 respectively. A review of 'dying with dignity' and associated issues has also been considered by a select committee created by the National Assembly in Quebec, with their report being released in March 12: Select Committee, *Dying with Dignity Report* (2012). This report is available at: <http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html> (accessed 10 September 2012).

on empirical research that has been conducted in permissive jurisdictions, providing data on the extent to which VE and AS occurs. Some commentators express concern in this writing that permissive jurisdictions, and most notably the Netherlands, have witnessed an expansion in VE and AS practices which has led to the vulnerable in our society being placed at risk.⁶² The literature includes concerns about the difficulties of ensuring that the legislative safeguards embodied in the legislation are observed, and that the practice of VE and AS is limited to the circumstances contemplated by the legislation. Other commentators express concern that the assertions raised in such literature are either overstated, not supported by the available empirical evidence, or in direct conflict with that evidence.⁶³

For any jurisdiction contemplating how best to regulate VE and AS, it is critical to establish what has occurred in those jurisdictions that have enacted legislation. Such information facilitates an informed debate and decision-making process. However, for the reasons explained above, there is a need to be cautious in reviewing and interpreting the available literature on the practices that are currently occurring.⁶⁴ Only a careful engagement with the available data and broader literature will enable policy makers to assess whether the concerns expressed about the practices in permissible jurisdictions, particularly about the risk to which the vulnerable in our society will be exposed, are justified.

For the purpose of this paper, we are not able to undertake a comprehensive review of the body of literature that is in the public domain in this area. Instead, we provide a snapshot of current practice, drawing on the recent review of empirical research undertaken by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making.⁶⁵

Netherlands

Information about medical practice at the end of life that is available in the Netherlands is helpful, as surveys have been undertaken at regular intervals since 1990. This enables trends in practice to be linked with the legal regime that operated at the relevant time. These legal changes over time are summarised below:⁶⁶

- 1973 – Case law recognised that a doctor could lawfully shorten a person’s life to prevent serious and irremediable suffering (although VE and AS were punishable in all circumstances). Despite this concession, in this case, the doctor was found guilty (although did not receive a harsh penalty). The law as a result of this case, therefore, remained unclear.
- 1984 – There was further case law development and it was recognised that where a doctor was faced with a request from a patient to die, the doctor faced a conflict of duty. He or she was entitled to assist the patient to die under the doctrine of necessity.

⁶² See, for example, J Pereira, ‘Casting stones and casting aspersions: let’s not lose sight of the main issues in the euthanasia debate’ (2012) 19 *Current Oncology* 139; J Pereira, ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls’ (2011) 18 *Current Oncology* e38; J Keown, ‘Defending the Council of Europe’s Opposition to Euthanasia’ in S McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, 2008).

⁶³ See, for example, J Downie, K Chambaere and J Bernheim, ‘Pereira’s attack on legalizing euthanasia or assisted suicide: smoke and mirrors’ (2012) 19 *Current Oncology* 133.

⁶⁴ For comment on the difficulty inherent in interpreting available data, see M Shariff, ‘Assisted death and the slippery slope – finding clarity amid advocacy, convergence, and complexity’ (2012) 19 *Current Oncology* 143.

⁶⁵ U Schüklenk et al, ‘End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making’ (2011) 25 *S1 Bioethics* 1, 61-5.

⁶⁶ This summary was based on information provided in U Schüklenk et al, ‘End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making’ (2011) 25 *S1 Bioethics* 1, 51-7.

- 1994-2002 – Prosecutorial guidelines operated which indicated when a doctor would and would not be charged in relation to ending a patient’s life or assisting the patient to die.
- 2002 – Legislation was passed and doctors could not be prosecuted if they acted with ‘due care’ as defined in the legislation.

The collection of empirical data about end of life medical practice was sponsored by the Dutch government to obtain information about the kind of practice that was occurring and demographics of those people who are dying as a result of the relevant legal regime. Nationwide surveys were conducted in 1990, 1995, 2001, 2005⁶⁷ and 2010⁶⁸ and they resulted in the below data in Table 3.⁶⁹

Table 3: Deaths due to VE and AS as a percentage of total deaths in the Netherlands

	1990	1995	2001	2005	2010
Annual number of deaths	128,824	135,675	140,377	136,402	136,056
	%	%	%	%	%
VE	1.7	2.4	2.6	1.7	2.8
AS	0.2	0.2	0.2	0.1	0.1
Life-terminating acts without explicit request of the patient ⁷⁰	0.8	0.7	0.7	0.4	0.2
Total	2.7	3.3	3.5	2.2	3.1

Belgium

The Belgian Act came into effect in 2002. A Federal Control and Evaluation Commission was established to oversee the operation of the legislation. The Commission has published reports on the instances of euthanasia since the commencement of the legislation. Between September 2002 and the end of 2003, the number of reported cases of euthanasia was 259; for the years 2004 and 2005, the number was 742; and for the years 2006 and 2007, the number was 924.⁷¹

⁶⁷ For information about the authors of these studies and where they are reported, see G Lewy, *Assisted Death in Europe and America, Four Regimes and Their Lessons* (Oxford Scholarship Online, 2011) 29 (accessed 30 July 2012).

⁶⁸ The results of the 2010 survey are reported in BD Onwuteaka-Philipsen et al, ‘Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey’ (2012) *The Lancet* [http://dx.doi.org/10.1016/S0140-6736\(12\)61034-4](http://dx.doi.org/10.1016/S0140-6736(12)61034-4) (accessed 30 July 2012).

⁶⁹ The information in this table, while sourced from these 5 surveys, was drawn primarily from U Schüklenk et al, ‘End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making’ (2011) 25 *S1 Bioethics* 1, 61-2, as well as from BD Onwuteaka-Philipsen et al, ‘Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey’ (2012) *The Lancet* [http://dx.doi.org/10.1016/S0140-6736\(12\)61034-4](http://dx.doi.org/10.1016/S0140-6736(12)61034-4) (accessed 30 July 2012).

⁷⁰ The circumstances in which such acts occur are explained in U Schüklenk et al, ‘End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making’ (2011) 25 *S1 Bioethics* 1, 62 as follows: ‘they typically involve patients who are very close to death and are presently incompetent but where there has been an earlier discussion about the hastening of death with them and/or their relatives, and where opioids were used to end life’ and ‘about one third of these cases can also be described as terminal sedation: cases in which high dosages of sedatives were given without hydrating the patient’.

⁷¹ These statistics were obtained from G Lewy, *Assisted Death in Europe and America, Four Regimes and Their Lessons* (Oxford Scholarship Online, 2011) 77 (accessed 30 July 2012).

The figures in Table 4 below allow comparisons in practice between 1998 (when VE was illegal) and 2007 (when VE was legal).⁷² Of particular interest is the decrease in the percentage of deaths that occurred as a result of action taken by a doctor without the explicit request of the patient.

Table 4: Deaths due to VE and AS as a percentage of total deaths in Belgium

	1998 %	2007 %
VE	1.1	1.9
AS	0.12	0.07
Life-terminating acts without explicit request of the patient	3.2	1.8
Total	4.42	3.77

Switzerland

It will be recalled that law reform has not occurred in Switzerland to permit VE or AS. However, AS that occurs other than for 'selfish motives' is not illegal. As a result of this, assistance to die does not have to be provided by a doctor. Also, there are not any residence requirements, so people are allowed to travel to Switzerland to receive assistance to die.

There are four major right-to-die organisations in Switzerland that have been established to assist individuals to end their lives: 'Exit – German Switzerland (Exit GS)', 'Exit – French Switzerland', 'Dignitas' and 'Exit International'. One research project reviewed the assistance provided by Exit GS with that provided by Dignitas for the period 2001-2004. This review revealed that Exit GS was involved in 147 suicides, and Dignitas in 274.⁷³ Dignitas has reported that it has assisted 15 Australians to die between the years of 2003 and 2011.⁷⁴

Oregon⁷⁵

The Oregon legislation, which survived a number of legal challenges since it was passed in 1994, had its first full year of operation in 1998. In 2008, the Department of Human Services published a summary report which reviewed how the legislation had functioned over the first decade of its operation. During this period, 341 people died after ingesting medication that had been prescribed

⁷² The information in this table was drawn from U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 S1 *Bioethics* 1, 62.

⁷³ S Fischer et al, 'Suicide assisted by two Swiss right-to-die organisations' (2008) 34 *Journal of Medical Bioethics* 810.

⁷⁴ Dignitas, 'Accompaniments to suicide per year and residence', available at: <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2011.pdf> (accessed 17 August 2012).

⁷⁵ The Washington legislation has only been in operation since 2009, and therefore fewer statistics are available on how it is functioning in practice. As Oregon and Washington have the same AS legislative model, and the legislation in Oregon has operated since 1998, only the data from Oregon will be considered in this paper. Suffice it to say that in Washington in 2010, medication was dispensed to 87 individuals, and 51 deaths took place after ingesting the medication: U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 S1 *Bioethics* 1, 63, drawing on official data.

under the *Death with Dignity Act*.⁷⁶ Table 5 below provides statistics of prescription history during this decade.⁷⁷

Table 5: Prescriptions filled and used, and death under Oregon's assisted suicide regime

Year	Prescriptions filled	Deaths	Percentage of prescriptions used
1998	24	16	67
1999	33	27	82
2000	39	27	69
2001	44	21	50
2002	58	38	66
2003	68	42	62
2004	60	37	62
2005	65	38	58
2006	65	46	71
2007	85	49	58
Total = 541		Total = 341	Average used = 65%
			Average not used = 35%

An interesting observation from the above data is that approximately one-third of individuals who obtained a prescription for medication did not use it. The summary report also provided demographic details of those who sought assistance to die under the legislation, and motivations for using the legislation:⁷⁸

- Those who sought medication were more likely to be better educated than those who died of natural causes;
- There was no evidence that women and older people (aged more than 84) were more likely to seek assistance;
- Minority groups (Blacks, Hispanics and Native Americans) were under-represented as those seeking assistance;
- Divorced and never married individuals were more likely to seek assistance;
- Fear of losing control and autonomy were the most frequently cited reasons for seeking assistance; and
- Being a burden on family and friends was also cited as a concern for almost half of the individuals seeking assistance.

8. A framework for considering regulatory options for VE and AS

The foregoing discussions reveal a range of views and considerations that inform decisions about the shape of the law in this area. This section proposes a framework for considering what position the

⁷⁶ In 2010, 97 prescriptions were written for medication, and 65 deaths took place (59 from prescriptions issued in 2010, and 6 from prescriptions written in previous years): U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 *S1 Bioethics* 1, 63, drawing on official data.

⁷⁷ These statistics were obtained from G Lewy, *Assisted Death in Europe and America, Four Regimes and Their Lessons* (Oxford Scholarship Online, 2011) 134 (accessed 30 July 2012).

⁷⁸ The points below were extracted from an analysis of the summary report in G Lewy, *Assisted Death in Europe and America, Four Regimes and Their Lessons* (Oxford Scholarship Online, 2011) 134-6 (accessed 30 July 2012).

law should take on VE and AS. We start by asking whether VE and AS should be criminal acts. If this conduct should continue to be regulated by the criminal law in this way, decisions need to be made about whether the current approach should be retained or whether the criminal law should treat this conduct more strictly or leniently. On the other hand, if VE and AS should be decriminalised, then issues arise as to how this conduct should be regulated. In both instances, appropriate vehicles for achieving any recommended policy outcomes need to be evaluated. This proposed framework for considering regulatory options is represented in diagrammatic form in Appendix C.

8.1 Should VE and/or AS be criminal acts?

A threshold question is whether VE and/or AS should be criminal acts. Commentators have identified a number of functions of criminal law.⁷⁹ Two that have particular significance here are the punishment of an offender to formally and publicly denounce conduct as morally culpable, and the protection of the community from harm through deterrence. These functions inform assessments as to whether VE and AS should attract criminal responsibility, along with consideration of the arguments for and against legalisation outlined above and the available evidence as to current practice in Australia and in the permissive jurisdictions.

The heading to this section deliberately contains a reference to ‘and/or’ because it is possible to favour either VE or AS being a criminal act but not both. Where a distinction is made between these two courses of action, it is generally to permit AS but not VE. Some favour this approach attaching moral significance to who is the final agent of death, namely the person who has died rather than the person assisting. Others disagree pointing to, for example, the discriminatory effect of a distinction that precludes assistance to die from those people with an illness or disability where they cannot do the final act themselves to end their life.

8.2 If VE and/or AS should be criminal acts

Culpability of VE and AS

If VE and/or AS should be criminal acts, then the next issue to consider is how seriously the criminal law should treat this conduct. The law could retain its current approach, or it could punish this conduct more or less than it presently does.

In terms of the current position, as noted above, VE and AS are unlawful in all Australian States and Territories, and police and prosecutors have pursued criminal proceedings where there is evidence to support that course of action.⁸⁰ However, for those who are convicted, the sentences imposed tend to be at the very low end of what is possible for these offences, often not involving a period of

⁷⁹ See, for example, D Lanham et al, *Criminal Laws in Australia* (Federation Press, 2006) in ch 1B ‘The Purposes of Criminal Law’, available at: <http://www.federationpress.com.au/pdf/Lanham%20Ch1B.pdf> (accessed 11 September 2012).

⁸⁰ M Otlowski, ‘Mercy Killing Cases in the Australian Criminal Justice System’ (1993) 17 *Criminal Law Journal* 10; L Bartels and M Otlowski, ‘A right to die? Euthanasia and the law in Australia’ (2010) 17 *Journal of Law and Medicine* 532. Note the case of Daryl Stephens, a urologist in Western Australia, where the Director of Public Prosecutions pursued criminal charges despite a magistrate initially finding there was insufficient evidence to warrant taking the matter to trial: D Weber, ‘Doctor releases book on woman's death’, *PM*, 8 October 2002, available at: <http://www.abc.net.au/pm/stories/s696378.htm> (accessed 19 August 2012).

imprisonment.⁸¹ One available policy choice is to retain this current position. It is important that this is acknowledged as a choice – leaving the status quo unchanged involves a decision not to act.⁸²

Another option is for the criminal law to treat VE and AS as more serious criminal acts than it presently does. Some who are of this view would argue that the law is inadequate in the way it marks this conduct as morally wrong and that it fails to adequately safeguard those who need the protection of the criminal law such as the elderly, people with disabilities and those who are otherwise vulnerable.

A third option is to accept that the criminal law has a role to play in prohibiting VE and AS but that this conduct is not as morally blameworthy as current law and practice state. This might involve acknowledging the symbolic importance of prohibiting this conduct as unlawful but taking a more lenient approach when dealing with people who acted with compassionate motives when assisting with a death or ending another's life. This could be achieved, for example, by not only taking a lenient approach to sentencing as already occurs, but also to the offences that are charged in such cases.

Legal options for change

For those who believe that VE and AS should be criminal acts, there are a number of legal options to either change the criminal law or how it is applied. Key options discussed here are sentencing reform, changes to the relevant offences that apply, and the use of prosecutorial discretion through offence-specific guidelines.

Sentencing reform

The sentences that can be imposed for VE and AS vary depending on the crime of which the person has been convicted and the State or Territory in which he or she lives.⁸³ For example, the sentence for murder in Australia is either a mandatory or maximum (but discretionary) life sentence whereas the maximum sentence for manslaughter varies from a discretionary life sentence to 20 years imprisonment. The maximum sentence for AS varies between life imprisonment to five years across the country. However, these sentences are the maximum available to the court and, as noted above, sentencing discretion in these cases has tended to be very much towards the lower end of the scale.⁸⁴

Some may consider the current approach to sentencing cases of VE and AS to be too lenient. Reform is needed to ensure that judges take adequate account of the gravity of the crime that has been committed, a crime that has led to a person's death. It could be argued that the current trend of non-custodial sentences should be reversed and that some period of imprisonment is necessary in such cases. Conversely, others argue that while it may be appropriate that the criminal law marks that a death has occurred, the imprisonment of a person who has assisted another to die at their request is unjust. These people should not be treated as 'criminals' and alternatives such as the use

⁸¹ L Bartels and M Otlowski, 'A right to die? Euthanasia and the law in Australia' (2010) 17 *Journal of Law and Medicine* 532.

⁸² M Kirby, 'The Fundamental Problem of Regulating Technology', paper presented at Conference on the Ethical Governance of Information & Communications Technology and the Role of Professional Bodies, 1 May 2008, Canberra.

⁸³ L Bartels and M Otlowski, 'A right to die? Euthanasia and the law in Australia' (2010) 17 *Journal of Law and Medicine* 532, 534-5.

⁸⁴ L Bartels and M Otlowski, 'A right to die? Euthanasia and the law in Australia' (2010) 17 *Journal of Law and Medicine* 532.

of diversionary programs from the mainstream criminal justice system represent more appropriate sentencing options.

Sentencing reform could be achieved through legislation, for example reducing the maximum sentence or, alternatively, imposing a mandatory minimum sentence. It could also be achieved through judicial means, for example, an appeal court delivering a judgment indicating the need to treat these offences more seriously (or leniently) than has occurred in the past. Change could also be supported through sentencing advisory councils in those States that have them.

Context-specific offences

Another option for reform is to amend the criminal law to create a specific offence for VE that is less serious than murder and manslaughter; an offence that recognises the particular *context* in which this conduct occurs. An example might be an offence of ‘mercy killing’ which is treated less seriously than murder or manslaughter by the criminal law. Arguments in favour of such an approach are that it recognises that such conduct is a criminal act but acknowledges that prosecution for crimes like murder or manslaughter is disproportionate to the person’s culpability. AS already has its own specific offence but there is also greater scope to recognise that criminal culpability for those assisting suicide may vary depending on the circumstances of the case. This variation could be recognised within the existing offence provision, or through the creation of a new offence that deals with different instances of AS.

A related development in three jurisdictions is to limit the offences available where a death occurs pursuant to a failed suicide pact. In New South Wales, those involved in suicide pacts may not be found guilty of murder and manslaughter but rather only the reduced charge of AS⁸⁵ while in South Australia and Victoria, a murder charge is not open but rather only the crime of manslaughter.⁸⁶

Prosecutorial guidelines

A third legal option for reform is to develop prosecutorial guidelines that deal specifically with when VE and AS will and will not be prosecuted.⁸⁷ Prosecutors in Australia have a discretion not to charge or prosecute a person where they conclude that doing so would not be in the public interest. In England and Wales, the Director of Public Prosecutions has developed a policy specifically dealing with AS and when it will and will not be in the public interest to prosecute such cases.⁸⁸

This reform option continues to recognise the criminality of such conduct but creates a discretion for the criminal law not to be enforced in appropriate cases. This may be a decision to not prosecute at all, or it may be a conditional decision that prosecution will not occur provided the person participates in a diversionary program of some kind. Alternatively, the prosecution may still occur but the discretion is exercised to charge the person with a less serious offence. However, prosecutorial guidelines need not be a ‘reform option’. For example, they have been used in the Australian Capital Territory not to achieve a liberalisation of prosecutorial practice, but rather to clarify the current law governing the end of life and how it will be enforced.⁸⁹

⁸⁵ *Crimes Act 1900* (NSW) ss 31B, 31C.

⁸⁶ *Criminal Law Consolidation Act 1935* (SA) s 13A; *Crimes Act 1958* (Vic) s 6B.

⁸⁷ B White and J Downie, ‘Prosecutorial guidelines for voluntary euthanasia and assisted suicide: Autonomy, public confidence and high quality decision-making’ (2012) *Melbourne University Law Review* (forthcoming).

⁸⁸ Director of Public Prosecutions, *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide* (2010), available at: http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf (accessed 19 August 2012).

⁸⁹ *Director of Public Prosecutions Direction 2006 (No 2)* (ACT) (Notifiable instrument NI2006-356).

A final point to note is that the use of prosecutorial guidelines is potentially quite different from the sentencing and offence reform options considered above. Those reform options are premised on the final result being a criminal conviction whereas the use of prosecutorial guidelines, if the discretion is used to not prosecute, can lead to a person avoiding the criminal justice system. In this way, it is possible for them to operate as de facto decriminalisation.

8.3 If VE and/or AS should not be criminal acts

We turn now to consider the alternative position where VE and AS should *not* be criminal acts but rather be regulated like other potentially lawful activity. This brings with it choices about the scope of conduct that should be permitted and regulated, and the legal reform options available to achieve that.

What conduct should be permitted and regulated?

One significant issue is whether VE, AS or both should be permitted and then regulated. As noted above, it is possible for the law to permit one but not the other. There are also a range of other factors that would need to be considered when designing a regulatory system that permits this conduct.

- **Competence:** Most permissive regimes provide that VE or AS may occur only in relation to a person who is competent to make their own decisions and, as outlined above, this paper deals only with VE and AS in this context.⁹⁰
- **Voluntary and informed choice:** Permissive regimes generally have processes to support decision-making that is voluntary and informed.
- **A person's condition:** An issue is whether a regulatory system should require a person to have a particular type of illness or condition. For example, does a person have to have a terminal illness or be experiencing unacceptable suffering? Some argue against these limitations as representing an infringement of a person's autonomy. Others consider them to be discriminatory, for example, against an individual with disabilities who may not be able to satisfy a terminal illness requirement but who considers his or her life intolerable. On the other hand, these limitations can be seen as an appropriate safeguard to ensure that the system is limited to those who are suffering unbearably.
- **Decision-making process:** Legislative regulatory systems have traditionally established a decision-making framework for accessing VE or AS. For example, there may be requirements as to the number and form (eg in writing) of requests for assistance, timing before assistance can be provided, and assessments by doctors. The role of doctors gives rise to other questions. Do they need to be involved? Are they the decision-makers as to when assistance may appropriately be provided or is their role more limited? Some argue that involvement of doctors can harm the doctor/patient relationship and erode trust and the ethic of care. Others argue that doctors must be involved to ensure access to information about treatment options, the safe and painless bringing about of death, and appropriate assessments of competence.
- **Oversight of decisions:** A final issue is to establish oversight mechanisms that ensure the system is operating properly and in accordance with the regulatory framework. Permissive legislative

⁹⁰ See above in Section 2 Definitions and scope of paper.

regimes establish various oversight mechanisms, but they vary with some focusing on assessing the appropriateness of individual decisions and others on systemic issues. An issue for regimes that focus on scrutiny of individual decision-making is whether any oversight should be prospective or retrospective. Another issue is the nature of any regulator and whether this oversight should be part of the criminal justice system, the coronial system, the political system (such as a parliamentary committee), the health system, or a combination of them.

Legal options for change

There are three main options for legal change where VE and AS are not criminal acts. The first is that the law that prohibits VE and AS is judicially found to be invalid. The second is where a defence in the criminal law is created either by judicial decision or by statute. The third is the more common situation where a legislative framework is established to decriminalise and then regulate VE and AS.

Invalidity of laws prohibiting VE and AS

One option for legal change is to judicially challenge the validity of criminal laws so far as they prohibit VE and AS. This occurred recently in Canada where the Supreme Court of British Columbia declared that provisions of the *Criminal Code* prohibiting this conduct unjustifiably infringed various rights protected by the *Canadian Charter of Rights and Freedoms*.⁹¹ The Court declared that the relevant provisions of the *Code* were invalid but that the declaration would only take effect in a year to give Parliament time to consider how it might alter the law to be consistent with the *Charter*.⁹²

This method of reform is unlikely to succeed in Australia. Only Victoria and the Australian Capital Territory have human rights instruments and Australian human rights jurisprudence generally is much less developed than in other similar jurisdictions such as Canada and the United Kingdom. There is not yet the same track record of effecting legal change in Australia through human rights as there is in some countries overseas. Further, a recent court challenge to this area of law failed in the United Kingdom, where one of the arguments specifically rejected by the court was that the law prohibiting VE and AS was incompatible with the *Human Rights Act 1998* (UK).⁹³

Even if such a challenge was successful in Australia, one of the problems that arises is that there can be uncertainty as to the legal situation that exists after the invalid aspects of the law fall away. Part of this relates to the difficulties of establishing the circumstances in which the law trespasses beyond its reach and those where it may still apply. Lynn Smith J of the British Columbian Supreme Court sought to establish criteria for when the law would be invalid, however, the nature of judge made law often means that this lacks the precision and certainty that can be achieved with legislative reform.⁹⁴ A judicial challenge can, however, act as a trigger for legislative reform to address the human rights concerns identified.

Defence to criminal law prosecution

A second law reform option is to not make VE or AS lawful, but to create a defence that doctors (or others) may rely upon to avoid criminal responsibility. This can occur through judicial decision. This

⁹¹ *Carter v Canada (Attorney-General)* [2012] BCSC 886.

⁹² The Supreme Court decision is currently being appealed by Canada's federal government: 'Appeal Court upholds B.C. woman's exemption from doctor-assisted suicide ban', 10 August 2012, available at: <http://www.canada.com/health/Appeal+Court+upholds+womans+exemption+from+doctorassisted+suicide/7071822/story.html> (accessed 19 August 2012).

⁹³ *Nicklinson, R (on the application of) v Ministry of Justice* [2012] EWHC 2381.

⁹⁴ *Nicklinson, R (on the application of) v Ministry of Justice* [2012] EWHC 2381, [86].

happened in the State of Montana, in the United States, where the law recognises consent as a general defence to a criminal charge, provided doing so is not 'against public policy'. The question before the Supreme Court of Montana was whether a doctor may rely on the consent defence if they provide assistance to die to a terminally ill, competent adult at his or her request. Without this defence, the doctors were potentially liable to be charged with homicide. The Court concluded that allowing doctors to assist patients was not against public policy and that the consent defence would be available to a doctor if the State chose to prosecute him or her.⁹⁵

The prospect of judicial reform of this type in Australia is again limited: the law in Australia in relation to consent is different from Montana and a recent attempt in England to rely on the common law 'defence of necessity' was rejected.⁹⁶ However, a defence governing VE and AS can also be created by statute and this model was adopted by a South Australian Bill: the Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011. Under the Bill, a defence to homicide⁹⁷ is created for a treating doctor to administer drugs where he or she believes on reasonable grounds that the life of an adult of sound mind was intolerable to that person. Such action must be at the request of the person and be regarded as a 'reasonable response to the suffering'. Of note is that the Bill expressly provides that the onus of proof rests on the doctor on the balance of probabilities to demonstrate that he or she falls within the protection provided by the defence. This criminal defence model is also consistent with how AS is regulated in Switzerland with people being allowed to assist another to die, provided they are acting with unselfish motives.⁹⁸

As noted above, this model (whether it is achieved through judicial or legislative reform) does not make VE and AS lawful, but rather creates a defence for such conduct. One of the implications of this is that usually at least some of the onus of demonstrating that criminal responsibility should not be imposed rests on the person who is alleged to have participated in VE or AS. Some would regard this as a disadvantage as the conduct still remains in the criminal law realm. Others would consider this appropriate. The comments made earlier about the potential uncertainty of judge made law would also apply here to a judicially created defence; the enactment of a legislative defence allows for greater precision.⁹⁹

Statutory framework to regulate the practice

A final reform option, and one favoured most by VE and AS advocates, is the creation of a statutory framework to permit and regulate the practice. This is the most common approach taken in the permissive jurisdictions, and the various models in operation are discussed above.¹⁰⁰

This option is the most permissive as it shifts this conduct outside the criminal law realm. Much of the commentary about the advantages and disadvantages of reform has focused explicitly on this model. Such an approach presents the best chance of these three reform options to enhance decision-making in this area as these regimes generally prescribe a clear process of decision-making before VE and AS are lawful which is accompanied by some oversight mechanism.

⁹⁵ *Baxter v Montana* (2009) 354 Mont. 234. Judicial reform also occurred in Colombia: see above note 26.

⁹⁶ *Nicklinson, R (on the application of) v Ministry of Justice* [2012] EWHC 2381.

⁹⁷ The Bill also creates defences for AS and other offences that might conceivably be charged in this context.

⁹⁸ See above in Section 5.2 Switzerland.

⁹⁹ *Nicklinson, R (on the application of) v Ministry of Justice* [2012] EWHC 2381, [86].

¹⁰⁰ See above in Section 5 Legislative schemes that permit voluntary euthanasia and/or assisted suicide.

9. What should happen next?

This paper has drawn together some of the key issues in the vast body of literature dealing with law, practice and opinion relating to VE and AS. It outlined the broader legal landscape at the end of life, the attempts to make these practices lawful in Australia, and the situation in those jurisdictions where VE and/or AS are lawful. It also considered the practices at the end of life in Australia and overseas, the arguments that have been advanced in favour of and against legalisation, and possible reform options. We have attempted to approach this exercise in a balanced way that acknowledges the complexity of these issues and the diversity of views held.

While a paper like this cannot be comprehensive, it provides a departure point for a conversation by interested parties about the future of how VE and AS should be regulated. Part of that conversation will include identifying what further research and information will be needed to properly consider this issue. At various places in this paper, we have suggested where further work is needed to inform consideration of these issues.

We hope that the debate and discussion that follows can put aside some of the sloganism and rhetoric that have sometimes dominated public and political discourse in this area. VE and AS are complex issues that give rise to a range of competing considerations. Rational engagement with law, ethics and practice can be obscured by outlandish claims and emotive language, and this has occurred in the past on both sides of the debate. We are hopeful for a new dawn of engagement on this issue where people of differing views are genuinely interested in understanding the perspectives of others.

Appendix A

Legislative reform attempts in Australia

Jurisdiction	Name of bill	Date introduced	Who introduced	Where introduced
Australian Capital Territory	Medical Treatment (Amendment) Bill 1995	20 September 1995	Michael Moore (Independent)	Legislative Assembly
	Euthanasia Referendum Bill 1997	18 June 1997	Michael Moore (Independent)	Legislative Assembly
New South Wales	Rights of the Terminally Ill Bill 2001	29 November 2001	Ian Cohen (Australian Greens)	Legislative Council
	Voluntary Euthanasia Trial (Referendum) Bill 2002	9 April 2002 (Notice of motion)	Ian Cohen (Australian Greens)	Legislative Council
	Voluntary Euthanasia Trial (Referendum) Bill 2003	17 September 2003	Ian Cohen (Australian Greens)	Legislative Council
	Rights of the Terminally Ill Bill 2003	30 April 2003 (Notice of motion)	Ian Cohen (Australian Greens)	Legislative Council
	Rights of the Terminally Ill Bill 2010	22 September 2010 (Notice of motion)	Cate Faehrmann (Australian Greens)	Legislative Council
	Rights of the Terminally Ill Bill 2010	19 October 2010 (Notice of motion)	Cate Faehrmann (Australian Greens)	Legislative Council
	Rights of the Terminally Ill Bill 2011	2 August 2011 (Notice of motion)	Cate Faehrmann (Australian Greens)	Legislative Council
	Rights of the Terminally Ill Bill 1995 ¹⁰¹	22 February 1995	Marshall Perron (Country Liberal Party)	Legislative Assembly
South Australia	Voluntary Euthanasia Bill 1995	9 March 1995	John Quirke (ALP)	House of Assembly
	Voluntary Euthanasia Bill 1996	6 November 1996	Anne Levy (ALP)	Legislative Council
	Dignity in Dying Bill 2001	14 March 2001	Sandra Kanck (Australian Democrats)	Legislative Council
	Dignity in Dying Bill 2001	15 March 2001	Dr Bob Such (Independent)	House of Assembly
	Dignity in Dying Bill 2003	24 September 2003	Dr Bob Such (Independent)	House of Assembly
	Dignity in Dying Bill 2005	16 February 2005	Dr Bob Such (Independent)	House of Assembly
	Voluntary Euthanasia Bill 2006	14 March 2007	Dr Bob Such (Independent)	House of Assembly
	Voluntary Euthanasia Bill 2007	31 May 2007	Dr Bob Such (Independent)	House of Assembly
	Voluntary Euthanasia Bill 2008	16 October 2008	Dr Bob Such (Independent)	House of Assembly
	Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008	12 November 2008	Mark Parnell (Australian Greens)	Legislative Council
	Voluntary Euthanasia Bill 2010	24 June 2010	Dr Bob Such (Independent)	House of Assembly
	Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010	16 September 2010	Stephanie Key (ALP)	House of Assembly
	Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010	29 September 2010	Mark Parnell (Australian Greens)	Legislative Council
	Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011	10 March 2011	Stephanie Key (ALP)	House of Assembly
	Voluntary Euthanasia Bill 2012	1 March 2012	Dr Bob Such (Independent)	House of Assembly
Tasmania	Dying with Dignity Bill 2009	26 May 2009	Nicholas McKim (Australian Greens)	House of Assembly

¹⁰¹ This bill was ultimately passed and became the *Rights of the Terminally Ill Act 1995* (NT), which was subsequently repealed by Commonwealth legislation (see note 102 below).

Jurisdiction	Name of bill	Date introduced	Who introduced	Where introduced
Victoria	Medical Treatment (Physician Assisted Dying) Bill 2008	28 May 2008	Colleen Hartland (Australian Greens)	Legislative Council
Western Australia	Voluntary Euthanasia Bill 1997	16 October 1997	Norm Kelly (Australian Democrats)	Legislative Council
	Voluntary Euthanasia Bill 1998	20 August 1998	Norm Kelly (Australian Democrats)	Legislative Council
	Voluntary Euthanasia Bill 2000	10 May 2000	Norm Kelly (Australian Democrats)	Legislative Council
	Voluntary Euthanasia Bill 2000	19 October 2000	Norm Kelly (Australian Democrats)	Legislative Council
	Voluntary Euthanasia Bill 2002	18 September 2002	Robin Chapple (Australian Greens)	Legislative Council
	Voluntary Euthanasia Bill 2010	20 May 2010	Robin Chapple (Australian Greens)	Legislative Council
Commonwealth	Euthanasia Laws Bill 1996 ¹⁰²	9 September 1996	Kevin Andrews (Liberal Party)	House of Representatives
	Euthanasia Laws (Repeal) Bill 2004	3 March 2004	Lyn Allison (Australian Democrats)	Senate
	Australian Territories Rights of the Terminally Ill Bill 2007	8 February 2007	Bob Brown (Australian Greens)	Senate
	Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008	14 February 2008	Bob Brown (Australian Greens)	Senate
	Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2008	17 September 2008	Bob Brown (Australian Greens)	Senate
	Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010	29 September 2010	Bob Brown (Australian Greens)	Senate

¹⁰² Note that this Bill was passed and overruled the *Rights of the Terminally Ill Act 1995* (NT). There were subsequently a number of attempts made by Senators to overturn the effect of the Commonwealth Act (and these are listed above).

Appendix B

Legislation in permissive jurisdictions

	Northern Territory	Netherlands	Belgium	Luxembourg	Oregon	Washington
Overview of the regulation						
Name of legislation	<i>Rights of the Terminally Ill Act 1995</i>	<i>Termination of Life on Request and Assisted Suicide Act 2000</i>	<i>Act on Euthanasia 2002</i>	<i>Law of 16 March 2009 on Euthanasia and Assisted Suicide</i>	<i>Death with Dignity Act 1994</i>	<i>Washington Death with Dignity Act</i>
Year commenced operation	1996	2002	2002	2009	1997	2009
Nature of activity that is regulated	VE and AS	VE and AS	VE ¹⁰³	VE and AS	AS	AS
Eligibility requirements						
Must be an adult?	Yes	No Legislation extends to: (a) Minor between 16 and 18 who has a reasonable understanding of own interests (where parents or guardians involved in decision-making process) (b) Minor between 12 and 16 who has a reasonable understanding of own interests (where parents or guardians agree)	No Legislation extends to emancipated minors	Yes	Yes	Yes

¹⁰³ Although the Belgian legislation does not expressly permit AS, the prevailing view is that it is covered by the regime: see above note 30.

	Northern Territory	Netherlands	Belgium	Luxembourg	Oregon	Washington
Must be competent at time death occurs?	Yes	No Legislation is not limited to competent individuals. It is also available for a person (16 years and older) who previously made a written request for termination of life	No Legislation is not limited to competent individuals. An advance directive requesting euthanasia that was made when a person was competent can also be acted upon	No Legislation is not limited to competent individuals. A person can also make 'end-of-life provisions in writing' when competent to request euthanasia be performed if he or she becomes unconscious, has a 'severe and incurable accidental or pathological disorder' and the situation is irreversible	Yes	Yes
Must person have a terminal illness?	Yes	No	No	Yes	Yes	Yes
Is pain and/or suffering required?	Yes Illness is causing 'severe pain or suffering'	Yes Suffering must be 'lasting and unbearable'	Yes Patient must be in a 'medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated'	Yes Patient must show 'constant and unbearable physical or mental suffering without prospects of improvement'	No	No
Must person be a resident in the jurisdiction?	No	No ¹⁰⁴	No However, doctor must be satisfied of the 'durable' nature of the patient's request. To this end, the doctor must have 'several conversations with the patient spread out over a reasonable period of time'.	No However, the doctor must have treated the patient for some time to ensure the 'persistence' of the patient's suffering, and to hold 'several interviews with the patient, at reasonable intervals'.	Yes	Yes

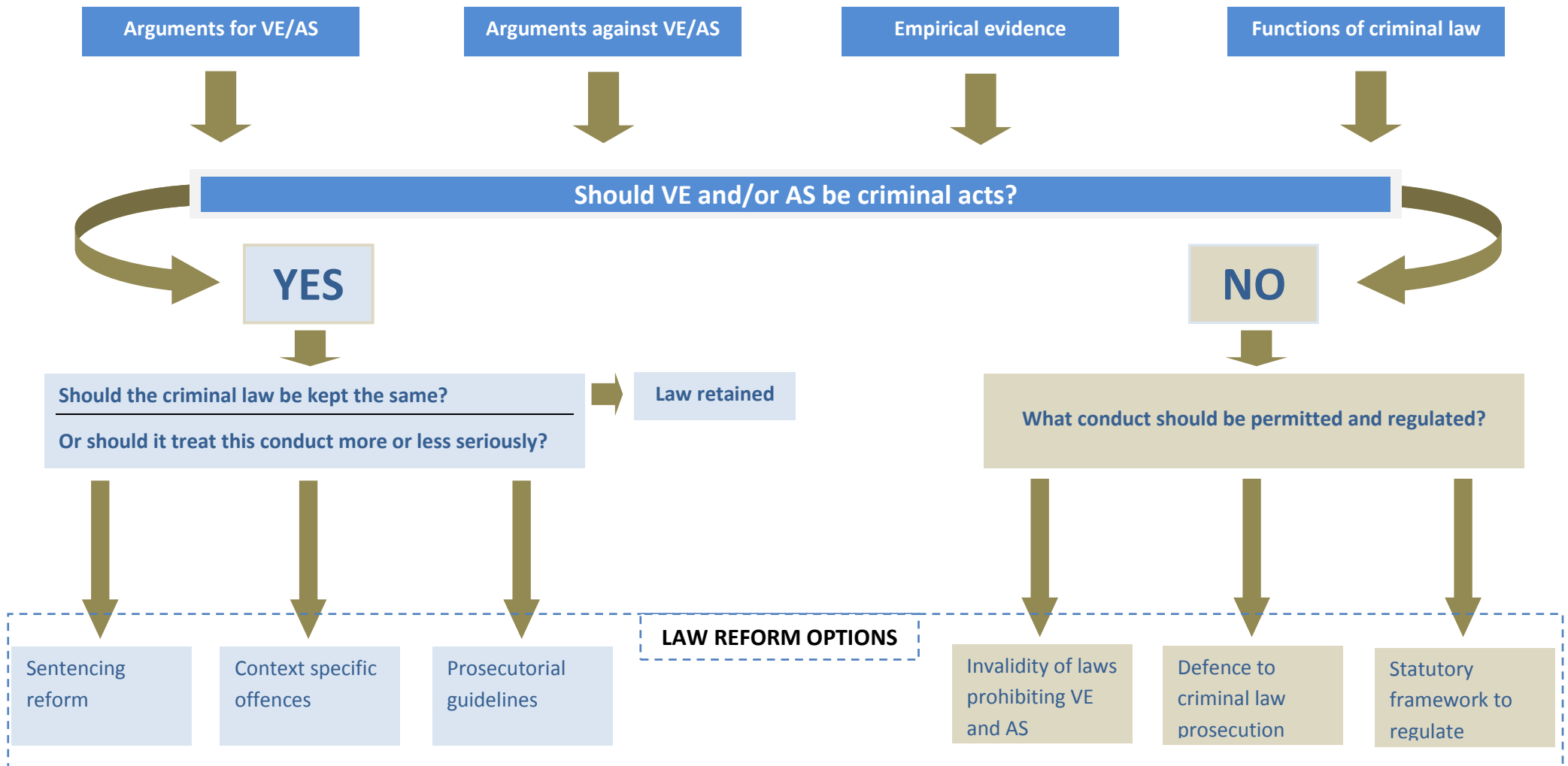
¹⁰⁴ Compare the Netherlands Ministry for Foreign Affairs which has stated that it would be 'impossible' for a non-resident to receive VE or AS on the basis that a close doctor-patient relationship is needed for the requirements of the legislation to be met: Netherlands Ministry of Foreign Affairs, *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice, FAQ Euthanasia*, 2010. It is not clear, however, on the face of the legislation as to why a person must be a resident for this to be so.

	Northern Territory	Netherlands	Belgium	Luxembourg	Oregon	Washington
Safeguards						
Involvement of health professionals	2 doctors and a psychiatrist	2 doctors	2 doctors (unless not expected to die in near future and, if so, 3 doctors)	2 doctors	2 doctors	2 doctors
Legitimacy of request	2 doctors must be satisfied that request made 'freely, voluntarily and after due consideration'	2 doctors must be satisfied that the 'request ... was voluntary and well-considered'	Doctor to be satisfied that the 'request is voluntary, well-considered and repeated, and is not the result of any external pressure'	Doctor to be satisfied that the 'request is made voluntarily, after reflection and, if necessary, repeated, and does not result from external pressure'	2 doctors satisfied that request is made voluntarily	2 doctors satisfied that request is made voluntarily
Patient must be professionally informed	Patient informed of the nature and likely course of illness and medical treatment and other support (including counselling and psychiatric support) available	Patient informed of the 'situation he was in and about his prospects'	Patient informed about health condition, life expectancy, the possible palliative and therapeutic courses of action and their consequences	Patient informed about state of health and life expectancy, therapeutic and palliative possibilities and their consequences	Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control)	Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control)
Cooling off period	Yes At least 7 days between advising doctor of decision and signing of certificate; and 2 days from signing the certificate.	[Legislation is silent]	Doctor must be certain of the 'durable' nature of request. Doctor must have had 'several conversations with the patient spread out over a reasonable period of time' (and if patient is not expected to die in near future, there must be at least one month between the written request and the act of euthanasia)	Doctor to 'hold several interviews with the patient, at reasonable intervals having regard to the evolution of the patient's condition'	Yes No less than 15 days between patient's initial oral request and writing prescription for medication; no less than 48 hours between the written request and writing a prescription for medication.	Yes No less than 15 days between patient's initial oral request and writing prescription for medication; no less than 48 hours between the written request and writing a prescription for medication.

	Northern Territory	Netherlands	Belgium	Luxembourg	Oregon	Washington
Relevance of depression	Patient is 'not suffering from treatable clinical depression in respect of the illness'	Legislation is silent regarding a patient who suffers from depression. However, the request must be 'well-considered'. If depression affects the patient's judgment, this may have an impact on whether the doctor can regard the request as 'well-considered'.	Legislation is silent regarding a patient who suffers from depression. However, the patient must be 'competent' to make a request. If depression affects the patient's judgment, he or she may not be regarded as 'competent'.	Legislation is silent regarding a patient who suffers from depression. However, patient must be 'capable' to make a request. If depression affects the patient's judgment, he or she may not be regarded as 'capable'.	Doctor to refer the patient for counselling if patient may be suffering from psychiatric or psychological disorder or depression causing impaired judgment and, if does, medication cannot be prescribed until counsellor determines patient is not suffering in a way that impairs judgment	Doctor to refer the patient for counselling if patient may be suffering from psychiatric or psychological disorder or depression causing impaired judgment and, if does, medication cannot be prescribed until counsellor determines patient is not suffering in a way that impairs judgment
Oversight of the legislation						
Reporting and strategic review	Doctor to notify coroner; Coroner advises the Attorney-General annually of number of deaths	Doctor to notify municipal pathologist of action; Regional Review Committees have overall responsibility for reviewing notifications	Doctor completes a form for every death and registers it with the Federal Control and Evaluation Commission, and form reviewed by Commission to ensure compliance	Doctor to submit documentation for every death to National Commission for Control and Assessment, and documentation reviewed to ensure compliance	Health care provider who dispenses medication to file a copy of dispensing record with the Department of Human Services; Department to review a sample of records annually; Department also to produce publicly available annual statistical report	Health care provider who writes a prescription or dispenses medication to file documentation with Department of Health; Department to review all records annually; Department also to produce publicly available annual statistical report

Appendix C

A framework for considering regulatory options for VE and AS





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