Submission Cover Sheet

End of Life Choices in the ACT

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23 March 2018  

Dear Mr Snedden  

Submission to the Inquiry into End of Life Choices in the ACT  

Executive summary  

In this submission, we identify the below end-of-life issues which the Committee may wish to consider during the Inquiry. (Where appropriate, we also make recommendations based on our research in the field.)  

1. The law should permit a narrowly defined cohort of individuals to request assistance to die, within the constraints of a legislative regime that protects the rights and interests of the vulnerable in our community.  

2. Although we prefer the enactment of legislation in which providing assistance to die is lawful in some circumstances, an alternative option is to develop prosecutorial guidelines that indicate how discretion to prosecute or not prosecute is likely to be exercised when individuals provide assistance to others to die.  

3. The nature of the emerging practice of ‘terminal’ or ‘palliative’ sedation, and the legal and ethical implications of that practice should be considered.  

4. The practice of voluntary stopping of eating and drinking, and the extent to which palliative care provided to an individual who has stopped eating and drinking is lawful should be considered.
Background

We are the Directors and (former) Centre Coordinator of the Australian Centre for Health Law Research (ACHLR), a specialist research centre within the Queensland University of Technology’s Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

Our research has examined the issues relating to death, dying and decision-making at the end of life in all Australian jurisdictions. Three of our current and past Australian Research Council funded research projects examine legal, regulatory and ethical issues relating to end of life law and practice, particularly in Victoria, New South Wales and Queensland. Since 2010 we have contributed to the end of life, assisted dying and guardianship law reforms in each of those States, including providing submissions and appearing before Parliamentary Committees and law reform bodies. We have also made a submission to the Joint Select Committee on End of Life Choices in Western Australia, and recently gave evidence before the Committee.

We provide this submission to outline some key areas for legal reform at end of life in the ACT, which we have identified from our research, and involvement in end of life law reform in other Australian jurisdictions. Please note this submission represents the personal views of the authors, and does not necessarily represent the views of other members of ACHLR or any other organisation with which any of the authors are affiliated. For this reason, we request that any mention of this submission refers to the named authors and not ACHLR as an entity.

Assisted dying

Assisted dying (commonly referred to as voluntary euthanasia and assisted suicide) is unlawful in the ACT and in all other Australian States and Territories. Recently, the Voluntary Assisted Dying Act 2017 was enacted in Victoria and that is due to commence operation in 2019. The issue of assisted dying is complex and gives rise to a range of competing considerations for regulation and legal reform.

Two of the authors of this submission have worked extensively in the field of assisted dying for more than 15 years. On the basis of the research that we have undertaken, we have concluded that it is possible to create a legislative framework that permits assisted dying and also protects the rights and interests of the vulnerable in our community.

We attach to this submission some of our more recent work in the field which we hope the Committee may find of assistance.


The book chapter outlines a proposed model for assisted dying that reflects and promotes the core values we consider should underpin the law in this area: life, autonomy, freedom of conscience, equality, the rule of law, protecting the vulnerable, and reducing human suffering. We favour a

1 For a discussion of these core values, see in particular pp. 488–99 (pp. 13–25 of attached electronic copy of chapter).
permissive decriminalisation model, which would allow a person to assist another to end their life, but regulates the circumstances in which this will be lawful by setting out eligibility and procedural requirements as well as other safeguards.\(^2\) This model treats assisted dying as a lawful activity (as opposed to a defence model, which regards this assistance as criminal conduct) thereby removing the stigma of the criminal law, and providing greater comfort to health professionals.\(^3\) The key features of our preferred model are discussed in detail in the book chapter.


This article charts the history of law reform attempts in this field which may provide some useful background context for the Committee’s deliberations. It analyses legislative reform attempts up to 31 December 2015.

3. Ben White, Andrew McGee and Lindy Willmott, ‘As Victorian MPs debate assisted dying, it is vital they examine the evidence, not just the rhetoric’, The Conversation, published online 20 September 2017.

This publication commented on the need for politicians (and the public) to focus on facts, not rhetoric, when they debate the Victorian assisted dying legislation. We focus on the need to identify whether opinion is based upon values (for example, the importance of autonomy or the sanctity of life) as opposed to facts (for example, as gleaned from the experience of assisted dying in other jurisdictions). Difference of opinion based on individuals having different values is understandable in a complex issue such as this. However, if an opinion purports to be influenced by facts, it is critical that these facts are accurate and informed by empirical evidence.


We also examined the speeches of the 15 Members of the Legislative Council who gave speeches opposing the assisted dying legislation,\(^4\) and identified four predominant themes: the inadequacy of the safeguards in the Bill to protect the vulnerable; the dangers of the slippery slope of legalising assisted dying; the need to first improve palliative services; and that assisted dying contravenes a doctor’s duty to treat. We considered each of these themes and concluded that the arguments were misleading and required greater scrutiny.

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\(^2\) This model has been adopted in most other jurisdictions where assisted dying is lawful, including the Netherlands, Belgium, Luxembourg, some jurisdictions in the United States (Oregon, Washington, Vermont, California, Colorado and the District of Columbia), Canada federally (amendments to their Criminal Code) as well as Quebec (under its separate legislation), and previously in the Northern Territory.

\(^3\) Willmott and White, above n1, 500 (p. 17 of attached electronic version of chapter).

\(^4\) 18 members voted no, but only 15 gave speeches when the Bill was being debated.

This article sets out the key arguments in favour of and against legalising voluntary euthanasia and assisted suicide, and a proposed framework for considering possible regulatory options.


This Report contains recommendations for reform of the law to legalise assisted dying. The Report was prepared following a roundtable of key stakeholders that was conducted at the Queensland University of Technology in 2013.


Though we consider the introduction of a legislative system that permits regulated assisted dying preferable, an alternative option for legal reform in this area is to develop prosecutorial guidelines that deal specifically with when voluntary euthanasia and assisted suicide will and will not be prosecuted. In Australia, prosecutors have a discretion not to charge or prosecute a person where to do so would not be in the public interest. In England and Wales, the Director of Public Prosecutions has a policy on assisted suicide which specifies when it will and will not be in the public interest to prosecute such cases.\(^5\) This reform option would continue to recognise the criminality of such conduct but create a discretion for the criminal law not to be enforced in appropriate cases.

**Terminal sedation**

‘Terminal’ or ‘palliative’ sedation is a practice used in Australia about which relatively little is known. The practice is defined by the European Association for Palliative Care as ‘the use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers’.\(^6\) It is understood to be used for the management of refractory symptoms (symptoms that cannot be otherwise adequately controlled) at the end of life. The primary purpose of palliative sedation is to sedate a patient near the end of their life in order to relieve their symptoms, not to cause or hasten their death.

In Australia, little is known about the extent to which this practice occurs at the end of life, and there has been little exploration about the legal and ethical implications of the practice. Issues that are relevant to the legality and ethical acceptability of the practice include:


• Whether the patient (or patient’s family) are involved in the decision-making process, particularly whether consent is obtained before this kind of sedation is provided;
• In what circumstances does it occur? For example, is it given to relieve physical symptoms only, or also to relieve psychological or existential suffering; and
• Whether artificial nutrition and hydration is provided or withdrawn during the period of sedation leading up to the patient’s death. The (questionable) legal and ethical implications of the practice were explored by Professor Sheila McLean in the article ‘Terminal Sedation – Good Medicine? Good Ethics? Good Law?’ (2016) 16 QUT Law Review 113.7

Voluntary palliated starvation

We also draw the Committee’s attention to the emerging practice of voluntary palliated starvation as an option for patients wishing to end their lives. We would argue that this practice is occurring more frequently given the lack of options that patients have as they approach the end of their lives. If the law allowing assistance in dying is introduced, there may be less need for individuals to resort to this practice. In the absence of assisted dying legislation, however, the law in the ACT should allow for this practice to occur, and protect medical professionals who provide palliative care to an individual who is dying as a result of his or her decision to refrain from eating and drinking. Further discussion of these issues is contained in the article Ben White, Lindy Willmott and Julian Savulescu, ‘Voluntary palliated starvation: A lawful and ethical way to die’ (2014) 22 Journal of Law and Medicine 276-386 which we also attach to this submission.

Palliative care and the doctrine of double effect

The common law doctrine of double effect operates in Australia to protect medical professionals from criminal or civil responsibility where a patient’s death is unintentionally hastened by the administration of palliative care for pain relief.8 The ACT has a reference to pain relief in two provisions: s 17 of the Medical Treatment (Health Directions) Act 2006 (ACT) and s 86 of the Powers of Attorney Act 2006 (ACT). These provisions are unusual in two respects. First, they are narrow in scope: they apply only where a person is under the care of a health professional and either has given a health direction that medical treatment be withdrawn or withheld or has an attorney who has made such a decision.9 The common law would continue to operate in all other situations. Secondly, where these provisions do apply, they are expressed in terms of granting a patient a ‘right to receive relief from pain and suffering to the maximum extent that it is reasonable in the circumstances’.10 It is difficult to determine the legal effect of these provisions so far as the issue of excusing criminal responsibility is concerned.

It could be argued that they create a modified statutory version of the doctrine of double effect for those limited situations where the provisions apply. However, it is suggested that interpretations more likely to be adopted by the courts are that either the provisions enact the common law in statute, or

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7 This article is available at https://lr.law.qut.edu.au/article/view/624.
8 We note the case of Re Baby D (No 2) (2011) 45 Fam LR 313, which provides some implicit support for the doctrine in Australian common law.
9 Medical Treatment (Health Directions) Act 2006 (ACT) s 17(1); Powers of Attorney Act 2006 (ACT) s 86(1).
10 Medical Treatment (Health Directions) Act 2006 (ACT) s 17(2); Powers of Attorney Act 2006 (ACT) s 86(2). In providing this relief, the health professional must adequately consider the patient’s account of their pain and suffering: Medical Treatment (Health Directions) Act 2006 (ACT) s 17(3); Powers of Attorney Act 2006 (ACT) s 86(3).
that the provisions are insufficient to create a criminal law excuse so the common law remains undisturbed. Therefore, it would be desirable to clarify the position through legislative amendment.

**Medical professionals’ knowledge of the law on end of life**

Over the past decade, two of the authors have undertaken empirical research in decision-making at the end of life. An important component of this research focused on the knowledge of doctors who practise medicine at the end of life. Information about this project (including relevant publications arising from this research) is available here: [https://research.qut.edu.au/achlr/projects/withholding-and-withdrawing-life-sustaining-medical-treatment-from-adults-who-lack-capacity-the-role-of-law-in-medical-practice/](https://research.qut.edu.au/achlr/projects/withholding-and-withdrawing-life-sustaining-medical-treatment-from-adults-who-lack-capacity-the-role-of-law-in-medical-practice/)

The findings of our research indicate that doctors have poor knowledge of the law, at least in relation to the withholding and withdrawing of treatment at the end of life from adults who lack decision-making capacity. We draw this body of research to the attention of the Committee as we believe this is a relevant factor that needs to be considered when drafting and implementing laws at the end of life. A relevant publication which sets out the key findings in relation to doctors’ knowledge of this area of law is also attached: Ben White, Lindy Willmott, Colleen Cartwright, et al, ‘Doctors’ knowledge of the law on withholding and withdrawing life-sustaining medical treatment’ (2014) 201(4) *Medical Journal of Australia* 229-232.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Committee further if additional information is required.

Yours sincerely

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Chapter 27

Assisted dying in Australia: A values-based model for reform*

Lindy Willmott and Ben White

Introduction

Assisted dying demonstrates starkly the tensions and traumas of health law as Australia, like jurisdictions around the world, wrestles with proposed changes to make voluntary euthanasia and/or assisted suicide lawful. Tensions are evident in the entrenched and opposing policy positions of individuals and organisations about whether reform should occur. And even those advocating for a change in the law will disagree about what should and should not be permitted and how a permissive regime should be regulated. These different positions are often driven by different ideological perspectives and are embedded in deeply held personal values and beliefs.

Assisted dying debates raise issues of trauma too. In our sophisticated health system which boasts a very high standard of palliative care,1 death is generally well-managed with the patient’s pain and symptoms being adequately controlled. Yet, this is not always possible. There is trauma for a small cohort of people whose suffering (whether physical, psychological, or existential) cannot be satisfactorily alleviated and who seek assistance to die. This trauma can extend to their loved ones and their treating teams.

The debate over whether we should reform our law on euthanasia and assisted suicide has been particularly prominent in Australia over recent years. We have seen bills drafted in all but one Australian state,2 parliamentary committee inquiries,3 police investigations, action by medical

*The authors thank our colleagues, Professor Jocelyn Downie and Professor Ian Freckelton QC, for their valuable contributions and comments on an earlier draft. Their insightful comments sharpened our thinking and improved the quality of this chapter. Of course, the views expressed in this chapter are of the authors alone and not necessarily shared by others. We also thank Juliet Davis and Penny Neller for their research assistance.


regulators\textsuperscript{4}, and a media-fuelled public debate. There has also been considerable movement towards liberalising euthanasia and assisted suicide internationally. We will expand on both Australian and international developments shortly.

The goal of this chapter is not to rehearse all of the arguments for and against reform. Instead, we advance a values-based model for assisted dying. These values – life, autonomy, freedom of conscience, equality, the rule of law, protecting the vulnerable, and reducing human suffering – are based on existing Australian legal principle, for example as reflected in common law, legislation or conventions or treaties that have been ratified by Australia. Drawing on these values, we conclude that the current criminal law prohibition on assisted dying cannot be justified and instead propose a model that permits and regulates assisted dying in certain circumstances. Our model is guided by the values identified but also draws on arguments based on reason and practice (consistent with the values), including the experience of assisted dying in other jurisdictions.

We acknowledge at this point two limitations of this chapter. First, there is not space here to articulate comprehensively and defend the values we propose. Nor is there scope to outline in detail the model that follows. That more detailed project will have to wait. Our purpose here is to put forward these values and this model for discussion and critique, and we do so with an awareness that a more robust case (including discussion of a wider body of literature) is not possible here.

The second limitation is that there are three important issues that have not been considered in developing our model and therefore fall outside the scope of this chapter. They are outside scope for two reasons. First, they are complex issues that require more detailed consideration than is possible in this chapter. The second reason is that they are not currently part of the mainstream Australian assisted dying debate, and so it is justifiable and appropriate to leave them to another time. We do not address the issue of assisted dying through advance directives. This issue requires a conceptual analysis (e.g., whether a present competent self should have the authority to bind a future incompetent person) as well as answers to implementation questions (e.g., rules about revocation, relationship to current advance care planning systems). We also do not address the issue of assisted dying requested by substitute decision-makers as this involves a different formulation of autonomy than that used in this chapter, and shifts the

\textsuperscript{4} See eg Nitschke \textit{v} Medical Board of Australia [2015] NTSC 39; Syme \textit{v} Medical Board of Australia [2016] VCAT 2150.
discussion of the balancing of the competing values in a way that also exceeds the space constraints of this chapter. Finally, we do not consider the position of Gillick-competent minors as Australian court authority recognising limits on the power of this cohort to refuse life-sustaining treatment would require detailed analysis which is not possible here.\(^5\)

A final point about terminology. We define ‘euthanasia’ in the following way:

For the purpose of relieving suffering, a person performs a lethal action\(^6\) with the intention of ending the life of another person.\(^7\)

And ‘voluntary euthanasia’ as where:

Euthanasia is performed at the request of the person whose life is ended, and that person is competent.\(^8\)

‘Assisted suicide’ is defined as following:

A competent person dies after being provided by another with the means or knowledge to kill him or herself.\(^9\)

‘Physician-assisted suicide’ is ‘where a doctor acts as the assistant’.\(^10\)

For the purpose of this chapter, unless we indicate to the contrary, we will use the term ‘assisted dying’ to refer to both ‘voluntary euthanasia’ and ‘physician-assisted suicide’ as defined above.

**A short history of Australian assisted dying reform**

The Northern Territory was the first jurisdiction in the world to legalise voluntary euthanasia with the enactment of the *Rights of the Terminally Ill Act 1995 (NT) (ROTTIA)*.\(^11\) Although ground-breaking reform, the Act was short-lived, and the Commonwealth overturned it a short

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\(^5\) See, eg, *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294 (an application from the New South Wales Court of Appeal for special leave to the High Court was dismissed as moot after the child in question turned 18 years of age: *X v The Sydney Children's Hospitals Network* [2014] HCASL 97); *Royal Alexandra Hospital for Children Trading as Children's Hospital at Westmead v J* (2005) 33 Fam LR 448; *Minister for Health v AS* (2004) 33 Fam LR 223. See further Freckleton & McGregor, Chapter 12.

\(^6\) Note that the authors do not include within this definition positive steps taken by a person to stop treatment which action results in death (such as removing a breathing tube).

\(^7\) Willmott et al, ‘(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics’, above n 2, 6.

\(^8\) Ibid.

\(^9\) Ibid 7.

\(^10\) Ibid.

\(^11\) For background regarding the passage of the bill and its repeal, see ibid 8-9.
time later by enacting the *Euthanasia Laws Act 1997* (Cth). Since the enactment (and repeal) of *ROTTIA*, there have been dozens of attempts at the State, Territory and Commonwealth level to: legalise euthanasia (the majority of bills), to overturn the Commonwealth *Euthanasia Laws Act 1997* (Cth) to enable territories to legislate on the topic, and to hold a referendum on law reform.\(^\text{12}\) Bills have been introduced in all Australian jurisdictions except Queensland.\(^\text{13}\) In the past, the majority of the proponents of reform have been independent members of parliament, or members of the Australian Greens or the Australian Democrats.\(^\text{14}\) More recently, private members’ bills have been proposed by Labor Party and Liberal Party politicians as well.\(^\text{15}\) Conscience votes have always been allowed when the bills have been considered in parliament.

Despite the large number of bills introduced, they have rarely reached the Committee or third reading stage. As such, there has been only limited detailed analysis of proposed legislation by our parliamentarians. More bills have lapsed rather than been defeated.\(^\text{16}\)

A recent analysis of the bills that have been proposed revealed common features:\(^\text{17}\)

- Most allow both euthanasia and physician-assisted suicide (including the *ROTTIA*).
- The overwhelming majority of the bills (including the *ROTTIA*) propose permissive models, that is, providing a legislative framework containing eligibility requirements and integrating safeguards which *allow* euthanasia in the described circumstances. (Other models provide defences while continuing to retain the offence of killing, and still other models provide for mitigation of penalties if killing occurs in certain circumstances.)

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\(^\text{12}\) Willmott et al., ‘(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics’, above n 2, 11.


\(^\text{17}\) Ibid 39-41.
• All permissive models (including the ROTTIA) provide that assistance to die would only be available to an adult who is enduring intolerable suffering and/or has a terminal illness. The person needs to be competent and the request voluntary. (Under some models, a person could receive assistance to die if they no longer had capacity, but the request was made when he or she did have capacity.)

• Generally, the person could determine for themselves whether the suffering was of a level acceptable to them, and most bills adopt a broad interpretation of the categories of suffering (often including physical, psychological, and existential).

• Most bills (including the ROTTIA) contain safeguards including requirements that the person obtain information from a range of specialists and specify a cooling off period.

• Most bills (including the ROTTIA) contain oversight mechanisms, commonly reporting to the Coroner.

So despite many attempts to reform the law, assisted dying remains unlawful in Australia. This has not, however, prevented people from assisting others to end their lives. From time to time, doctors have admitted to providing such assistance to patients who are approaching the end of their lives and are experiencing unbearable suffering. For the most part, such admissions by doctors have not resulted in police investigation or prosecution.\(^\text{18}\) Also at risk are individuals who respond to requests from a terminally ill family member or friend who seeks their assistance to die. There are reasonably regular prosecutions in such cases\(^\text{19}\) although judges frequently hand down sentences less than the maximum permitted, and often do not impose a custodial sentence on the accused in these cases.\(^\text{20}\)

Pressure to change the law continues to build. Media interest in reform has been unparalleled, perhaps fuelled by the campaign for reform spearheaded by Andrew Denton, the high profile entertainer. Media attention is also sparked, and public debate ensues, when health professionals are investigated for assisting one of their terminally ill patients to die (as is reportedly the case for Dr Alida Lancee in Western Australia)\(^\text{21}\) or conditions are imposed on

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\(^\text{18}\) See, eg, admissions by Dr Rodney Syme about providing assistance to die: Norman Hermant, ‘Euthanasia debate: Doctor confirms he helped patients die, wants to be charged’, \textit{ABC News} (online), 8 May 2014 <http://www.abc.net.au/news/2014-05-07/doctor-confirms-he-helped-patient-die/5437686>. Despite that report, Dr Syme was not arrested or prosecuted for a criminal offence.


\(^\text{20}\) Ibid.

their ability to practise medicine (as in the case of Dr Rodney Syme in Victoria). We have also seen a great deal of political activity by members of parliament federally and in all Australian States. For example, at the Commonwealth level, the Australian Greens plan to table a bill during the current term of parliament, and at State level, there are bills that have been introduced or which are being drafted in New South Wales, Western Australia and Tasmania. In South Australia, the State where there have been more reform attempts than in any other Australian jurisdiction, the *Death with Dignity Bill* was defeated in November 2016 by just one vote. Even in Queensland, where an assisted dying bill has never been introduced, Peter Wellington (an independent member of parliament) has recently called for a parliamentary inquiry into end-of-life decision-making with a goal of providing individuals with more choice.

But it is currently in Victoria where reform appears most likely. At the time this book goes to print, an expert panel appointed by the Premier, the Honourable Daniel Andrews, is tasked to draft an assisted dying bill with a view to it being tabled in Victorian parliament in the second half of 2017. The establishment of an expert panel follows a recommendation by the

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22 In 2016, the Medical Board of Australia imposed a condition on the registration of Victorian doctor, Dr Rodney Syme, following a mandatory notification from a general practitioner that Dr Syme was to assist a terminally ill patient to end his life: Julia Medew, ‘Medical Board of Australia investigates euthanasia doctor Rodney Syme’, *The Age* (online), 7 March 2016 <http://www.theage.com.au/victoria/medical-board-of-australia-investigates-euthanasia-doctor-rodney-syme-20160307-gnca3j.html>. The condition prevented him from engaging in ‘… the provision of any form of medical care, or any professional conduct in his capacity as a medical practitioner that has the primary purpose of ending a person’s life’. On appeal, the Victorian Civil and Administrative Tribunal set aside the condition, ‘on the basis the Tribunal is not able … to form a reasonable belief that Dr Syme’s conduct places persons at serious risk or that it is necessary to take immediate action to protect public safety’: *Syme v Medical Board of Australia* [2016] VCAT 2150 at [185].


27 23 votes were in favour and 24 votes opposed the Bill.


Victorian Parliament Legislative Council Legal and Social Issues Committee to legalise assisted dying in Victoria.\(^\text{30}\) Interestingly, the legal framework recommended by the Committee has many similar features to those of the repealed \textit{ROTTIA} (and indeed many of the bills subsequently introduced in Australian States) including that assistance would only be available to an adult who is competent at the time of the request, the request must be repeated, voluntary, and not as a result of undue influence and the adult must be at the end of their life (NT – ‘terminally ill’; Vic – ‘end of life’)\(^\text{31}\) and informed about their illness or disease as well as palliative care options. Under both regimes, eligibility must be assessed by more than one doctor, and safeguards are imposed in relation the assessment of capacity (NT – psychiatrist required in all cases; Vic – psychiatrist required if there are doubts about capacity). A key difference, however, is that the \textit{ROTTIA} permitted both voluntary euthanasia and assisted suicide whereas the Victorian Committee has recommended a primarily physician assisted suicide model.

After initially leading the world, Australia has not had an assisted dying law for over twenty years, despite repeated efforts to change the law. But recent indications suggest this may soon change with momentum for reform building, particularly in Victoria. If the law does change in one Australian jurisdiction to allow assisted dying, other States and Territories are likely to follow. This follows a trend of liberalisation internationally, to which we now turn.

**A brief snapshot of international assisted dying regimes**

This section provides a brief overview of the international jurisdictions that permit assisted dying. The focus is on the three main areas in the world that have legislated to permit assisted dying – Europe, the United States and Canada.

**Europe.**

There are four jurisdictions in Europe where assisted dying is lawful: the Netherlands, Belgium, Luxembourg and Switzerland. The focus of the below discussion is the Netherlands and

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\(^\text{31}\) Note, however, that under the proposed Victorian model, the relevant condition is described as ‘serious and incurable’ rather than ‘terminal illness’ as under the Northern Territory legislation.
Belgium as they have been in operation longest (and the Luxembourg regime is similar to Belgium). There is also a brief discussion of the Swiss approach.

The Netherlands

Both voluntary euthanasia and physician-assisted suicide are permitted in the Netherlands. Under the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*[^32] doctors are protected from criminal charges provided that they adhere to the stipulated requirements for assisting patients to die. When a voluntary and well-considered request is made by a patient for assistance to bring about their death, a doctor concludes that their suffering is lasting and unbearable, and the patient holds the conviction that there is no other reasonable solution to their situation, a doctor is legally permitted to provide them with assistance to bring about their death (Art 2). It is obligatory for the doctor to have informed the patient about their situation and their options, and for the practitioner to have consulted at least one other doctor (Art 2). If the patient is between 16 and 18 years old, and has a reasonable understanding of their interests, their parents must be involved in the decision process although there is no requirement for them to agree with their child’s request. If they are between 12 and 16, and have a reasonable understanding of the process, the doctor can only act on the patient’s request if the parents agree. If the patient is aged 16 years or older and is no longer capable of expressing their wishes, the doctor can act on their earlier wishes if, prior to reaching this condition, the patient, who had a reasonable understanding of their interests, made a written request for assisted dying.

The Netherlands has established Regional Review Committees for assisted dying.[^33] Their role is to assess whether doctors who have terminated a life on request or assisted in a suicide have acted in accordance with the requirement of due care (Art 8). They can provide information to prosecutors as they deem appropriate (Art 10).

Belgium

[^32]: *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands).
Belgium legalised voluntary euthanasia in designated circumstances in 2002. The **Belgian Act on Euthanasia 2002** permits euthanasia if the person is in ‘a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident’. The patient’s request must be in writing and signed by the patient and must be ‘durable’. The doctor must explain to the patient information regarding his or her health condition and life expectancy. The doctor and patient must consider there to be no reasonable alternative to the patient’s situation. The doctor must also be satisfied that the patient’s request is completely voluntary and that the patient is in a state of constant physical or mental suffering. Belgium’s Federal Control and Evaluation Committee on Euthanasia undertakes monitoring of the application of the law.

In 2013, the law was extended to permit access for children provided they have the ‘capacity of discernment’, that is, are able to demonstrate an understanding of the absolute consequences of such a request. This is analogous to the Australian law concept of *Gillick* competence. Other requirements include that the child’s parents approve the decision, the child’s illness must be such that death is expected in the short term and ‘they must be in great pain, with no available treatment to alleviate their distress’. The doctor assisting the minor must also consult a child psychiatrist or psychologist to discuss the case.

**Switzerland**

The legislative regime in Switzerland differs from those in the Netherlands and Belgium in that Switzerland has not passed legislation to make either euthanasia or assisting a suicide lawful in specific circumstances.

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35 ‘Euthanasia’ is defined as ‘intentionally terminating life by someone other than the person concerned, at the latter’s request’: *Belgian Act on Euthanasia 2002*, s 2.

36 *Belgian Act on Euthanasia 2002*, s 3§(1).

37 *Belgian Act on Euthanasia 2002*, s 3§(4).

38 *Belgian Act on Euthanasia 2002*, s 3§(2).

39 *Belgian Act on Euthanasia 2002*, s 3§(2).

40 *Belgian Act on Euthanasia 2002*, s 3§(2).

41 *Belgian Act on Euthanasia 2002*, s 3§(2).


43 Bhatia, White and Deliens, ‘How Should Australia Respond to Media-Publicised Developments on Euthanasia in Belgium?’, above n 34, 842.
Instead, the law in Switzerland is governed by its Criminal Code, and under that Code, both of these acts are unlawful (euthanasia – in all circumstances; and assisted suicide – if done for selfish motives). Under 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 deals with assisting another to commit suicide and provides that ‘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’ (emphasis added).

The effect of article 114 is that voluntary euthanasia 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 assisting a suicide will be illegal. Assisting a suicide is only an offence if it is done for ‘selfish’ motives. There is unlikely to be a breach of article 115 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.

The United States

In most of the United States, physician-assisted suicide is illegal. However, it is legal in seven jurisdictions: Oregon, Washington, Vermont, California, Colorado and the District of Columbia through legislation, and in Montana by way of court decision which concluded that consent provides a statutory defence to a charge of homicide. In the legislative jurisdictions, the statutes are closely modelled on Oregon so we focus here on that jurisdiction given its two decade history of physician-assisted suicide.

44 Criminal Code 1937 (Switzerland).
45 Criminal Code 1937 (Switzerland), art 114.
46 Criminal Code 1937 (Switzerland), art 115.
52 Death with Dignity Act, Law 21-577 D.C (2016).
Since 1997, an Oregon law (passed in 1994)\(^{54}\) has permitted residents of Oregon to receive prescriptions for self-administered lethal medication from their doctors provided the patient is ‘capable’, namely able to make and communicate decisions about their health care, and has an illness expected to lead to death within six months.\(^{55}\) The patient must make one written and two oral requests to their physician, the latter separated by at least 15 days.\(^{56}\) The patient's primary physician and a consultant must confirm the diagnosis of a terminal condition and the prognosis, determine that the patient is capable,\(^{57}\) and refer the patient for counselling, if either believes that the patient's judgment is impaired by depression or some other psychiatric or psychological disorder.\(^{58}\) The primary physician must also inform the patient of all feasible alternatives, such as comfort care, hospice care, and pain-control options.\(^{59}\) Physicians must report all prescriptions that they write for lethal medications to the Oregon Health Division.\(^{60}\)

**Canada**

There has been considerable judicial and legislative activity in Canada over recent years. Legislation was first enacted in Quebec with *An Act Respecting End-of-Life Care*\(^{61}\) commencing operation in December 2015. The stated objective of the Act is ‘to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy’.\(^{62}\) Unlike the European models, the Act regulates end-of-life care more broadly and includes both palliative care and medical aid in dying.\(^{63}\)

The second development affected the entire country. In *Carter v Canada (Attorney General)*,\(^{64}\) the constitutionality of the provisions of the Canadian *Criminal Code* that prohibited voluntary euthanasia and assisted suicide was challenged on the basis of breaching sections 7 (the right to life, liberty and security of the person) and 15 (the right to equality) of the Canadian *Charter of Rights and Freedoms*. The case originated with Kay Carter, a woman who had a severe case

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\(^{55}\) *Death with Dignity Act*, Or Rev Stat §§ 127.800–127.995 (1994), s 2.01


of spinal stenosis. She asked her family to take her to Switzerland so that she could end her life, and they did so. Her daughter and son-in-law became the first plaintiffs in the case. Gloria Taylor subsequently joined the case as another central plaintiff. She was a woman who suffered from amyotrophic lateral sclerosis which causes progressive and fatal muscle weakness. She asked the court to strike down the Criminal Code barriers to physician-assisted death.

The Supreme Court held that the Criminal Code breached s7 of the Canadian Charter of Rights and Freedoms, which protects “the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”. The prohibitions imposed by the Criminal Code were overbroad and thus not in accordance with the principles of fundamental justice. That is, the prohibitions were broader than was necessary to achieve the objective of the provision, namely the protection of the vulnerable from being induced to end their lives suicide in times of weakness. The violation of s7 was not “demonstrably justified in a free and democratic society” (because the provisions limit the rights more than necessary to achieve the objectives) and so the provisions were unconstitutional. The Supreme Court issued a declaration that the relevant provisions of the Criminal Code were void insofar as they prohibited physician-assisted death for a competent adult who clearly consented to the termination of life and had a grievous and irremediable medical condition (including an illness, disease or disability) that caused enduring suffering that was intolerable to the individual in the circumstances of their condition. The Supreme Court also declared that ‘irremediable’ did not require the patient to undertake treatments that were not acceptable to him or her.

In response to the Carter decision, the Canadian Parliament passed a law which came into force on 17 June 2016.65 The legislation contains a range of eligibility criteria and procedural safeguards. In terms of eligibility, the person must be an adult, be capable of making health decisions, have made a voluntary request, have given informed consent, and have a grievous and irremediable condition. The legislation provides that to have such a condition:

- the person must have a serious and incurable illness, disease or disability;
- the person must be in an advanced state of irreversible decline of capability;
- the person must have enduring physical or psychological suffering that is intolerable to them which cannot be relieved under conditions that are acceptable to them; and

• the person’s natural death must be reasonably foreseeable.

Core values that should underpin this area of law

There will never be total agreement on whether permissive assisted dying laws should be enacted in Australia. People hold positions which are shaped by deeply held personal values and beliefs. Individuals have different value systems which will result in different positions about whether it should ever be lawful to assist another person to end his or her life. However, the law must ultimately take a position on this issue – retain the prohibition full stop, retain the prohibition but introduce a defence, or adopt a permissive regime. In this section, we articulate the core values that we contend should underpin the law: life, autonomy, freedom of conscience, equality, the rule of law, protecting the vulnerable, and reducing human suffering. These values are derived from existing Australian legal principle, as reflected in common law, legislation or conventions or treaties that have been ratified by Australia. In the section that follows, we then draw on these values to determine what the legal position should be in relation to assisted dying in Australia.

Life

The fundamental importance of human life is recognised by our legal system. The criminal law in all States and Territories makes the killing of another person unlawful unless it is authorised, justified or excused. It also makes assisting another person to commit suicide unlawful. Further, the value of human life is recognised by the common law, as revealed in court decisions about whether to permit the withholding or withdrawal of potentially life-sustaining treatment. In the landmark case of Airedale NHS Trust v Bland, for example, the House of

66 In this section we draw heavily on the descriptions of values previously set out by two of the authors in Jocelyn Downie, Lindy Wilmott and Ben White, ‘Cutting the Gordian Knot of Futility: A Case for Law Reform on Unilateral Withholding and Withdrawal of Potentially Life-Sustaining treatment’ (2014) 26(1) New Zealand Universities Law Review 24.
67 We do not, here, discuss the value ‘dignity’ because it is relied upon to justify opposite conclusions on end-of-life issues by all sides of the debate. There is also no agreed upon definition. We believe that the debate about end-of-life decision-making can more usefully proceed by setting aside the term ‘dignity’ and instead focusing on the concepts that most commonly lie behind it – that is, equality and autonomy. We take this position for the reasons articulated in Udo Schuklenk 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 Bioethics 1-73, 38-45.
68 LexisNexis, Halsbury’s Laws of Australia (at 18 November 2016) 130 Criminal Law, ‘3 Homicide’ [130-3000].
Lords accepted that ‘sanctity of life’ formed part of the English legal system70 and Australian courts have also recognised the State’s interest in preserving human life.71

The value of life can be upheld through prohibiting assisted dying and this is the principal way in which this value is drawn upon in current debates. However, there is a sense in which the value of life can be advanced through permitting assisted dying. This was recognised by the Supreme Court of Canada in Carter v Canada (Attorney General), which held that the current blanket prohibition on assisted suicide breached the right to life.72 The Court’s reasoning included that where suicide is legally permitted but assisted dying is not, some individuals may die earlier than they would if assisted dying were permitted. That is, they may commit suicide before they would request assisted dying because they fear losing the physical capacity to commit suicide and being trapped with no way out.73

Furthermore, preserving human life is not an absolute value. The law in Australia (and indeed in many common law jurisdictions throughout the world) recognises that the value of an individual’s life can sometimes be outweighed by the disvalue of their suffering. In other words, a person may decide that life is no longer worth living to them. For this reason, the law allows a competent individual to refuse treatment, even if that treatment is necessary to preserve life and is recommended by doctors.74 Where a person has completed a valid advance directive,75 and, in some cases, where a substitute decision-maker refuses treatment,76 the law also allows treatment to be withheld from a person who lacks decision-making capacity. While we, as a society, recognise the intrinsic value of life and the possibility of instrumental value for life (for the individual and those the individual cares about), we already acknowledge that

71 See, eg, Hunter and New England Area Health Service v A (2009) 74 NSWLR 88, [5]-[16], and more recently a reference by a majority of the Australian High Court in Patel v The Queen (2012) 247 CLR 531, [87] to ‘the value the law places on human life’.
73 Carter v Canada (Attorney General) [2015] 1 SCR 331, [57]-[58].
for some individuals who are enduring suffering that is unacceptable to them, other values can outweigh the intrinsic and instrumental value of their life.

**Autonomy**

The principle of respect for autonomy is a fundamental part of Australian common law. In the High Court case of *Stuart v Kirkland-Veenstra*, Gummow, Heydon and Hayne JJ recognised, in the context of a negligence action, ‘an underlying value of the common law which gives primacy to personal autonomy’\(^77\) and observed that personal autonomy is ‘a value that informs much of the common law’.\(^78\) The value of autonomy is also a core value in the context of health law. It prevails over the value of life when a competent adult, for whatever reason, refuses medical treatment even if that treatment is needed to stay alive. In *Brightwater Care Group (Inc) v Rossiter*, Martin CJ refers to the ‘common law principle of autonomy and self-determination’\(^79\) and also notes that the principle is ‘well established at common law’.\(^80\) In that case, a man with quadriplegia was being kept alive by the delivery of artificial nutrition and hydration and decided that he no longer wished to receive such medical treatment. The Western Australian Supreme Court recognised his right to self-determination, and that this prevailed over the State’s interest in keeping him alive.

Although the law prioritises autonomy over life in decisions to refuse medical treatment, the current legal position is reversed if a competent adult seeks assistance to end his or her life in the context of assisted dying. The criminal law prohibits this assistance, and the fact that the person requests help to end his or her life (in the exercise of his or her autonomy) does not alter the legal position. This anomaly begs the question about the different possible meanings of the term ‘autonomy’ in law.\(^81\) In the context of refusals of treatment, autonomy has generally been interpreted in Australia as the narrow right to prevent physical interference with one’s bodily

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\(^77\) *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, [87].


\(^79\) *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84, [48].


\(^81\) In philosophy, it has even more different meanings. For example, contrast the conception of autonomy articulated by John Stuart Mill (a liberal individualist) in *On Liberty* (Longman, Roberts & Green, 4th ed, 1869) with that articulated by Susan Sherwin (a feminist relational theorist) in ‘A Relational Approach to Autonomy in Health Care’ in Susan Sherwin (ed), *The Politics of Women’s Health: Exploring Agency and Autonomy* (Temple University Press, 1998) 19.
integrity. This is what requires a refusal of treatment to be respected at law. A wider view, a right to self-determination, involves having one’s will respected and acted upon and would include the ability to receive assistance to die.

These different views about what autonomy might mean do not detract from accepting autonomy as an appropriate value to underpin decisions about regulation of assisted dying; rather, they point to the need to clarify which sense of respecting autonomy is meant. We consider that it is the latter view of autonomy – as self-determination – that should inform regulation of decision-making for a person who is approaching the end of their life and enduring intolerable suffering. The case for embracing autonomy as self-determination starts with how autonomy is understood in contemporary Australian society. It is unlikely that Australians understand autonomy in the narrow sense of only preserving bodily integrity; if asked, they would talk in terms of the broader concept of self-determination. We note that this wider approach was also adopted by the Victorian Legislative Council Legal and Social Issues Committee when articulating the core values that they believed should underpin end-of-life care. And while the narrow view has received firm and unwavering support in law, this has occurred in the context of cases involving refusals of treatment. The narrow view is sufficient for deciding these cases so it is not surprising that they have been confined in this way. Judges are inclined to decide cases on the narrowest possible basis and so this should be taken only as silence, and not rejection, of autonomy as self-determination.

We consider that given society’s understanding of autonomy as self-determination (which is reflected in the approach of the Victorian Parliamentary Committee), the value of autonomy

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82 See, eg, Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion’s Case) (1992) 175 CLR 218, 232-233, 265, 309-210; Hunter and New England Area Health Service v A [2009] NSWSC 761, [5], [17]; Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84 at [23], [24], [26], [31]-[32].
83 Although in the context of decisions to withhold or withdraw potentially life-sustaining medical treatment, see Loane Skene, ‘Disputes about the Withdrawal of Treatment: the Role of the Courts’ (2004) 32 Journal of Law Medicine and Ethics 701 where she comments on the narrow and wide interpretations of the concept of autonomy. The wider approach to autonomy, again in the context of requesting potentially life-sustaining treatment, was adopted by Justice Munby at first instance in R (Burke) v General Medical Council [2005] QB 424, [130] where he commented that article 8 of the Human Rights Act 1998 means that it is for a competent patient to decide the treatment he or she should or should not be given. Note however Munby J’s decision and this more expansive approach to autonomy were overturned by the Court of Appeal: R (Burke) v General Medical Council [2006] QB 273.
85 For example, in Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84 at [20], the judge explicitly noted that ‘I should only answer questions directly and explicitly raised by the facts of this particular case, and refrain from making any observations with respect to any other hypothetical scenarios.’
proposed here should be understood in the wider sense of having one’s will respected and acted upon. As with all values, however, promoting self-determination is not unqualified and is subject to the claims of other competing values.

**Freedom of Conscience**

Conscience is a value recognised generally by the Australian legal system and respecting the conscience of health professionals in particular is also reflected in law. Further support for conscience is found in position statements of peak medical bodies which endorse the need for doctors to be able to practise medicine in accordance with their conscientiously held beliefs. The value of conscience suggests that doctors (and other health professionals) should not be required to participate in assisted dying where doing so is contrary to their conscience.

While the conscience of health professionals who oppose assisted dying and the need to protect them from an obligation to practise contrary to their beliefs is important and has been prominent in the Australian debate, the right to act according to conscience is not absolute. It can be overridden where competing values require. An example is a competent refusal of potentially life-sustaining treatment. Here, the law requires that such treatment not be given notwithstanding that a doctor may conscientiously believe that this is wrong because the patient will die without treatment.

We also note that conscience can tilt toward permitting assisted dying. Some health professionals want to be able to provide assisted dying as they believe it is a part of good end-of-life care. Some believe that they would fail in their duty to their patient not to assist them to die. Even in Australia where the practice is unlawful, a small number of doctors have

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88 See, eg, the following with respect to abortion: *Health Act 1993* (ACT) s 84; *Medical Services Act* (NT) s 11(6)-(7); *Criminal Law Consolidation Act 1935* (SA) s 82A(5)-(6); *Health Act 1911* (WA) s 334(2).


admitted to assisting their patients to die in a bid to relieve their suffering.\(^92\) In a rare (and famous) case in which a doctor, Dr Cox, was prosecuted and ultimately convicted of attempted murder following the death of his patient. Five days before her death, Dr Cox’s patient pleaded for an injection to end her life. Three days later, Dr Cox wrote in his notes: ‘She still wants out and I don’t think we can reasonably disagree.’\(^93\) The current law prohibits these health professionals from following their conscience and assisting their patients to die.

Thus, while respecting conscience is important,\(^94\) we need to recognise everyone’s consciences are implicated in assisted dying policy decisions. This points to a permissive regime that does not compel health professionals to assist individuals to die, but also does not prevent health professionals from providing that assistance in certain circumstances.

**Equality**

The Australian legal system has made significant commitments to the value of equality through becoming a signatory to the Convention on the Rights of Persons with Disabilities,\(^95\) and passing human rights\(^96\) and anti-discrimination legislation.\(^97\) These instruments endorse equality and reject discrimination, including discrimination on the basis of disability. The rule of law (which underpins the Australian legal system and itself a core value which is discussed below) also requires that the law treat people equally.\(^98\)

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\(^92\) See, eg, the media report by Julia Medew, ‘Doctor admits giving dying man the drugs to end his life’ that Dr Rodney Syme admitted giving a terminally-ill man Nembutal prior to the man’s death: *The Age* (online) 28 April 2014: <http://www.theage.com.au/victoria/doctor-admits-giving-dying-man-the-drugs-to-end-his-life-20140427-zr07i.html>. See also an open letter to *The Age* newspaper calling for euthanasia law reform by 7 Melbourne doctors in which they wrote: ‘It cannot be right to tolerate this totally unsatisfactory situation, where it is a matter of chance whether patients will receive the treatment which they so desperately seek and where it must be only a matter of time before some doctor is prosecuted by the state for following the dictates of his conscience’: 25 March 1995, ‘Helping Patients to Die’, *The Age*.

\(^93\) Dr Cox’s patient, Mrs Boyes, had suffered from acute rheumatoid arthritis for 20 years, had ‘developed ulcers and abscesses on her arms and legs, a rectal sore penetrating to the bone, fractured vertebrae, deformed hands and feet, swollen joints, and gangrene from steroid treatment’: C Dyer, ‘Rheumatologist Convicted of Attempted Murder’ (1992) 305 *British Medical Journal* 731 as cited in R Magnusson, *Angels of Death: Exploring the Euthanasia Underground*, (Melbourne University Press, 2002) 25.


\(^98\) See, eg, the second key principle identified by the Law Council of Australia in their Policy Statement on the Rule of Law: Law Council of Australia, *Policy Statement: Rule of Law Principles* (March 2011)
Equality is implicated in the assisted dying discussion in various ways – both in terms of whether assisted dying laws should be introduced, and also the substantive content of those laws. In terms of whether assisted dying should be allowed, we note that individuals without disabilities are able to end their suffering through suicide. But this option may not be open to some individuals who have a physical disability that prevents them from doing so. Prohibiting assisted dying can thus be seen as offending the value of equality through discrimination on the basis of physical disability. 99

We turn next to how the value of equality can influence the nature of regulation. First, similar to the point above, a legislative framework that is limited to physician-assisted suicide and so requires the individual to administer the medication themselves, discriminates against those whose disability does not allow them to do this. Limiting assisted dying in this way would be inconsistent with the value of equality. Secondly, we believe that having a disability should not of itself prevent a person from receiving assistance under assisted dying legislation. That is, if the person satisfies the eligibility requirement of ‘medical condition’, he or she should not be regarded as ineligible because that medical condition results from a disability. More will be said on this later.

Rule of law

The Australian legal system is built upon the rule of law. 100 There is no universally accepted definition of the rule of law, and the concept is generally regarded as incorporating a range of

99 Support for this position can be found in the judgment of Justice Smith at first instance in Carter v. Canada (Attorney General) [2012] BCSC 886, [1158]-[1159]: ‘The law, viewed as a whole, embodies the following principles: (1) persons who seek to take their own lives, but fail, are not subject to criminal sanction because there is no longer a criminal offence of suicide or attempted suicide; (2) persons who are rendered unable, by physical disability, to take their own lives are precluded from receiving assistance in order to do so by the Criminal Code offence of assistance with suicide. Those principles create a distinction based on physical disability. The effect of the distinction is felt particularly acutely by a subset of persons with physical disabilities represented by the plaintiff Gloria Taylor and others such as Mr. Fenker (now deceased), Mr. Morcos and Ms. Shapray – persons who are grievously and irretrievably ill and physically disabled or will soon become so, are mentally competent, have full cognitive capacity, and wish to have a measure of control over their circumstances at the end of their lives. They may not wish to experience prolonged pain. They may wish to avoid the anxiety that comes with fear that future pain will become unbearable at a time when they are helpless. They may not wish to undergo palliative sedation without hydration or nutrition for reasons including concern for their families, fear for themselves or reaction against the total loss of independence at the end of their lives.’

principles that are fundamental to a liberal western democracy. The rule of law has ancient origins, but the modern concept encompasses important principles including the separation of powers between the judiciary, executive and legislature; the equal application of laws to all; and procedural requirements, such as the availability of a fair hearing. In 2011, the Law Council of Australia produced a policy statement setting out its formulation of the key principles comprising the rule of law in the Australian context.

There are two important dimensions to the rule of law that are particularly important to the assisted dying debate: key principles one and two from the Law Council’s policy statement. The first key principle is that the ‘law must be both readily known and available, and certain and clear’. This principle continues:

The intended scope and operation of offence provisions should be unambiguous and key terms should be defined. Offence provisions should not be so broadly drafted that they inadvertently capture a wide range of benign conduct and are thus overly dependent on police and prosecutorial discretion to determine, in practice, what type of conduct should or should not be subject to sanction.

This component of the rule of law is important if a decision is made to allow assisted dying. Any regulatory regime should provide sufficient clarity so individuals (health professionals and those seeking assistance) understand how the regime operates and can assess the implications of the regime for him or herself. That is, the scheme should have clearly expressed legal parameters.

Allied to this requirement is the need for regulation to have in-built protections to ensure that it is operating in the manner intended by parliament. For example, there would need to be appropriate safeguards to ensure that only individuals who are eligible receive assistance to die. Further, there should be robust oversight systems in place both in terms of reviewing individual cases for regulatory compliance, but also to address any systemic issues that may arise in relation to non-compliance.

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[103] Ibid, Key Principle 1.

[104] Ibid.
The second key principle identified by the Law Council is that the ‘law should be applied to all people equally and should not discriminate between people on arbitrary or irrational grounds’. There are two aspects of this principle that are relevant in the assisted dying context. The first is determining who should be eligible to receive assistance under the legislation. For example, if a decision is made that individuals with a specified ‘medical condition’ are eligible, there would need to be ‘a demonstrable and rational basis’ for excluding people who had such a medical condition from the ambit of the legislation. Different treatment of a person or group of individuals (such as those with a disability) without a rational basis would breach the rule of law. This aspect of the rule of law links with, and supports, the value of equality outlined above.

The second aspect of this principle is that ‘no one should be regarded as above the law and all people should be held to account for a breach of law, regardless of rank or station’. This means that compliance with law matters and further supports the case for safeguards and oversight to ensure that the law is being followed.

**Protecting the vulnerable**

A further value found within Australian law is protecting vulnerable persons within the community. For example, the High Court has recognised that vulnerability, albeit a wider meaning of vulnerability in terms of an inability to protect oneself from another’s failure to take reasonable care, is an important feature of tort law. A narrower form of vulnerability and one more akin to that raised in assisted dying debates is also protected by the common law through the equitable doctrines that permit transactions involving undue influence and unconscionable transactions to be set aside. Australian law also recognises the importance of protecting the vulnerable through adult guardianship law with all Australian States and Territories recognising only decisions made by competent adults and imposing duties on others to safeguard the interests of persons who are not able to make their own decisions.

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107 Ibid.
110 For an overview of the principles that govern how decisions are made on behalf of others under guardianship legislation, see Ben White, Lindy Willmott and Shih-Ning Then, ‘Adults who Lack Capacity: Substitute Decision-
But it is the criminal law, with one of its central purposes being protection of the community,\(^{111}\) which provides the strongest statement about the importance of protecting the vulnerable. An illustration of this are the criminal law duties imposed on certain people to provide the ‘necessaries of life’ to various vulnerable groups in their care who cannot secure these necessaries themselves.\(^{112}\) Protecting the vulnerable from taking their own life through the encouragement or coercion of others is also at the heart of the criminal law prohibition on assisting a suicide.\(^{113}\)

The nature of vulnerability and who is vulnerable is contested.\(^{114}\) Vulnerability could arise in a range of ways including because of: personal (e.g. family) or institutional (e.g. treating health professionals or hospitals) relationships that could possibly lead to coercion or undue influence; age or disability (including cognitive disability); or inadequate access to resources including financial resources or medical care. This value aims to protect those who are vulnerable to ensure they are not accessing assisted dying regimes where that is not a genuine desire on their part. Caution is needed, however, to ensure that a person is not regarded as incapable of choosing assisted death just because they belong to a group that has traditionally been regarded as vulnerable. For example, there is a risk of paternalism and not respecting autonomy and equality if a person with a disability is judged as too vulnerable to be able to access the scheme simply by virtue of that disability.\(^{115}\)

This value requires that any legal response to assisted dying protect the vulnerable.\(^{116}\) This justifies eligibility criteria and procedural safeguards to ensure that a person seeking assistance to die is able to make their own decision and does so free from pressure or coercion. However,
the need to protect the vulnerable does not justify an absolute ban on assisted dying. Individuals who may be regarded as ‘vulnerable’ may want access to assistance to die, and the empirical evidence from permissive regimes around the world does not support the claim that the vulnerable cannot be protected.\footnote{In addition to the studies described next, this also represents the view of the trial judge in \textit{Carter v. Canada (Attorney General)} [2012] BCSC 886 [852], [1242] (these findings were not disturbed by the Canadian Supreme Court who noted that the trial judge’s findings were ‘reasonable and open to her’: \textit{Carter v Canada (Attorney General)} [2015] 1 SCR 331 [109]).} While relevant studies have employed significantly different methods to gather data, they consistently find that groups who are generally regarded as ‘vulnerable’ are not more likely to access euthanasia or assisted dying.

In 2012, Rietjens et al published their findings from a systematic review of articles published over an 11 year period (1998-2009) that collected data about end-of-life decision-making and social factors of those who died.\footnote{JAC Rietjens et al, ‘Medical End-of-life Decisions: Does its Use Differ in Vulnerable Patient Groups? A Systematic Review and Meta-analysis’ (2012) 74(8) Social Science and Medicine 1282. Note that for the purpose of this study, ‘the administration of medication with a potential or certain life-shortening effect’ included the provision of medication for pain relief that could also have ended life, as well as euthanasia and assisting a suicide.} They concluded that the administration of medication with a potential or certain life-shortening effect ‘seemed generally to be practiced (sic) less often among the elderly, females and less-educated patients compared with younger, male or more educated patients’.\footnote{Ibid 1282. Note that these findings are consistent with an earlier study by Margaret P Battin et al, ‘Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in Vulnerable Groups’ (2007) 33(10) \textit{Journal of Medical Ethics} 591, 594-596 which reviewed data in Oregon and the Netherlands over 9 years and 15 years respectively (the latter data drawing on four death certificate surveys conducted during this period). This study concluded that those who received assistance to die ‘appeared to enjoy comparative social, economic, educational, professional and other privileges’: 591.} Another review of evidence was carried out more recently by Emanuel and colleagues.\footnote{Ezekiel J Emanuel et al, ‘Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe’ (2016) 316(1) \textit{JAMA} 79.} Their study collected evidence about various aspects of euthanasia and assisted dying practices from a range of sources.\footnote{The public literature was searched including surveys from 1947 to 2016, with a focus on original data from three main sources: surveys providing data on attitudes and practices; data from jurisdictions that have legalised euthanasia and assisted suicide that have data on prevalence and practices; and death certificate studies in the Netherlands and Belgium: Ibid 80.} In terms of who is likely to access assistance to die, the researchers concluded that ‘typical patients are older, white, and well-educated’.\footnote{Ibid 79.} Finally, a very recent published study by Blanke et al analysed 18 years of data collected in Oregon since the commencement of its legislation.\footnote{Charles Blanke et al, ‘Characterizing 18 years of the Death with Dignity Act in Oregon’ (2017) \textit{JAMA Oncology} doi: 10.1001/jamaoncol.2017.0243.} During this time, of the 1545 prescriptions that were written, 991 (64\%) individuals died from ingesting the medication.
those 991 individuals, 51.4% were men, 96.6% were white, 98.6% were insured and 71.9% had some form of tertiary education.\textsuperscript{124}

**Reducing human suffering**

The value of reducing human suffering is different from the preceding values in that it is specific to the end-of-life setting and is not a higher-level concept that applies across a legal system like the values of autonomy, life or freedom of conscience. As such, its recognition in law derives from analysing the particular legal areas that deal with palliative care and the relief of pain and symptom management. The common law has given great weight to the relief of pain through the doctrine of double effect which permits the hastening of death through medication provided this is necessary to relieve pain and suffering, and it is the health professional’s intention to relieve pain rather than cause the person’s death.\textsuperscript{125} As such, the doctrine recognises that the value of reducing human suffering may trump that of life in some circumstances.

The doctrine of double effect is likely to be part of Australian common law\textsuperscript{126} and appears to have been recognised in the case of *Re Baby D (No 2)*.\textsuperscript{127} Some States have also enacted a statutory excuse for criminal responsibility to ensure appropriate palliative care can be provided where that is needed to relieve pain.\textsuperscript{128} The Australian Capital Territory even enacted a limited right to ‘receive relief from pain, suffering and discomfort to the maximum extent that is reasonable in the circumstances’\textsuperscript{129}.

These laws show clear policy support in Australian law for the value of reducing human suffering and this is also reflected in the Victorian Standing Committee on Legal and Social Issues report which included alleviating pain and suffering as one of its core values for end-of-

\textsuperscript{124} Ibid E3. Note that the percentages for individuals who were insured and who had some form of tertiary education quoted in the text were obtained through email correspondence with the author (dated 21 April 2017) as there were typographical errors in the published article.

\textsuperscript{125} Ben White and Lindy Willmott, ‘Double Effect and Palliative Care Excuses’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2nd ed, 2014) [15.20].

\textsuperscript{126} Ibid.

\textsuperscript{127} *Re Baby D (No 2)* (2011) 45 Fam LR 313.

\textsuperscript{128} White and Willmott, ‘Double Effect and Palliative Care Excuses’, above n 124, [15.30]-[15.110].

\textsuperscript{129} *Powers of Attorney Act 2006* (ACT), s 86 and *Medical Treatment (Health Directions) Act 2006* (ACT), s 17. For a discussion of the likely interpretation of this ‘right to pain relief’, see White and Willmott, ‘Double Effect and Palliative Care Excuses’, above n 124, [15.30].
life regulation. This legal recognition is further bolstered by widespread medical, ethical and policy endorsement of reducing pain and managing symptoms as being critical to good end-of-life care.

While recognising the value of reducing human suffering is not controversial, the weight it carries and how it interacts with other values can be. As has been already noted, the law has prioritised relieving pain (where that is the primary intention) even if this may hasten death, but it has stopped short of allowing suffering to be a justification for intentionally ending a person’s life. As we explain further below, we consider that, in some circumstances, the value of reducing human suffering supports making assisted dying lawful.

A regulatory model that reflects core values

Legislative reform is needed to make assisted dying lawful

After considering the above core values, we consider reform is needed. Allowing assistance to die enables a competent adult to assess and balance the value of their life and the disvalue of their suffering and to exercise their autonomy. This promotes both the values of life and autonomy. The value of conscience can be promoted by allowing health professionals the freedom not to participate in assisted dying as well as through an appropriately constructed system for transfers of care. The regime should ensure access to assisted dying for competent adults (autonomy) and eligibility criteria must avoid unjustifiable discrimination, including on the basis of disability (equality and the rule of law). The value of the rule of law can also be promoted through clearly expressed legal parameters about access to assisted dying and establishing safeguards and oversight mechanisms to ensure the law is followed. A regime with adequate safeguards (which empirical evidence demonstrates can be effective) can also serve the value of protecting the vulnerable. By respecting a person’s decision to seek assistance to

end their life when they are experiencing intolerable suffering, the value of reducing suffering, as assessed by that person, is also promoted. In summary, these values demonstrate the need for reform and that their sometimes competing claims can be accommodated in a regime that permits and regulates assisted dying. We favour reform by way of legislation rather than prosecutorial guidelines or evolution through case law.\textsuperscript{134} A carefully drafted statute is more likely to provide the clarity and certainty that is critical here (promoting the rule of law).

In the remainder of this section, we outline a proposed model for assisted dying that reflects and promotes the core values. In some cases, these values push in different directions and so we explain how we have balanced them against each other in arriving at a position (expanding on some of the discussion in the values section). We also note that for some issues, the values provide a higher policy level direction for a legislative regime but do not provide guidance in relation to its specific details. To inform our thinking in these instances, we have reflected on all of the international legislative models, as well as the Act that operated briefly in the Northern Territory. We have also drawn on two proposals for reform that have currency in Australia: the Death with Dignity Bill which was narrowly defeated in South Australia in November 2016, and the Victorian model which was proposed (in broad terms) in June 2016 by the state’s Legal and Social Issues Committee of the Legislative Council.

**Nature of the model**

*Permissive or defence model*\textsuperscript{135}

A permissive decriminalisation model allows a person to assist another to end their life, but regulates the circumstances in which this will be lawful by setting out eligibility and procedural requirements as well as other safeguards. Most jurisdictions where assisted dying can be lawful adopt this model: the Netherlands, Belgium, Luxembourg, some jurisdictions in the United States (Oregon, Washington, Vermont, California, Colorado and the District of Columbia), Canada federally (amendments to their *Criminal Code*) as well as Quebec (under its separate

\textsuperscript{134} Different ways in which changes to the law or practice could be achieved are discussed in Ben White and Lindy Willmott, ‘How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?’ (2012) 20 *Journal of Law and Medicine* 410, 427-432.

\textsuperscript{135} The authors note that a ‘penalty mitigation’ model has also been proposed under which minor fines are imposed for conduct that remains unlawful provided certain procedural safeguards are observed: Willmott et al, ‘(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics’, above n 2, 33. Such models have not been in any legislative regime to date.

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legislation), and previously in the Northern Territory. Under the defence model, as in Montana, assisting someone to die remains unlawful, but a defence is created in certain circumstances.\textsuperscript{136}

We favour a permissive model for the reasons outlined above as to why assisted dying should be permitted and regulated. In particular, we rely on the values of autonomy and reducing human suffering. Because allowing assisted dying is justified, we favour an approach that treats it as a lawful activity. By contrast, the defence model treats this assistance as \textit{prima facie} criminal conduct. The framing of assisted dying as potentially lawful in a permissive model is also likely to provide more comfort to health professionals who are assisting people to die within the criteria prescribed by the regime. This model removes the stigma of the criminal law, and also the requirement of health professionals to satisfy an onus of proof to raise the relevant defence to avoid liability. Such an approach therefore removes a potential barrier for patients gaining access to what the core values conclude is a lawful and appropriate form of care.

\textit{Voluntary euthanasia, physician-assisted suicide, or both}

Some models allow (or did allow) a doctor to participate in both voluntary euthanasia and physician-assisted suicide (see, for example, Canada, the Netherlands, and the Northern Territory). In the United States, however, the legislatures have adopted the more restrictive model of physician-assisted suicide. The Belgium and Quebec legislation, on the other hand, provides for voluntary euthanasia only (at least on its face).\textsuperscript{137}

The authors favour permitting both voluntary euthanasia and physician-assisted suicide. The value of autonomy grounds the suggestion that a person be able to choose to receive assistance to die either by a doctor directly providing that assistance or by enabling the person to bring about his or her own death. The value of equality would also favour access to both. Providing only physician-assisted suicide would unfairly exclude individuals who lack the physical ability to end their own life from assisted dying regimes. The value of life would also favour

\textsuperscript{136} See, eg, Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA). Note also Switzerland where, as discussed above, assisting a suicide for ‘selfish’ motives is an offence. If a person assists another to die and is charged under this provision, he or she must demonstrate that the assistance was provided for ‘selfless’ motives. Although the legislation does not contain a formal ‘defence’ provision, the legislation is more akin to a ‘defence’ model as it does not provide a regulatory framework to govern assisted death as occurs under the permissive models.

\textsuperscript{137} Note that in Quebec, this is referred to as ‘medical aid in dying’: \textit{An Act Respecting End-of-Life Care}, R.S.Q. c. S-32.0001, s 3(6). In relation to Belgium, although the law does not expressly permit assisted suicide, the practice does occur and is reported to the Federal Control and Evaluation Commission as such: see Bhatia, White and Deliens, ‘How Should Australia Respond to Media-Publicised Developments on Euthanasia in Belgium?’, above n 34, 836.
access to both as limiting access to assisted suicide could lead individuals to kill themselves earlier than they otherwise would in order not to become trapped in a body incapable of ending their own life.

**Eligibility**

There are four important aspects of eligibility to consider: competence; age; medical condition; and suffering.

**Competence**

It is the value of autonomy that primarily underpins our recommendation that assisted dying be permitted and a person must be competent to exercise that autonomous choice. This approach reflects most legislative models including those in the United States, Canada (both the federal and Quebec legislation), and the repealed Northern Territory legislation which apply only to competent persons. However, this is not universally the case and in the Netherlands and Belgium, for example, a person can make a request for assistance to die in advance of losing their capacity. Despite the breadth of their legislation, however, we note that in practice it is not common for doctors to end a person’s life after he or she has lost decision-making capacity and is not able to make a competent request for assistance to die.

We consider that competent adults should be able to request assistance to die. Assisted dying for individuals who make a competent request to end their lives and later lose capacity is a complex issue, and is beyond the scope of this chapter. However, in this regard we observe that over the past few decades in Australia, the focus of the debate has been on whether assisted

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138 We note though that in Canada the issue of advance requests for assisted dying is included in a statutorily mandated review the results of which must be placed before Parliament by December 2018.

139 See, eg, Mette L Rurup, ‘The First Five Years of Euthanasia Legislation in Belgium and the Netherlands: Description and Comparison Cases’ (2011) 26(1) Palliative Medicine 43, 45. More recently, however, it was noted that in 2013 euthanasia based on an advance directive rose to 5.5% of all cases; Kenneth Chambaere et al, ‘Recent Trends in Euthanasia and Other End-of-life Practices in Belgium’ (2015) 372(12) New England Journal of Medicine 1179 (Supplementary Index).

140 Some argue that a competent self does not have the moral authority to bind a (different) incompetent self: see, eg, R Dresser, ‘Precommitment: A misguided strategy for securing death with dignity’ (2003) 81 Texas Law Review 7; R Dresser, ‘Dworkin on dementia: Elegant theory, questionable policy’ (1995) 25(6) The Hastings Center Report 32; R Dresser, ‘Missing persons: Legal perceptions of incompetent patients’ (1994) 46 Rutgers Law Review 609; R Dresser, ‘Life, death, and incompetent patients: Conceptual infirmities and hidden values in the law’ (1986) 28 Arizona Law Review 373. Others argue that the choice of the competent self should prevail over the later incompetent self: see, eg, R Dworkin, Life’s Dominion: An Argument about Abortion and Euthanasia (Harper Collins: London, 1993) and R Dworkin, ‘Autonomy and the demented self’ (1986) 64 (Suppl 2) The Milbank Quarterly 4. Other values can also be engaged such as the value of protecting the vulnerable when considering providing assistance to die for a person who no longer has capacity to make that decision, or who may even express an (incompetent) desire to continue living.
dying should be allowed for competent adults, and there has been only very limited discussion about advance requests for assistance to die.

Age

Most of the legislative models limit (or limited) access to assisted dying to adults: Canada,\textsuperscript{141} the United States jurisdictions and the Northern Territory. It is only in the Netherlands\textsuperscript{142} and Belgium\textsuperscript{143} where this is not the case. As argued above, we believe that a person seeking assistance to die should be competent. Because adults are presumed by our legal system to be competent, all adults would prima facie be eligible to access the regime unless doctors were satisfied of incompetence.

The more challenging issue of whether assistance to die should be available to children who satisfy the test of \textit{Gillick} competence is, as noted in the introduction, beyond the scope of this chapter given the complexity of issues raised and that it has not been part of the Australian debate.

Medical condition

The values of autonomy and life are integral in determining when a person is sufficiently unwell to qualify for assistance to die.\textsuperscript{144} Autonomy unfettered could suggest that any competent person\textsuperscript{145} should be able to receive assistance to die if that were his or her choice regardless of whether or not they have a medical condition. But autonomy is constrained by the value of life (and other values such as the protection of the vulnerable), and so a more nuanced approach is needed. Allowing assisted dying is also partly grounded in the value of reducing suffering and so the regime should include suffering as an eligibility criterion.

We argue that the balancing exercise involving the value of life can change as circumstances change. A justifiable approach is to recognise that the State’s interest in preserving life is

\textsuperscript{141} The Quebec legislation is also limited to adults. In Canada, the issue of mature minors is also part of the statutorily mandated review the results of which must be placed before Parliament by December 2018.

\textsuperscript{142} As discussed above, pursuant to Article 2 of the \textit{Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002} (Netherlands), assistance is available to a minor between 16 and 18 years if the minor has a reasonable understanding of his or her interests and parents are involved in the decision-making, and also to a minor between 12 and 16 years if the child has a reasonable understanding and the parents agree with the decision.

\textsuperscript{143} As discussed above, in 2013 the Belgian legislation was extended to permit access for children provided they have the ‘capacity of discernment’.

\textsuperscript{144} We note that the value of protecting the vulnerable is a critical value when formulating a legislative model around assisted dying. However, that value is better protected when considering ‘safeguards’ underpinning the regime and is dealt with below.

\textsuperscript{145} Bearing in mind the restrictions suggested regarding age above.
weighty where a person is healthy, well and free from pain. But that interest is outweighed by other values such as autonomy and reducing suffering when both: (1) the person has a condition that will inevitably cause death, and (2) the person too has formed the view that the value of his or her life is outweighed by the disvalue of his or her suffering (this second aspect is discussed further below). So the State’s interest in preserving life would prevent a healthy and well person who is free from pain from having assistance to die as the value of life would prevail over autonomy and reducing suffering. However, the balance between these values shifts where a person has a medical condition that will cause their death and they do not want to continue living due to their suffering. In such a case, the value of life would yield to the collective weight of the values of autonomy (as expressed in that person’s choice to die) and reducing suffering.

Drawing on this balancing exercise, we argue it is justifiable, based on the values expressed, to permit assisted dying but limit access to those who have a medical condition that will cause their death (we also propose that there must be intolerable suffering as well and this is discussed below). The values do not, however, provide guidance as to how this medical condition criterion should be operationalised. To do this, we consider existing assisted dying models and how they have functioned in practice.

There is considerable variation in the legislative models about the qualifying medical condition that a person must have, and whether the condition must result in the death of the person (or their death within a certain period). In some jurisdictions, there is a requirement that the person has a terminal illness and be expected to die within a specified period (often six months) as in the United States jurisdictions. Other models require that the person have a serious and incurable condition and that the person be at the end of their life, without expressly requiring that there be a causal link between the two (Victoria and Quebec). The relevant medical condition in Canada is that the person has a ‘grievous and irremediable condition’. This condition is defined to mean that the person (among other things) has a ‘serious and incurable illness’, is in an ‘advanced state of irreversible decline’ and his or her ‘natural death’ is ‘reasonably foreseeable’. In the South Australian bill, the person had to have an ‘incurable medical condition’ that would cause the person’s death. In Belgium, the person must have a

146 In Oregon, for example, a person may request medication for the purpose of ending life only if he or she has a ‘terminal illness’; ‘terminal illness’ is defined to mean ‘an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months’: *Death with Dignity Act*, Or Rev Stat § 127.80 2.01 and 1.01 (1994).
‘medically futile condition’ while in Netherlands legislation does not contain a required condition.

We favour requiring a ‘serious and incurable medical condition that will cause the person’s death’. A medical condition should be regarded as ‘incurable’ by reference to available medical treatment of a kind that is acceptable to the person. For example, if a patient with cancer has already undergone two rounds of chemotherapy, the condition should not be regarded as ‘curable’ if he or she does not wish to undergo further chemotherapy. For a range of reasons, we also do not impose a time limit or require a particular proximity to death. First, the balancing of values exercise undertaken above does not point to the need for a specified period of time. Secondly, it is difficult to predict with any certainty when a person is likely to die, making the eligibility certification a challenging if not impossible task for the doctor.147 Thirdly, a practical harm that can occur when temporal limits are imposed is that people who have a relevant medical condition that will cause their death but are outside the relevant time period may choose to starve themselves until they are close enough to death that the time condition is satisfied.148

The proposed criterion will enable people with fatal illnesses such as cancer, motor neurone disease (MND) and dementia (provided he or she retains capacity) to obtain assistance to die. We note that the application of our proposed criterion would also include a person with a medical condition such as quadriplegia who required artificial nutrition and hydration to survive.149 In such a case, the medical condition of quadriplegia would, without medical intervention (namely the artificial hydration and nutrition), result in the person’s death. This criterion would therefore be satisfied if that person was of the view that the medical treatment was unacceptable to him or her and he or she would die as a result of not having it. This may be troubling to some, for example, on the basis that allowing access for people with a disability in this way would devalue their and others’ lives. However, the values of equality and the rule of law would argue against excluding a group of people who would otherwise fall within this


149 This was the condition of Mr Rossiter in the case of Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84 (discussed above).
criterion on the basis of disability. If a person with a disability has a medical condition which, if untreated, would result in death, and that person satisfies the other eligibility requirements, we consider there to be no justification for excluding that person from assisted dying should they choose it.

**Nature of suffering**

In our model, the person must be ‘suffering’ as well as meeting the ‘medical condition’ criterion to qualify for assistance to die. This is because, as noted above, where these criteria are both met, the values of autonomy and reducing suffering are engaged together to outweigh the value of life. Focusing on the issue of suffering, we argue that where a person has intolerable suffering, it is open to them to conclude that the disvalue of continued life diminishes the weight that should be attached to the value of life and/or that the value of reducing suffering takes on increasing weight when balanced against the value of life.

The balancing of these values can also shed some light on how this criterion of ‘suffering’ should be conceptualised. First, because the above rationale for eligibility requires both suffering and a particular medical condition, it is appropriate to require that the suffering be caused by the medical condition or, we would argue, the treatment of the medical condition. Suffering that arises from a cause unrelated to the medical condition that will lead to death is not sufficient to outweigh the value of life. Secondly, the degree of suffering must be sufficiently high and of an enduring nature for the values of autonomy and reducing suffering to trump the value of life. Suffering that is fleeting and not sustained would be insufficient. Similarly, suffering that is not significant, as judged by the individual (see further below), would not qualify.

We suggest ‘intolerability’ as an appropriate standard, but note that the legislative models employ a variety of different expressions to describe the standard of suffering required including ‘unbearable’ (Victoria, Quebec, Netherlands and Belgium), ‘intolerable’ (South Australia), ‘severe’ (Northern Territory), and ‘intolerable’ (Canada). For the most part, relevant regimes recognise (either expressly or implicitly) that the patient should be the one to assess whether that standard of suffering is met, and we endorse this approach. Only a subjective assessment of the relevant standard of suffering promotes the value of autonomy.

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150 Note that in the United States jurisdictions where the individual must have a ‘terminal illness’, there is no requirement for the person to demonstrate ‘suffering’.
Most models also require the suffering to be enduring, for example by stating that the suffering be ‘constant’ (Belgium and Quebec), ‘lasting’ (Netherlands) or ‘enduring’ (Victoria). The authors favour a model that requires the suffering to be ‘enduring’.

The final issues to be resolved here are the nature of the suffering required (physical or broader) and who assesses whether the suffering is sufficient. Here, the value of reducing human suffering is engaged. As a society, we care about individuals who are suffering as a result of a serious medical condition, and we strive to reduce their suffering. People can and do suffer in different ways: some physically and others psychologically. We argue that we should not distinguish between different kinds of suffering. Recognising only physical suffering would fail to adequately reduce suffering. We therefore favour a model that recognises suffering, whether that be physical, psychological, or existential, that is intolerable to the person. We note that this reflects the approach in most of the legislative models. Some models refer only to the term ‘suffering’ and it is clear from the context that the term encompasses more than physical pain (Northern Territory, Netherlands, Victoria and South Australia). Other models use express terms to include mental (Belgium) or psychological (Canada and Quebec) suffering.

To summarise then, we propose that the relevant threshold be that of ‘intolerable’ and ‘enduring’ suffering which can be physical, psychological or existential, caused by either the medical condition or the available treatment, and assessed by the individual him or herself. Only if these conditions are satisfied, would the values of autonomy and reducing suffering justifiably prevail over that of life.

Safeguards

A legislative framework permitting assisted dying must have appropriate checks and balances to ensure that only individuals meeting the eligibility criteria outlined above can receive assistance. These safeguards promote the value of the rule of law by establishing processes to ensure legal criteria are met. They also provide assurance that the value of life is promoted, and only overtaken by the values of autonomy and reducing suffering for the limited class of individuals who satisfy the eligibility criteria. In so doing, these safeguards also play an important role in protecting the vulnerable so that only competent individuals acting voluntarily, having access to all relevant information, can seek assistance to die. Further, they ensure the request is truly an autonomous one and so promote the value of autonomy. Balance in designing safeguards is important. If they are too prescriptive (difficult to satisfy), the value of autonomy will not be promoted. And if they are too easily satisfied, there will be no
confidence that the criteria of the legislation are being complied with which will undermine values such as those of life, protecting the vulnerable and the rule of law.

While the values lead us to the conclusion that robust safeguards are needed, they are of limited use in articulating precisely what those safeguards should be. So in making the recommendations below, we are guided both by various legislative models as well as international experience regarding the effectiveness and operation of those safeguards. We address a number of safeguards that are routinely found in assisted dying models: who should be involved with ensuring that the eligibility requirements are satisfied and that the request is voluntary; information that should be provided to the person; and waiting periods or other measures for assessing the enduring nature of the request.

Assessment of eligibility regarding medical condition and suffering

International models have similar safeguards to ensure eligibility regarding the medical condition. In the Victorian, South Australian and Northern Territory models, two doctors must independently confirm the diagnosis and prognosis; in the Netherlands, Oregon and Quebec, two doctors must be involved (and under the federal Canadian law, the two practitioners can be either a doctor or a nurse practitioner); and in Belgium, two doctors assess eligibility although a third doctor is required if the person is not expected to die in the near future. In terms of suffering, although we recommend a model that intolerable suffering be assessed by the person, the doctors must also be satisfied that the person has reached this view. We favour a model which requires eligibility regarding the medical condition to be confirmed by two doctors who are independent of each other following an examination of the patient and review of the patient’s medical record by each doctor. Both doctors should also confirm that the patient has assessed his or her suffering as intolerable.

Assessment of capacity and voluntariness of the request

Under the legislative models described above, this assessment is generally undertaken when eligibility about the medical condition is being considered. There is some variation across models though. For example, under the Victorian and South Australian models, a psychiatrist must also be involved if there are concerns about capacity and, in South Australia at least, about
the voluntariness of the request.\textsuperscript{151} The authors recommend that two doctors must confirm capacity of the patient and the voluntariness of the request but, if there is doubt regarding either, a doctor with relevant expertise should also be involved to assess the patient and their request. Most cases will not give rise to such doubts so the two doctors dealing with other eligibility issues can adequately assess these matters. However, further and specialised assessment is needed to ensure the decision is truly autonomous where there are doubts about the person’s capacity and/or the voluntary nature of his or her decision. This may be undertaken by a psychiatrist where he or she possesses the necessary expertise required for the case but it could also be undertaken by, for example, a geriatrician with particular experience in assessing capacity of older people.

\textit{Assessment of the enduring nature of the request}

Autonomy is advanced where requests for assistance to die are settled and non-ambivalent. A model which acted on a fleeting or ambivalent request would also not uphold the values of life and protecting the vulnerable. We argue therefore that the request for assistance to die must be enduring. Most legislative models contain some mechanism to prevent assistance being given to a person after just one request. Some of the models (Northern Territory, South Australia, Oregon and Canada) set out waiting periods, while others indicate that the request must be settled in other ways (Victoria – request must be ‘enduring’ and a reasonable amount of time has passed between the request and provision of the drug; Quebec – the wish is ‘unchanged’ and the doctor must talk to the patient ‘at reasonably spaced intervals’; Belgium – request must be ‘durable’). There is no waiting period in the Netherlands, the only requirement being that the request is ‘well-considered’.

We propose that a person must make a formal request after doctors have assessed that person to be eligible, and that assistance to die be provided only after a specified time period passes after that request and the individual then reconfirms their desire for assistance. This delay and reconfirmation would provide confidence that the request was enduring. A period of 15 days is common in other legislative regimes and may be an appropriate time between an eligible request and the provision of assistance to die after reconfirmation.

\textsuperscript{151} Note that only general principles were set out in the recommendations of the Victorian Parliamentary Committee so it is not clear whether a referral to a psychiatrist is required where the doctor has concerns about the voluntariness of the person’s request.
However, the model should also contain discretion in limited cases both in relation to the specified period and the reconfirmation requirement where the doctors are satisfied that the request is enduring. For example, if the patient is expected to die before the specified period has passed, that time could be abridged if the doctor were satisfied that the request was an enduring one. Also, if the person loses capacity after making the formal request, for example as a result of receiving high doses of medication to relieve their pain, and so reconfirmation is not possible,\textsuperscript{152} assistance should still be allowed provided the doctor remains satisfied of the enduring nature of the request.

\textit{Information to be provided}

To promote the value of autonomy, the person should be provided with relevant information so that a request to receive assistance to die is fully informed. This is a feature of all legislative models. Although there are some minor variations across jurisdictions, generally doctors must provide the following information to the patient: the patient’s diagnosis and prognosis; treatment options available and their likely results; palliative care options and their likely results; the medical procedure that will be used to assist a person to die and the likely risks and results; and that the person is able to rescind the request at any time. We recommend that legislation contain a requirement for two doctors to be satisfied that this information has been provided to the patient.

\textit{Oversight}

An assisting dying regime needs robust oversight mechanisms to ensure that the framework operates as parliament intends. In doing so, this oversight promotes all of the values that underpin our proposed legislative model. But robust oversight mechanisms especially advance particular values. One is the rule of law. This value is promoted where oversight mechanisms monitor not only individual deaths but also any systemic issues that may arise when a legislative model is implemented. Oversight mechanisms also promote the values of life and protecting the vulnerable by reviewing the circumstances surrounding each death to ensure that assistance is provided only in accordance with the requirements of the legislation. The value of autonomy is promoted by reviewing evidence of an autonomous choice to seek assistance to die.

\textsuperscript{152} This issue is raised in Downie, ‘Medical Assistance in Dying: Lessons for Australia from Canada’, above n 148.
There are two main options for oversight mechanisms: prospective or retrospective review. As their description suggests, a prospective oversight mechanism requires an independent party to review the facts *prior* to the provision of assistance to die, while a retrospective model will review evidence after death occurs. There are also a range of possibilities in terms of the body that is charged with the oversight: should existing structures be used, or new bodies established?

As was the case for safeguards, while the articulated values point to establishing robust oversight mechanisms, they do not necessarily provide precise guidance as to what that system might look like. That said, we suggest that one value – reducing suffering – is relevant to the question of the timing of the review of decision-making. The proposed legislative model requires at least two independent doctors to be satisfied of eligibility, part of which is to be satisfied of the intolerable nature of the patient’s suffering. Given this safeguard, the value of reducing suffering points us towards a retrospective model rather than requiring further delay for the person who is in this intolerable state while yet another body be satisfied that he or she is eligible to receive assistance.

In terms of the body charged with oversight, we considered a variety of established or proposed models. Under the Northern Territory and proposed South Australian models, deaths are monitored by the Coroner while in Victoria, the recommendation is to report the death to a proposed Assisted Dying Review Board. International models include reporting to a Regional Review Committee through a municipal pathologist (Netherlands), the Federal Control and Evaluation Commission (Belgium), the Department of Human Services (Oregon) and the Commission on End of Life Care (Quebec). Under all of these models, reporting of the assisted dying occurs retrospectively.

We favour the establishment of a new retrospective review body dedicated to overseeing an assisted dying regime. We do note that responsibilities for reviewing individual deaths and also systemic issues around the operation of the legislation align well with the existing responsibilities of the Office of Coroner. Coroners also currently have duties and powers in relation to investigating certain types of deaths as well as making recommendations about systems improvement arising from the deaths investigated. However, oversight by the Coroner is not our favoured approach primarily because we do not consider deaths that result from a practice that is recognised as lawful should be in the same category as ‘reportable deaths’
currently investigated by Coroners (which sometimes includes connotations of these deaths being ‘suspicious’).

By contrast, there are advantages of establishing a dedicated body (such as a review board) with sole responsibility for oversight of an assisted dying framework. This removes questions or associations of unlawful or inappropriate behaviour and the body’s focus on assisted dying means it could be comprised of people with specific and relevant expertise in this area. The body’s functions could include independent review of assisted dying cases (retrospectively), systems-level monitoring of the assisted dying regime (including the ability to make recommendations for systemic reform), and appropriate data collection and reporting.

**Role of conscience**

As discussed in the core values section, there is a long-recognised ethical principle that a doctor may refuse to provide a lawful medical service that is contrary to his or her conscience. Yet refusing to provide assistance to die has potentially significant implications for an eligible patient, particularly if the objecting doctor has been responsible for the patient’s ongoing care or is the only doctor who could provide treatment for the patient due to location (for example, in regional and remote areas).

The value of conscience supports doctors not being required to participate in assisted dying where doing so contradicts their conscience (although as we noted above, for some doctors, conscience points to being able to provide assisted dying for patients). However, other important values compete with conscience. The value of autonomy is not promoted if a doctor is permitted to deny an eligible request for assistance to die on the basis of his or her views. The same is true for the value of reducing suffering if a patient with intolerable suffering is denied access to a lawful medical service. Finally, the value of equality is implicated. Some eligible patients may be less able to physically seek assistance elsewhere than others who, for example, may be able to discharge themselves from one doctor’s care to travel to another doctor. Other equality considerations can also arise including the more limited access to medical care and an alternative doctor that can arise from living in a regional or remote area.

In balancing these conflicting values, we consider that a legislative model should excuse a doctor from participation if that is inconsistent with their conscience. However, an objecting doctor should be obliged to transfer the patient’s care (including advising of the request for assistance to die) to a doctor who is willing to assist, and the state should establish a transfer
of care system so as to protect the conscience of objecting doctors while ensuring access for patients. Such a position would respect the value of conscience but not allow it to trump the other values outlined above which require that eligible patients be able to access to a lawful medical service.

Conclusion

Whether or not the law in Australia should be reformed to permit assistance to die is hotly contested. All would agree that individuals should receive the highest possible medical care as they approach the end of their lives. And, for the most part, good quality medical care should enable seriously ill patients to experience good deaths. However, that is not always the case, and some individuals experience intolerable suffering at the end of their lives. This suffering causes trauma to the patients themselves, their families and can lead to distress for their treating teams. Consensus will never be reached on how the law should respond to calls for reform. There will always be tensions between those who believe that a law that permits intentional killing is wrong, and those who believe that such a law can not only be justified but is necessary in a compassionate society.

In this chapter, we have sought to move this debate forward in two ways. We have first articulated a set of core values that we believe should underpin how assisted dying is regulated, and then proposed a legislative model that seeks to promote and balance these values in a principled way. This chapter is published at a critical time in our history. Legislators across the country are determining whether or not assisted dying laws should be introduced, and the nature of those laws. We offer the values and model articulated in this chapter for their consideration.
(FAILED) VOLUNTARY EUTHANASIA LAW REFORM IN AUSTRALIA: TWO DECADES OF TRENDS, MODELS AND POLITICS

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1 INTRODUCTION

Euthanasia remains a topical issue in Australia. Legislative attempts to reform the law occur regularly. In 2013 alone, three Bills seeking to legalise voluntary euthanasia (‘VE’) or physician-assisted suicide (‘PAS’) were introduced into different state parliaments; and two issues and background papers were written to inform those debates. In June 2014, the Australian Greens Senator and now leader of that party, Richard Di Natale, released an exposure draft of a Bill for consultation which would enable an Australian resident to

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The authors wish to thank Stephanie Jowett for her research assistance. This article is an accurate statement of the law as at 31 December 2015.

1 Ending Life with Dignity Bill 2013 (SA); Rights of the Terminally Ill Bill 2013 (NSW); Voluntary Assisted Dying Bill 2013 (Tas).
receive assistance to die. In May 2015, the Victorian Legislative Council directed the Standing Committee on Legal and Social Issues to report on the need for laws to allow citizens to make ‘end-of-life choices’ (a reference that is sufficiently broad to include VE and PAS). Most recently, in December 2015, Senator David Leyonhjelm from the Liberal Democratic Party introduced a Bill into the Senate seeking reform in this field. VE and PAS also became a critical policy platform for political parties during the 2013 federal election. Discussion of these issues remains prevalent in the media. In part, this is fuelled by the not infrequent prosecutions of family members, friends and medical practitioners who have been involved with the death of persons who were terminally ill or who otherwise requested assistance to terminate their own life.

This issue is also topical internationally, as we witness a trend towards the legalisation (or decriminalisation) of VE and PAS. There has been legislative reform in the Netherlands, Belgium, Luxembourg, the United States (Oregon, Washington, Vermont and California) and in Canada (Quebec). Assisting another to die is also lawful in Switzerland provided the assistance is not given in a medical context.

4 Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015.
8 Wet toetsing levensbeëindiging op verzorg en hulp bij zelfdoding 2000 [Termination of Life on Request and Assisted Suicide Act 2000] (Netherlands).
for ‘selfish motives’. Last year, the Canadian Supreme Court held unanimously that criminal law provisions prohibiting physician assistance in dying contravened rights conferred by the Canada Act 1982 (UK) c 11, schedule B part I (‘Canadian Charter of Rights and Freedoms’). In some jurisdictions, such as in British Columbia in Canada and the United Kingdom, VE and PAS have been the subject of specific prosecutorial guidelines.

16 The Strafgesetzbuch [Criminal Code] (Switzerland) was not specifically amended (ie, after its enactment) to permit assisted suicide for unselfish reasons. In the first draft of the Bill in 1893 prepared by its progenitor, Carl Stooss, the draft code prohibited assisted suicide for all reasons. However, a criminal law professor, Ernst Hafter, before the adoption of the draft code, argued that only where a person provides assistance to suicide for selfish motives should they be exposed to criminal penalties. Hafter’s arguments stimulated debate, and were taken into account by the draft code prepared by the Federal Council in 1918 under the then art 102. The debate surrounding the inclusion of the selfish motives clause within the draft code, surprisingly, did not entail any material discussion of medically assisted dying (unlike the present art 114), but rather focused on the philosophical complexities of criminalising the assistance of a non-criminal act, and romantic notions appertaining to ‘honour’ suicides, or the suicide of rejected lovers. The draft code was adopted by referendum in 1938, which included the amended provisions, and entered into force in 1942. Therefore, the ‘selfish reasons’ element has always been present in Swiss law since the codification of the criminal law: Olivier Guillod and Aline Schmidt, ‘Assisted Suicide under Swiss Law’ (2005) 12 European Journal of Health Law 25; National Advisory Commission on Biomedical Ethics, Assisted Suicide (Opinion No 9/2005, 27 April 2005) 31 <http://www.nek-cne.ch/fileadmin/nek-cne-datenen/Themen/Stellungnahmen/en/suizidbeihilfe_en.pdf>. For a critique of these guidelines, see Jocelyn Downie and Ben White, ‘Prosecutorial Discretion in Assisted Dying in Canada: A Proposal for Charging Guidelines’ (2012) 6(2) McGill Journal of Law and Health 113.

17 Carter v A-G (Canada) [2015] 1 SCR 331.


19 In R (Pretty) v DPP (UK) [2002] 1 AC 800 and Pretty v United Kingdom [2002] III Eur Court HR 427, the House of Lords and the European Court of Human Rights rejected the existence of a right to PAS or VE. However, in R (Purdy) v DPP (UK) [2010] 1 AC 345, the House of Lords concluded that, pursuant to arts 8(1)–2 of the Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 UNTS 222 (entered into force 3 September 1953), as amended by Protocol No 14bis to the Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 27 May 2009, CETS No 204 (entered into force 1 September 2009) (‘European Convention on Human Rights’), the code for Crown Prosecutors was required to provide greater guidance to promote accessibility and foreseeability in prosecutions, and therefore a more specific policy identifying the facts and circumstances relevant to the institution of criminal proceedings should be established. For the prosecutorial guidelines, see Director of Public Prosecutions (UK), Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (February 2010) Crown Prosecutor Service <http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html>. For commentary on these guidelines, see Ben White and Jocelyn Downie, ‘Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide: Autonomy, Public Confidence and High Quality Decision-Making’ (2012) Melbourne University Law Review 656; Penney Lewis, ‘Informal Legal Change on Assisted Suicide: The Policy for Prosecutors’ (2011) 31 Legal Studies 119; Glenys Williams, ‘Assisting Suicide, the Code for Crown Prosecutors and the DPP’s Discretion’ (2010) 39 Common Law World Review 181; Alexandra Mullock, ‘Overlooking the Criminally Compassionate: What Are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?’ (2010) 18 Medical Law Review 442.
Within Australia, there have been many attempts to pass VE legislation. From 16 June 1993 until the date of writing, 51 Bills have been introduced into Australian parliaments dealing with legalising VE or PAS. Despite these numerous attempts, the only successful Bill was the Rights of the Terminally Ill Act 1995 (NT) (‘ROTTIA’), which was enacted in the Northern Territory, but a short time later overturned by the controversial Euthanasia Laws Act 1997 (Cth). Yet, in stark contrast to the significant political opposition, for decades Australian public opinion has overwhelmingly supported law reform legalising VE or PAS.

While there is ongoing debate in Australia, both through public discourse and scholarly publications, about the merits and dangers of reform in this field, there has been remarkably little analysis of the numerous legislative attempts to reform the law, and the context in which those reform attempts occurred. The aim of this article is to better understand the reform landscape in Australia over the past two decades. The information provided in this article will better equip Australians, both politicians and the general public, to have a more nuanced understanding of the political context in which the euthanasia debate has been and is occurring. It will also facilitate a more informed debate in the future.

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21 Within this figure of 51, the authors have included the attempts at a Commonwealth level to abolish the Euthanasia Laws Act 1997 (Cth) which deprives the territories of the power to pass legislation legalising VE or PAS.

22 In 1962, the earliest Morgan Gallup poll indicated VE support was at 47 per cent. Similar polls were conducted on a regular basis until 1995 when public support for VE had increased to 78 per cent: Margaret F A Otlowski, Voluntary Euthanasia and the Common Law (Clarendon Press, 1997) 263. More recent polls from varying sources (Morgan Poll, Newspoll and other independently administered surveys) in 2002–12 indicate that national support has varied between 78 per cent and 85 per cent: Your Last Right, Australian Public Desire for Legalisation of Assisted Dying in Restricted Circumstances (White Paper, 2012) <http://www.dwdnsw.org.au/documents/2013/POLL%20WHITE%20PAPER%202012.pdf>; South Australian Voluntary Euthanasia Society, Public Opinion Polls on Voluntary Euthanasia Law Reform in Australia (Fact sheet No 02, 2012) <http://www.saves.asn.au/facts/fs02.pdf>.


article seeks to achieve this aim by considering two separate but related aspects of the reform attempts. First, in Part III, the authors chart the many legislative attempts to reform the law over the previous two decades (including the circumstances surrounding the passage of the Northern Territory legislation and its demise when overturned by the Commonwealth Government), and the jurisdictions in which these reform attempts are occurring. Part III then considers some political dimensions of the debate including who has been proposing reform, relevant political affiliations and the role, more broadly, that party politics has played in the past and may play in the future. That Part also provides a detailed analysis of how far the Bills progressed through parliaments and how they were disposed of. Finally, through an analysis of parliamentary records, the authors have identified which Bills came close to passing, and comment on whether any conclusions can be drawn from the fact that these particular Bills had a greater level of political support.

The second way in which this article seeks to deepen understanding is through an in-depth examination of the 51 Bills. If there is to be legislative reform in Australia, there will and should be close scrutiny and debate about the details of the Bills. As we shall see in Part IV, there can be significant variation in the content of the legislative proposals which affects, in important ways, how the regimes would operate. Decisions made about the content of the Bill will affect issues such as eligibility criteria (restricted to adults with capacity who are terminally ill and seek assistance to die, or available to a broader cohort), safeguards (involvement of treating doctor only, or should other specialists be involved), and state oversight (should each death be independently reviewed to ensure compliance with the regime, and should such review be prospective or retrospective). Yet, to date, there has not been a comprehensive analysis of how the Australian Bills have dealt with these and other issues. We do not know whether there has been general consensus or diversity on these and other critical points in the Bills to date. A consensus in some areas but variation in others, if this is the case, may signal the issues on which there might be particular focus when these Bills are debated in future years. Part IV analyses in detail the various legislative models and notes those areas of convergence and divergence. In this analysis, particular mention is made of the features of the Bills identified in Part III as ‘close to passing’. In Part V, the authors make some concluding remarks about the Australian reform experience to date, and speculate about the implications that this may have for reform attempts in the future.

We begin, however, in Part II, by defining frequently used terms. In this debate, people can be at cross-purposes because of different understandings of the same term. It is important to clarify what we mean in this article when we use various terms.
II TERMINOLOGY

Both in Australia and overseas, the VE and PAS debates have been undermined by semantic ambiguity. We therefore seek to clarify what we mean when we refer to the terms included in the table below.25

Table 1: Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthanasia</td>
<td>For the purpose of relieving suffering, a person performs a lethal action with the intention of ending the life of another person</td>
<td>A doctor injects a patient with a lethal substance to relieve that person from unbearable physical pain</td>
</tr>
<tr>
<td>Voluntary euthanasia ('VE')</td>
<td>Euthanasia is performed at the request of the person whose life is ended, and that person is competent</td>
<td>A doctor injects a competent patient, at their request, with a lethal substance to relieve that person from unbearable physical pain</td>
</tr>
<tr>
<td>Competent</td>
<td>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</td>
<td>A doctor injects a patient in a post-coma unresponsive state (sometimes referred to as a persistent vegetative state) with a lethal substance</td>
</tr>
<tr>
<td>Non-voluntary euthanasia</td>
<td>Euthanasia is performed and the person is not competent</td>
<td>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</td>
</tr>
<tr>
<td>Involuntary euthanasia</td>
<td>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 does not die</td>
<td>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</td>
</tr>
</tbody>
</table>

25 This table is based on that included in White and Willmott, above n 2, 412.
26 Note that the authors do not include within this definition positive steps taken by a person to stop treatment which results in death (such as removing a breathing tube). In this regard, see further our definition of ‘withholding or withdrawing life-sustaining treatment’ below and accompanying footnote references.
### III LEGISLATIVE AND POLITICAL HISTORY IN AUSTRALIA

This Part of the article analyses the many attempts to reform euthanasia law in Australia’s states and territories. It commences with a detailed consideration of the first attempts to introduce VE laws and the circumstances surrounding the enactment of the Northern Territory legislation and its overturn, and then provides an overview of all reform attempts in Australia. Importantly, this Part extends beyond a description of the legislative attempts and unpacks some of the politics associated with the euthanasia reform efforts: political affiliations of proponents, voting trends of members of parliament (along party lines or not) and, more generally, the role politics has played in euthanasia reform in Australia. Next, this Part charts how far the various Bills progressed, and identifies seven Bills that garnered the most political traction. Based on identification and analysis of these seven Bills, this Part concludes with some

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<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withholding or withdrawing life-sustaining treatment</td>
<td>Treatment that is necessary to keep a person alive is not provided or is stopped</td>
<td>Withdrawing 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. Withholding 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.</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>A competent person dies after being provided by another with the means or knowledge to kill him- or herself</td>
<td>A friend or relative obtains a lethal substance (such as Nembutal) and provides it to another to take.</td>
</tr>
<tr>
<td>Physician-assisted suicide (‘PAS’)</td>
<td>Assisted suicide where a doctor acts as the assistant</td>
<td>A doctor provides a person with a prescription to obtain a lethal dose of a substance.</td>
</tr>
</tbody>
</table>

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27 This is sometimes referred to as ‘passive euthanasia’ as the death arises from not giving life-sustaining treatment. There has been considerable debate concerning whether withdrawing life-sustaining treatment can relevantly be distinguished from giving a lethal injection. We will not discuss that controversy here because we are concerned with how VE has been understood in the context of the legislative reforms that have been proposed. For discussion of the debate, however, see Andrew McGee, ‘Does Withdrawing Life-Sustaining Treatment Cause Death or Allow the Patient to Die?’ (2014) 22(1) Medical Law Review 26; Andrew McGee, ‘Acting To Let Someone Die’ (2015) 29 Bioethics 74.
observations and speculation about what factors may be influential in achieving reform.

A Early Years of Reform (Attempts)

The first VE Bill introduced into any Australian parliament was the Voluntary and Natural Death Bill 1993 (ACT). The Bill was introduced into the Legislative Assembly of the Australian Capital Territory by Michael Moore (independent) on 16 June 1993. The Bill was designed to achieve three purposes: (a) to facilitate VE in limited circumstances; (b) to permit a doctor to withhold or withdraw treatment in limited circumstances; and (c) to enable a person to give a direction about future treatment to operate when that person becomes incompetent. When the Bill was introduced, the matter was referred to the Select Committee on Euthanasia, chaired by Michael Moore, whose report was tabled in Parliament on 14 April 1994. The Select Committee concluded that it would not be appropriate and politically inopportune to pass legislation to allow for VE, and the Bill was discharged from the notice paper by Michael Moore on 11 May 1994 prior to the 1995 election. In coming years, Michael Moore would introduce into the Legislative Assembly four further Bills to legalise or decriminalise euthanasia.

On 22 February 1995, soon after the discharge of the Voluntary and Natural Death Bill 1993 (ACT), the Chief Minister of the Northern Territory, Marshall Perron, tabled a private member’s Bill to legalise VE and PAS. On the same day, that Bill was referred to a Northern Territory Select Committee on

29 See Voluntary and Natural Death Bill 1993 (ACT) long title, cl 4.
30 See Voluntary and Natural Death Bill 1993 (ACT) long title, cl 21. This aspect of the proposed Bill clarified the common law position that withholding and withdrawing treatment was lawful in some circumstances.
31 Voluntary and Natural Death Bill 1993 (ACT) cls 4–6.
32 Australian Capital Territory, Parliamentary Debates, Legislative Assembly, 14 April 1994, 818 (Michael Moore).
34 Ibid.
36 Despite the Voluntary and Natural Death Bill 1993 (ACT) being discharged, Parliament enacted the Medical Treatment Act 1994 (ACT) which was limited to the withholding and withdrawal of medical treatment, and the making of directions and powers of attorney in relation to withholding and withdrawal of treatment that would apply after the patient has lost capacity.
37 Medical Treatment (Amendment) Bill 1995 (ACT); Medical Treatment (Amendment) Bill 1997 (ACT); Euthanasia Referendum Bill 1997 (ACT); Crimes (Assisted Suicide) Bill 1997 (ACT).
38 Interestingly, Marshall Perron is the only member affiliated with the Liberal Party (he was the leader of the Country Liberal Party in the Northern Territory) to have introduced a Bill pertaining to VE.
Euthanasia for consideration. The report of the Committee, which was tabled in May 1995, provided no specific recommendations regarding whether legislation permitting VE should be introduced, although it recommended amendments to the initial Bill. On 24 May 1995, Marshall Perron resigned as Chief Minister, indicating that he did not want his position to influence the manner in which the members of his party voted. After extensive debate, the Assembly divided and on a vote of 13:12, the Bill passed the second reading stage. After a debate extending into the early morning of 25 May 1995, the Bill passed the committee stage and third reading on a vote of 15:10. With the enactment of the ROTTIA, the Northern Territory became the first, and only, jurisdiction within Australia to introduce legislation for VE. It also became the first jurisdiction in the world to establish a legislative regime that permitted the practice.

However, the ROTTIA did not last long on the statute book. On 9 September 1996, Liberal Party member, Kevin Andrews, introduced into the Commonwealth Parliament the controversial Euthanasia Laws Bill 1996 (Cth) which sought to amend the territories’ Self-Government Acts to deprive them of their capacity to pass VE or PAS legislation. Despite serious remonstrations by the Northern Territory and the Australian Capital Territory Governments, on 9 December 1996, the Euthanasia Laws Bill 1996 (Cth) passed the second reading stage 90:39, and passed the committee and third reading stages with a resounding 88:35 majority. The Bill was introduced into the Senate on 12 December 1996 by Senator John Herron of the Liberal Party. On 24 March 1997, the Bill passed the second reading and third reading stages without amendment 38:33. The Euthanasia Laws Act 1997 (Cth) came into effect on 27 March 1997, amending the territory Self-Government Acts and dismantling the ROTTIA. Since the passage of the Euthanasia Laws Act 1997 (Cth), there have been six unsuccessful attempts by members of the Australian Democrats and Australian Greens to remove the limitation on the legislative power of the

40 Ibid 2505–28 (Shane Stone).
42 Northern Territory, Parliamentary Debates, Legislative Assembly, 24 May 1995, 3734.
43 Ibid 3782.
44 Northern Territory (Self-Government) Act 1978 (Cth); Australian Capital Territory (Self-Government) Act 1988 (Cth); Norfolk Island Act 1979 (Cth).
49 Commonwealth, Parliamentary Debates, Senate, 24 March 1997, 2326 (Margaret Reid).
50 Ibid 2331 (Margaret Reid).
51 Euthanasia Laws Act 1997 (Cth) s 2.
53 These Bills have been:
territories. Most recently, in December 2015, a member of the Liberal Democratic Party introduced a Bill into the Senate seeking to do the same.54

**B Trends in Legislative Attempts**

There have been 51 Bills introduced into the various Australian parliaments since 1993. The names of these Bills, when, where and by whom they were introduced are listed in the Appendix. Seven of these Bills sought to remove the prohibition on territories legislating in this area and a further five sought to hold a referendum on law reform. The remaining 39 Bills proposed a model for law reform permitting VE and/or PAS.

Figure 1 provides a graphic illustration of the number of these VE Bills introduced and the year of their introduction.

Figure 1: Number of VE/PAS Bills Introduced into Australian Parliaments

As demonstrated by the trendline,55 the number of Bills introduced has been progressively increasing. The increasing trend is significant having regard to the

- Australian Territories Rights of the Terminally Ill Bill 2007 (Cth), introduced by Bob Brown: Commonwealth, Parliamentary Debates, Senate, 8 February 2007, 17 (Bob Brown);
- Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 (Cth), introduced by Bob Brown: Commonwealth, Parliamentary Debates, Senate, 14 February 2008, 335 (Bob Brown);
- Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2008 (Cth), introduced by Bob Brown: Commonwealth, Parliamentary Debates, Senate, 17 September 2008, 4983 (Bob Brown);
- Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010 (Cth), introduced by Bob Brown: Commonwealth, Parliamentary Debates, Senate, 29 September 2010, 304 (Bob Brown); and

54 Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015. This Bill is still before the Senate.
fact that, since 1997, no Australian territory has been able to introduce a VE Bill due to the effect of the *Euthanasia Laws Act 1997* (Cth). Furthermore, between 1993 and 1997, the Northern Territory and the Australian Capital Territory introduced two and five VE Bills respectively into parliament, in contrast to the states’ and Commonwealth’s average of 0.67 Bills per jurisdiction over this same five-year period. The territories, rather than the states, were more active in introducing VE initiatives prior to the *Euthanasia Laws Act 1997* (Cth). Indeed, the significant decline in the number of Bills introduced between 1998 and 1999 directly correlates with the reduction in legislative attempts in the territories’ parliaments. Since 1998, the states and the Commonwealth have assumed a more active role in introducing an average of 2.22 Bills each year. Since 2007, the average has increased to 2.7 Bills each year across Australia. South Australia (20), New South Wales (8) and Western Australia (6) have led the states in introducing VE Bills. Tasmania has introduced two VE Bills, Victoria has only introduced one Bill, and Queensland is the only jurisdiction never to have introduced a VE or PAS Bill. There have been seven attempts at a federal level to abolish the *Euthanasia Laws Act 1997* (Cth).

### C Politics of Euthanasia Law Reform

The politics of euthanasia law reform – in particular, the extent to which euthanasia has been a political issue and the reason that this has (or has not) been the case – has received remarkably little attention in the Australian literature. This article does not aim to fill that gap in the literature, but in this section, we provide information about the political positions taken (or not taken) by Australian political parties, as well as the political affiliations of those members of parliament who have proposed reform. We provide an analysis of some of the voting patterns that have occurred, and make some observations about the political nature of the debate in Australia and the implications of this on the likelihood of reform.

Despite the ongoing and sustained media attention on VE and public support for reform, the largest political parties in Australia, the Liberal Party, the Australian Labor Party and the National Party, have not developed policy positions on the topic. This is in stark contrast to other parties that have deemed this to be an issue that should not be ignored. The Australian Greens have consistently supported VE since the party was formed in 1992, its policy being in

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55 A trendline is a simplified line of best fit demonstrating the direction of a correlation between a dependent and independent variable.
56 Between 1993 and 1997, 11 Bills were introduced into Australian parliaments. Seven were introduced in the Northern Territory and the Australian Capital Territory. The remaining four were introduced in the other six jurisdictions over this time period, making an average of only 0.67 Bills per jurisdiction.
57 This calculation is taken from 1998 to 2015.
58 The average number of Bills introduced into Australian parliaments between 2007 and 2013 was 3.29 annually. In 2014 and 2015, only one VE Bill was introduced.
favour of allowing terminally ill patients to seek assistance to die from their doctor. Historically, the Australian Democrats have also supported reform of the law, and more recently, the Australian Sex Party and the Liberal Democratic Party. Both the Christian Democratic Party and the Family First Party have adopted a position at the other end of the spectrum, and are strongly opposed to legalising VE.

The table below provides a breakdown of the VE Bills by affiliation of the proponent to a political party, if any, as well as by jurisdiction.

Table 2: Voluntary Euthanasia Bills by Political Affiliation of Proponent and Jurisdiction

<table>
<thead>
<tr>
<th>Number of Bills introduced</th>
<th>Cth</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Total</th>
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<tr>
<td>7</td>
<td>5</td>
<td>8</td>
<td>20</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Political Affiliation of Proponent</th>
<th>Cth</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Australian Democrats</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>9</td>
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<tr>
<td>Australian Greens</td>
<td>5</td>
<td>0</td>
<td>7</td>
<td>0</td>
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<td>1</td>
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<td>Australian Labor Party</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Country Liberal</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Liberal Democratic Party</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Australian Greens –Australian Labor Party Joint Bill</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

* All VE Bills introduced into Australian parliaments have been private members’ Bills.

As can be seen, the independents and the members of the Australian Greens and the Australian Democrats have been the major proponents of VE reform. The Australian Greens introduced their first VE Bill in 2001 in New South Wales, and have accounted for 37 per cent of all VE Bills introduced in parliaments.

across Australia, while the Australian Democrats have introduced 18 per cent. Independent members have been responsible for the introduction of 31 per cent of VE Bills. While this might seem significant, all independent VE Bills have been introduced by only two individuals, Michael Moore and Dr Bob Such. Indeed, it would seem that VE has primarily been the responsibility of individual members of parliament, with only 21 individuals having introduced all 51 Bills over the past 20 years. Only six Bills have been introduced by Australian Labor Party members. Significantly, only one Bill has been introduced by a member of a conservative political party, Marshall Perron, when he introduced the ROTTIA, the only Bill within Australia to have been successfully enacted.

Regardless of whether a political party has developed a policy position on VE or, if one has been developed, the stance taken, all parties have universally allowed conscience votes on the matter of VE. Nevertheless, there appears to be a strong correlation between party affiliation and voting preferences, and indeed, many decisions are determined virtually according to the chosen party lines. For example, in relation to the Euthanasia Referendum Bill 1997 (ACT), every Australian Labor Party member voted against the Bill, and every Liberal Party member (except one) voted against the Bill. Similarly, every Liberal and Australian Labor Party member voted against the Crimes (Assisted Suicide) Bill 1997 (ACT), a Bill that significantly mitigated penalties for medical practitioners engaging in VE, while every Australian Greens member supported the Bill. Similarly, when the Voluntary Euthanasia Trial (Referendum) Bill 2003 (NSW) was introduced, every Australian Greens and Australian Democrat member voted in favour of the Bill, and every member from the Liberal and Labor Parties voted against the Bill. The same occurred when voting on the Voluntary Euthanasia Referendum Bill 1997 (NSW). Furthermore, in both the Voluntary Assisted Dying Bill 2013 (Tas) and the Rights of the Terminally Ill Bill 2013 (NSW), all members of the Liberal Party voted against the proposed VE regimes. In recent times, Australian Labor Party members are more likely to have an even distribution of votes, but the tendency has continued for members of conservative political parties to vote against VE Bills.

62 Note that this includes the Voluntary Assisted Dying Bill 2013 (Tas), which was a joint initiative of the Australian Greens and the Australian Labor Party.
63 Note that this includes the Voluntary Assisted Dying Bill 2013 (Tas), which was a joint initiative of the Australian Greens and the Australian Labor Party.
64 Note, however, this is not always the case, as noted by Plumb, above n 59 in the context of two attempts to reform in SA and Tasmania.
65 Australian Capital Territory, Parliamentary Debates, Legislative Assembly, 5 November 1997, 3672 (Michael Moore).
66 Ibid 3673 (Michael Moore).
69 Tasmania, Parliamentary Debates, House of Assembly, 17 October 2013, 114 (Tim Morris); New South Wales, Parliamentary Debates, Legislative Council, 23 May 2013, 20 785 (Don Harwin).
70 This practice has resulted in allegations of political gamesmanship: New South Wales, Parliamentary Debates, Legislative Council, 23 May 2013, 20 781 (Cate Faehrmann); Tasmania, Parliamentary Debates, House of Assembly, 16 October 2013, 118 (Michelle O’Byrne).
The apparent influence of political allegiances on voting practices raises the broader question of what role politics currently plays in euthanasia law reform in Australia, and will play in the future. As evident from the above, a range of political coalitions have formed. The most common coalition (in favour of VE reform) is the Australian Greens and Democrats, frequently supported by sympathetic independents. Parties with direct religious affiliations forming the foundation of their policies, such as the Family First and Christian Democratic Parties, have universally opposed the passage of VE legislation. While the Liberal and Australian Labor Parties allow conscience votes, Liberal Party members are more likely to oppose VE, and Australian Labor Party members are more likely to have an even distribution.

The role that politics will play in future attempts to reform euthanasia in Australia is an interesting question in a country where the major political parties are secular and whose policy positions, for the most part, not born of religious influence. As we have seen, the Liberal, Labor and National Parties do not have a formal position on euthanasia, so this issue is not one in which any of these parties can differentiate themselves from one another in the electorate. It is likely that none of these parties perceive that any political advantage will be gained by making euthanasia law reform a political issue. While the Christian Democratic Party has a policy that stems from its religious philosophy, it is a minor political party which currently lacks political influence.

The Australian political landscape can be contrasted with countries such as the Netherlands and Belgium where there are more political parties, frequent (and varied) coalitions are negotiated to form government and parties can be divided along secular and non-secular lines. In such environments, having an articulated position (either for or against) euthanasia provides a point of differentiation, so can be a basis upon which voters can choose one party over another. It was this secular–non-secular divide that was influential in euthanasia becoming a political issue in both the Netherlands and Belgium.

Although historically, religiously based parties have had little, if any, political influence in Australia, in the current political climate, minor parties have had a great deal more influence in some jurisdictions than has ever been the

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71 Cfr the views expressed by Neil Francis, a pro-euthanasia advocate and Chief Executive Officer of YourLastRights.com Ltd in Neil Francis, ‘Australian Public Desire for Legislation of Assisted Dying in Restricted Circumstances’ (White Paper, YourLastRight.com, 2012). The white paper is based on research undertaken by Newspoll and commissioned by YourLastRights.com Ltd. In that white paper, it is suggested that ‘[m]ore than a quarter of all voters (29%) will change their vote if their otherwise most likely candidate or party’s stance on assisted dying law reform is opposed to their own stance’ and that ‘[a] politician whose stance is opposed to assisted dying law reform will lose significantly more votes at a general election (23%) than a politician who supports reform (6%)’: at [1] (emphasis altered).

This fact, combined with the political alliances that have already formed in Australia on this issue, may mean there is an increased likelihood for euthanasia reform to become a political issue in the future. This is certainly consistent with other indicators. For example, ‘euthanasia’ is raised as a political issue on ‘Vote Compass’, an online tool that has been increasingly used and promoted in the lead-up to elections, to assist the voting public to analyse political positions of the parties. Further, position statements on the topic are emerging not only from political parties but also from some peak groups, possibly an indicator that this is an issue upon which it is no longer possible or appropriate not to have a position. These developments, of course, occur against the backdrop of regular and ongoing opinion polls that reveal sustained public support for reform.

D Results of Bills

Having considered some of the political aspects of the euthanasia debate, including the political affiliations of members introducing the Bills into parliament and some of the voting patterns that have emerged, it is instructive to examine in more detail how far in the parliamentary process the Bills reached, and how they were disposed of. For law reform to occur, it is not enough to have a proponent for change. The relevant parliament must be prepared to allocate time for the Bill to be considered and debated. If a high proportion of Bills remain as notices of motion without being introduced into parliament, for example, that signals less of an appetite for reform than if they all reached the


second (or third) reading stage and were debated in full. As evident from the analysis below, the 50 Bills\textsuperscript{75} that have been introduced over the past two decades have had varying degrees of progress through and consideration by their respective parliaments. In this section, we identify the stage that all of the Bills reached and how they were disposed of, that is by being passed, withdrawn, discharged or defeated, or by lapsing.

Table 3 provides a summary of the stage that the Bills reached and the disposition of the various Bills, broken up by jurisdiction.

Table 3: Summary of the Stage Reached and Disposition of Australian Voluntary Euthanasia Bills

<table>
<thead>
<tr>
<th>Number of Bills introduced</th>
<th>Cth (12%)</th>
<th>ACT (10%)</th>
<th>NSW (16%)</th>
<th>NT (4%)</th>
<th>SA (40%)</th>
<th>Tas (4%)</th>
<th>Vic (2%)</th>
<th>WA (12%)</th>
<th>Total (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage Bill Attained in Parliamentary Process\textsuperscript{76}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not introduced</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>First reading</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Second reading</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>15</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>38 (76%)</td>
</tr>
<tr>
<td>Committee stage/ third reading</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Passed both houses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Disposition of Bills

| Discharged        | 1         | 2         | 0         | 0      | 1        | 0       | 0       | 0       | 4 (8%)      |
| Withdrawn         | 0         | 0         | 2         | 0      | 0        | 0       | 0       | 0       | 2 (4%)      |
| Lapsed            | 5         | 0         | 2         | 0      | 0        | 14      | 0       | 0       | 5           | 26 (52%) |
| Defeated          | 0         | 3         | 3         | 1      | 5        | 2       | 1       | 1       | 16 (32%)    |
| Passed            | 0         | 0         | 0         | 1      | 0        | 0       | 0       | 0       | 1 (2%)      |

\textsuperscript{75} Note that the recent Bill introduced by Liberal Democratic Party member, Senator David Leyonhjelm, is not included in the analysis in this section because the Bill is still before the Senate at the time of writing.

\textsuperscript{76} References to first, second and third readings relate to the first house of parliament in which the Bill originated. Apart from the ROTTIA, no Bill has successfully passed through one house of parliament let alone two.
1 \textbf{Progress through Parliamentary Stages}

As can be seen from Table 3, a high majority of the Bills (88 per cent) reached at least the second reading stage, with only 8 per cent failing to be introduced into parliament. While 88 per cent of Bills reached the second reading stage, only 12 per cent passed that stage. In this section, we consider the various stages reached by the VE Bills against the backdrop of the historical purposes of the various parliamentary phases.

The purpose of the first reading stage is to enable the relevant chamber of parliament to inform itself of the nature and content of the Bill.\textsuperscript{77} Parliamentary practice prescribes that the first reading stage is a purely formal procedure and one in which Bills are ordinarily passed without opposition.\textsuperscript{78} The Voluntary Euthanasia Referendum Bill 1997 (NSW), introduced by Elisabeth Kirkby on 15 May 1997, is the only VE Bill that was defeated at the first reading stage.

The second reading stage is the most important element of the legislative process. Its purpose is to debate the principle of the Bill, rather than individual clauses.\textsuperscript{79} Accordingly, Bills containing technical defects or limitations capable of rectification by reasoned amendment should be permitted to progress to the committee or consideration in detail stages, at which time closer scrutiny can be given to any technical issues. For this reason, some parliamentary speakers have ruled it impermissible for members to discuss a Bill by debating each individual clause. Instead, it has been ruled that the second reading debate should be confined to the objectives and foundation of the legislative proposal.\textsuperscript{80}

Despite 88 per cent of Bills (44 Bills) reaching the second reading stage, all but one of those Bills did not progress any further. Having regard to the purpose of the second reading stage, this suggests that it is the efficacy or justifiability of VE at a policy level that is the problem, rather than the perceived inadequacy of the framework or procedural safeguards contained within the relevant legislative proposals. If the majority of politicians supported the principle of VE, but objected to the procedural safeguards or regulatory framework of the proposed legislation, a larger number of Bills would be expected to pass the second reading stage, though possibly fail during the consideration in detail stage.

The consideration in detail stage involves a rigorous and detailed analysis of the specific provisions, procedures, and mechanisms of the legislative proposal.\textsuperscript{81} The applicable standing rules and orders often provide for the consideration of each provision of the Bill in order to ensure that all provisions are properly scrutinised and evaluated, and prohibit any amendments which would negative or

\begin{itemize}
  \item \textsuperscript{77} B C Wright (ed), \textit{House of Representatives Practice} (Department of the House of Representatives, 6\textsuperscript{th} ed, 2012) 356; Robert Rogers and Rhodri Walters, \textit{How Parliament Works} (Routledge, 6\textsuperscript{th} ed, 2013) 208–9.
  \item \textsuperscript{78} Wright (ed), above n 77, 357.
  \item \textsuperscript{79} Ibid 361–3; Rogers and Walters, above n 77, 209–10.
  \item \textsuperscript{80} See, eg, Commonwealth, \textit{Parliamentary Debates}, House of Representatives, 24 November 1920, 6906 (Elliot Johnson); Commonwealth, \textit{Parliamentary Debates}, House of Representatives, 22 November 1932, 2601 (George Mackay).
  \item \textsuperscript{81} Wright (ed), above n 77, 374–5; Rogers and Walters, above n 77, 210–24.
\end{itemize}
undermine the purpose of the Bill. This is because the relevant chamber of parliament has already assented to the underlying principle of the Bill during the second reading stage, and any further debate of the objectives of the Bill would be unnecessarily duplicative, constitute a collateral attack on the previous division, and subvert the function of the consideration in detail stage. Only 12 per cent of VE Bills have reached the consideration in detail stage. Accordingly, 88 per cent of VE Bills have not been subject to a detailed analysis of their specific clauses. Therefore, the common arguments that VE Bills lack adequate procedural safeguards, or that euthanasia cannot be safely regulated, present presumptive conclusions that often have not been adequately tested or examined by the relevant chamber of parliament.

2 Disposition of Bills

Once introduced into parliament, and regardless of the parliamentary stage reached, there was significant variation in how the Bills were disposed of. More than half (52 per cent) of Bills lapsed, 12 per cent were discharged or withdrawn, and only 32 per cent were defeated. A Bill is defeated when a division is called and a vote taken. Of interest, however, is that many of the Bills were not disposed of in this fashion. In the sections that follow, we consider circumstances in which VE Bills were discharged, withdrawn or, as is most commonly the case, lapsed.

(a) Discharge and Withdrawal of Bills

Six of the 50 VE Bills (12 per cent) have been either discharged (4 Bills or 8 per cent) or withdrawn (2 Bills or 4 per cent). Although this is not a large number, it is worth attempting to understand why 12 per cent of VE Bills were terminated in this way rather than by being defeated or lapsing. A Bill is ‘discharged’ when it has been formally presented to parliament and is subsequently removed from the notice paper. A Bill is ‘withdrawn’ when the sponsor of the Bill has recorded a notice of intention to present the legislative proposal in the notice paper and subsequently removes the notification from the notice paper prior to the first reading. In each Australian jurisdiction, it is the sponsor of the Bill who most commonly is responsible for the discharge or withdrawal of the Bill.

A Bill is generally withdrawn or discharged for one of the following reasons: an equivalent Bill is proceeding through another chamber of the parliament; the Bill possesses latent substantive defects which may impede its passage through parliament; the Bill is procedurally or formally noncompliant with an applicable

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82 Wright (ed), above n 77, 376–7.
83 Out of the 50 Bills analysed in Table 3, five were Bills seeking to facilitate a referendum on VE. Two of these Bills lapsed, and three were defeated.
85 Ibid.
86 Ibid.
standing rule or order; the Bill has no reasonable prospect for success; or it is considered that keeping the Bill on the notice paper is politically inconvenient.

It is difficult to obtain direct evidence on why a Bill is discharged or withdrawn by its sponsoring member. Possibly the prevailing sociopolitical circumstances and the relatively controversial nature of VE Bills may explain why some VE Bills are terminated in this way. Putting aside one New South Wales Bill, the mean period in which the remaining five VE Bills were discharged or withdrawn was 249 days, or approximately eight months, from an election. In each instance, the election date was reasonably foreseeable at the time of discharge or withdrawal as it was held towards the end of the three- or four-year prescribed legislative term for the relevant jurisdiction. The fact that VE Bills were discharged or withdrawn on average within eight months of a reasonably foreseeable election date may suggest a perception among certain parliamentarians that VE Bills are politically undesirable policies to be associated with during an election campaign.

(b) Lapsing of Bills

The dissolution or prorogation of parliament causes all proceedings to conclude and any outstanding Bills on the notice paper to lapse regardless of their stage of progression. As more than half the VE Bills (26 Bills or 52 per cent) are disposed of by lapsing, it is important to explore why this might be the case. The authors suggest that this occurs as a result of two, integrally related, issues: the lack of appetite of the three major political parties to debate the issue; and the relatively limited amount of parliamentary time devoted to private members’ Bills.

A private member’s Bill is one that is advanced by a member of parliament which has not officially been introduced by the government. All Bills introduced by independent politicians or the opposition are private members’ Bills unless formally adopted by the government. Even Bills introduced by ministers of the incumbent government will be private members’ Bills where they are not submitted as part of government business. Under the Australian Westminster parliamentary system, the majority of time in parliament is allocated to considering government business. As explained in the House of Representatives Practice handbook:

The increasing need for Governments to control House time, assisted by the growth of strong party loyalty, led to a steady curtailment of opportunities for private Members to initiate bills and motions, and procedures to expedite the consideration of government business.

Although procedural changes have resulted in more time being allocated to private members’ business, it remains substantially constrained by the political
and temporal exigencies of the relevant chamber of parliament. For example, between 1990 and 2014, only 8.3 per cent of time within the Commonwealth House of Representatives was assigned to private members’ business, which includes legislation and motions.

Private members’ motions and petitions are often limited to the private members’ business period in the chamber of parliament which, in some jurisdictions, is not assigned separate time periods from that allocated to committee and delegation business. Furthermore, in many jurisdictions, private members’ motions and petitions are not heard in the order of submission, but in an order determined by a selection committee which prioritises private members’ business. Finally, private members’ Bills are frequently referred to advisory committees for consideration, which further delays the progress of the Bill through parliament.

The reluctance of the three major political parties to engage with the contentious issue of VE was considered in Part III(C). As these political parties are in government in all jurisdictions, the above practices and protocols enable governments to dictate the parliamentary agenda which, as evidenced in Table 3, has resulted in many of the VE Bills lapsing.

The practical impediments that can be encountered by the proponents of reform are illustrated by considering the procedural history of the Voluntary Euthanasia Bill 1996 (SA). The Bill was introduced into the South Australian Legislative Council on 6 November 1996 by a member of the Australian Labor Party, Anne Levy. However, as a result of frequent and protracted adjournments, the division for the second reading was not called until eight months later on 9 July 1997. On the same date, the Bill was moved for consideration by a select committee. Sandra Kanck, leader of the Australian Democrats, questioned the legitimacy of the referral of the Bill to a select committee, stating that:

I am not sure how much a select committee will achieve. We all know that the committee will disappear when the election is called, so I query its usefulness other than as a ploy to stop its becoming a controversial issue at the election. Nevertheless, I will support the committee.

The Bill was referred to the Select Committee on 9 July 1997 and, after convening only twice, the Bill lapsed when Parliament was prorogued before the general election held on 11 October 1997. Despite the lapsing of the Bill, on 25 February 1998, Carolyn Pickles, leader of the Australian Labor Party in opposition, moved for the Social Development Committee to consider the Voluntary Euthanasia Bill 1996 (SA). The Bill was not reintroduced, and the report of the Social Development Committee that was tabled on 20 October 1999 recommended against the reintroduction of the Bill.

91 Ibid.
92 Ibid 861.
93 See, eg, ibid 574–5.
94 Ibid.
95 South Australia, Parliamentary Debates, Legislative Council, 9 July 1997, 1783 (Sandra Kanck).
E Analysis of Bills That Were ‘Close to Passing’

In this section of the article, we take the analysis of reform attempts one step further. We seek first to identify those Bills that came ‘close to passing’. If Bills in a jurisdiction are regularly being narrowly defeated after a considered debate in parliament, this may suggest law reform is imminent in that jurisdiction. The opposite will be the case if there is consistently so little support for the Bill in the house that they are generally disposed of without division. Second, we consider whether identifying Bills that were ‘close to passing’ sheds any light on the circumstances or environment in which it is more likely that reform will occur, or at least be seriously debated.

The process of identifying Bills that were ‘close to passing’ was an exacting and time-consuming task. A detailed investigation into each of the 50 Bills was undertaken to determine whether the particular Bill was debated in parliament and, if so, whether a division was called to determine support for the Bill. The criterion to assess whether a Bill was ‘close to passing’ is necessarily subjective in nature, but that chosen by the authors was as follows: the Bill was supported by at least 70 per cent of the number of members required to pass the Bill through the house.

As a result, the following Bills did not satisfy this criterion:

- Bills that were not introduced to parliament;
- Bills that were discharged or withdrawn without being debated;
- Bills that lapsed without being debated; and
- Bills that were debated but were defeated on the voices, or for which no division was called, or where less than 70 per cent of the support needed to pass the Bill was received.

Using this method, only 7 of the 50 Bills that have been proposed were ‘close to passing’. Table 4 below lists these Bills, the proponent and party affiliation (if any), the jurisdiction, how the Bill was disposed of, and the numbers that supported and opposed the Bill.

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96 Note that the recent Bill introduced by Liberal Democratic Party member, Senator David Leyonhjelm, is not included in the analysis in this section because the Bill is still before the Senate at the time of writing.

97 For example, if there were 23 members in the relevant house, 12 members would need to support the Bill for it to be passed. A Bill would be regarded as ‘close to passing’ for the purpose of this article if 70 per cent or above of the 12 members supported the Bill.
Table 4: Summary of the Australian Voluntary Euthanasia Bills ‘Close to Passing’

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Affiliation</th>
<th>Jurisdiction</th>
<th>Status</th>
<th>Support</th>
<th>Oppose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rights of the Terminally Ill Bill 1995\footnote{Rights of the Terminally Ill Amendment Act 1996 (NT).}</td>
<td>Marshall Perron</td>
<td>Country Liberal</td>
<td>NT</td>
<td>Passed</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Voluntary Euthanasia Bill 1996</td>
<td>Anne Levy</td>
<td>Australian Labor Party</td>
<td>SA</td>
<td>Lapsed\footnote{This Bill passed the second reading stage, and then lapsed.}</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Dying in Dignity Bill 2001</td>
<td>Sandra Kanck</td>
<td>Australian Democrats</td>
<td>SA</td>
<td>Lapsed\footnote{This Bill passed the second reading stage, and then lapsed.}</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008</td>
<td>Mark Parnell</td>
<td>Australian Greens</td>
<td>SA</td>
<td>Defeated</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Dying in Dignity Bill 2002</td>
<td>Sandra Kanck</td>
<td>Australian Democrats</td>
<td>SA</td>
<td>Defeated</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Voluntary Euthanasia Bill 2012</td>
<td>Bob Such</td>
<td>Independent</td>
<td>SA</td>
<td>Defeated</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Voluntary Assisted Dying Bill 2013</td>
<td>Larissa Giddings and Nicholas McKim</td>
<td>Australian Greens–Australian Labor Party joint Bill</td>
<td>Tas</td>
<td>Defeated</td>
<td>11</td>
<td>13</td>
</tr>
</tbody>
</table>

Some observations can be made from this analysis. The first is to note that reform of the law governing VE is difficult. Of all the attempts over the past two decades, only one Bill was successful and only six others were ‘close to passing’. These seven Bills represent only 14 per cent of all attempts. This is perhaps a surprising outcome, especially in light of a high level of community support for...
the enactment of legislation.\textsuperscript{101} The second observation is that there is nothing particularly remarkable about those Bills that were closer to passing than the 43 Bills that did not satisfy the criterion. There were no particular features that these Bills possessed which, as a group, distinguished them from the Bills that were not ‘close to passing’.\textsuperscript{102} Third, these seven Bills are not all recent, nor does there seem to be a trend for the more recent Bills (those passed between 2010 and 2014) to be ‘closer to passing’. Of the 14 Bills that were introduced over the past five years, only two were in this group of ‘close to passing’.

Fourth, it is interesting to consider the extent to which political factors, including affiliation of the proponent, are influential in the progress of Bills. The proponents of the seven Bills cover the political spectrum with the proponent of the (successful) Northern Territory Bill coming from the Country Liberal Party, two proponents from the Australian Labor Party, two from the Australian Greens as well as an independent. However, this distribution is not proportionate to the affiliations of the proponents of the total number of Bills that were introduced. The percentage chance of a Bill being ‘close to passing’ is greater if the Bill is introduced by a member of a major political party, namely the Country Liberal Party or the Australian Labor Party. Of the 16 attempts by independents, only one was in the top seven Bills. Of the 19 attempts by a member of the Australian Greens, only two were in the top seven Bills. Furthermore, of the nine introduced by a member of the Australian Democrats, only two were in the top seven Bills. By contrast, of the six introduced by a member of the Australian Labor Party, two were in the top seven Bills; and the one Bill introduced by a member of the Country Liberal Party in the Northern Territory was successful.


\textsuperscript{102} The only observation that can be made regarding the likelihood of a particular kind of Bill to be successful or not is that the referendum Bills have never been ‘close to passing’ and appear to attract even less support than the defensive and permissive models. These models are discussed further in the following Part.
What does not appear to be significant is the political persuasion of the
government in power at the time the ‘close to passing’ Bills were debated. At the
time the seven ‘close to passing’ Bills were introduced, the Country Liberal Party
was in government in the Northern Territory, the Australian Labor Party was in
government in Tasmania, and the Liberal Party was in power on two occasions
and the Australian Labor Party was in power on three occasions when Bills were
introduced in South Australia.

The final, and most remarkable, feature revealed by this analysis is that all of
these seven Bills were introduced in the Northern Territory, South Australia and
Tasmania, and five of the seven in South Australia. None of the 26 Bills
introduced in the other jurisdictions satisfied the ‘close to passing’ criterion.
Without further empirical research, it is difficult to know why this is the case. We
can speculate that advocacy for controversial reform of this kind is more likely to
succeed in smaller jurisdictions where there are fewer politicians who need to be
persuaded for the Bill to succeed. 103

However, there are likely to be a range of other issues at play as well. The
high profile of either the proponent or supporter of the Bill has been a feature in
each of the Northern Territory, South Australia and Tasmania Bills that have been
‘close to passing’. In the Northern Territory, Marshall Perron was the Chief
Minister for much of the time that the reform Bill was being debated, but he was
also seen as a passionate and charismatic advocate for change. The 2012 South
Australian Bill that was narrowly defeated by two votes, although proposed by
independent member Bob Such, was supported by the Premier, Jay Weatherill, as
well as two senior ministers, Pat Conlon and Paul Caica. 104 In Tasmania, the
proponents of the 2013 reform attempt were the Premier and leader of the
Australian Labor Party, Larissa Giddings, as well as the leader of the Australian
Greens, Nicholas McKim, both powerful political figures in that state.

Another feature that may be at play here, and identified by Plumb in her
research of euthanasia reform activity in South Australia and Tasmania, is the
power and influence of interest groups that support reform in those
jurisdictions. 105 In South Australia, for example, there has been a long history of
an active pro-euthanasia reform group. Plumb notes that the South Australian
Voluntary Euthanasia Society (‘SAVES’), founded in 1983, has a large
membership base and has consistently campaigned to reform the law. 106 She
comments that a key strategy of SAVES is to increase visibility of the topic
among politicians and the public, and refers to its monthly presence on the steps
of Parliament where it distributes information pamphlets as well as displaying
placards. An active pro-euthanasia lobby group, Dying with Dignity Tasmania,
was also a feature in the Tasmanian 2013 campaign. In addition to running a
public awareness campaign, Plumb notes that a key strategy of the group was to

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103 The members of Parliament in SA (69), Tasmania (40) and NT (25) are small when compared with, eg,
NSW (135), Victoria (128), WA (95) and Queensland (89).
104 Plumb, above n 59, 72.
105 Ibid 73–4.
106 Ibid 73.
provide ‘good quality’ information to parliamentarians to assist them with their deliberations.107

The goal of Part III was to provide detail of reform attempts, the political context in which they occurred, and to make some observations about those reform attempts that came ‘close to passing’. In the next Part, we take a closer look at the Bills themselves.

IV LEGISLATIVE MODELS OF VOLUNTARY EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

Building on the above discussion of the general nature of the Bills introduced and whether they came ‘close to passing’, we will now analyse the critical features that have emerged from all the legislative models introduced into Australian parliaments. We will make specific reference to the seven Bills identified as being ‘close to passing’ to determine if there is anything significant in the legislative models adopted which may have impacted upon the ‘success’ of the Bill. Identifying the common elements of the legislative models – especially those that have been close to passing – is important because it may signal valuable information about what model might be close to achieving a consensus position in parliament. This information is useful for generating informed debate about reform in this context.

There are obviously many ways in which these legislative models can be classified and analysed. Some of these are substantive in that the law may permit different categories of behaviour, be it VE, PAS or both. Other modes of classification are structural in the sense that, if it does permit, say VE, PAS or both, there are different ways of doing so. For instance, it may provide that VE, PAS or both remain an offence, but create a defence to such conduct in certain circumstances. Alternatively, it may expressly decriminalise VE, PAS or both in certain specified circumstances. Finally, the legislative regimes can be grouped by examining procedural characteristics, including examining how eligibility is determined, for example in terms of illness and/or suffering criteria. This Part presents the analysis of the Australian legislative attempts in light of these various analytical approaches, but it should be borne in mind that there will be some overlap between them.

1 Voluntary Euthanasia and Physician-Assisted Suicide Models

Perhaps the most fundamental substantive issue concerns whether the legislative models permit only VE, only PAS, or both. VE models permit the administration of a lethal substance by a physician to the patient. PAS models permit only the prescription of a lethal substance by medical practitioners –

107 Ibid 81.
which the patient then administers to himself or herself. For some, this distinction is critical.108

(a) Exclusively Voluntary Euthanasia Model

Only one Australian Bill has been exclusively limited to VE. Subject to proposed safeguards, the Voluntary Euthanasia Bill 2010 (WA) provided that a medical practitioner may “administer euthanasia to the applicant by administration of a recognised drug”.109 Clause 11(6) provided that it is unlawful for any person other than the patient’s medical practitioner to administer VE to the applicant. These provisions suggest that the legislation was limited to VE and was not intended to encompass PAS.110 The reasons for this, and whether the omission was intentional, do not emerge from the limited debates surrounding the Bill.

(b) Exclusively Physician-Assisted Suicide Model

The PAS model enables medical practitioners to allow patients, generally through the prescription of lethal substances, to terminate their own lives with, or without, the assistance of family members. The Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) is the only Australian Bill to permit solely PAS,111 allowing a treating doctor to provide assistance to an ‘adult sufferer’ to terminate his or her life.112

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109 Voluntary Euthanasia Bill 2010 (WA) cl 11(1).

110 While this may have merely been a drafting error, it is noted that each VE Bill introduced into the WA Parliament prior to 2010 either directly or indirectly contemplated self-administration by the patient: Voluntary Euthanasia Bill 1998 (WA) cl 8(5); Voluntary Euthanasia Bill 2000 (WA) cl 8(5); Voluntary Euthanasia Bill 2002 (WA) cl 8. The rationale for limiting permissible conduct to VE and not PAS is unclear. However, Robin Chapple, the proponent of the Bill, opened her second reading speech by stating that “[t]his Bill is not about legalising suicide’: Western Australia, Parliamentary Debates, Legislative Council, 20 May 2010, 3017 (Robin Chapple). Therefore, the decision to exclude PAS may have been a deliberate political choice to circumscribe any arguments that VE legislation effectively legalised or promoted suicide.

111 After the passage of the Euthanasia Laws Act 1997 (Cth), Michael Moore from the ACT introduced the Crimes (Assisted Suicide) Bill 1997 (ACT). While this Bill was primarily crafted in terms of PAS, cls 5(d(ii), (e)–(f) clearly contemplated the direct administration of lethal substances by the medical practitioner. Therefore, this was a mixed Bill.

112 Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5. In this context, ‘assistance’ includes giving information, prescribing, preparing or providing a drug, and providing assistance for the sufferer to ingest a drug, but does not include injection of lethal substances: at cl 3 (definition of ‘assistance’).
(c) Combined Voluntary Euthanasia and Physician-Assisted Suicide Models

All other Australian Bills allowed both VE and PAS. The ROTTIA is a prime example of this model. It provided that a patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request their doctor to assist them in terminating their life. 113 ‘Assist’ was defined to include the prescribing, preparation or giving of a substance to the patient for self-administration, and the administration of a substance to the patient. 114 By employing the phrase ‘the administration of a substance’, the ROTTIA’s formulation of ‘assist’ exceeds mere PAS and permits VE. This definition of ‘assist’ was also adopted, for example, in New South Wales and Tasmanian Bills. 115 Another common approach uses the operative section, not the definitional provisions, to specify what constitutes administering VE. 116 For example, the Voluntary Euthanasia Bill 2002 (WA) expressly provided for the administration of a lethal substance to the patient by the medical practitioner, or the provision of substances for self-administration by the patient. 117

(d) Expanded Conceptions of ‘Voluntary Euthanasia’

Some South Australian Bills have widened their conception of VE. For example, the Voluntary Euthanasia Bill 2012 (SA) provided that a medical practitioner may administer VE to an adult suffering unbearable pain in the terminal phase of a terminal illness by (a) administering drugs in appropriate concentrations to end life; (b) prescribing drugs for self-administration by a patient to allow them to end their life; or (c) withdrawing or withholding medical treatment in circumstances which will result in an end to life. 118 The first ground contemplates VE; the second expands VE to incorporate PAS; while the third

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113 ROTTIA s 4.
114 ROTTIA s 3 (definition of ‘assist’).
115 Rights of the Terminally Ill Bill 2001 (NSW) cl 3 (definition of ‘assist’); Dying with Dignity Bill 2009 (Tas) cl 3 (definition of ‘assist’).
116 See, eg, Voluntary Euthanasia Bill 2002 (WA) cl 8; Voluntary Euthanasia Bill 2000 (WA) cl 8; Crimes (Assisted Suicide) Bill 2007 (ACT) cl 5.
117 Voluntary Euthanasia Bill 2002 (WA) cl 8(2).
118 Voluntary Euthanasia Bill 2012 (SA) cl 11(2).
ground incorporates the withholding or withdrawing of medical treatment which is legally\textsuperscript{119} and, many would argue, conceptually or ethically distinct from VE.\textsuperscript{120}

2 Permissive, Defence and Penalty Mitigation Models

Legislative attempts to legalise VE can also be categorised as permissive, defence and penalty mitigation models. The permissive model provides a legislative framework, integrating appropriate safeguards, thereby positively allowing VE. This has been the most common model (35 Bills). We call it ‘permissive’ because, under such a model, if a medical practitioner complies with the requirements imposed under the framework, no offence is committed. The onus is on the prosecution to prove that the practitioner failed to comply with the provisions, beyond reasonable doubt. The defence model (2 Bills), by contrast, provides criteria which, if satisfied, will constitute an effective defence to a charge of murder or manslaughter. Under this model, VE and/or PAS would remain an offence, to which the defendant would have a defence if he or she can show, on the balance of probabilities, that he or she complied with the requirements of the defence provisions in the relevant Act. The penalty mitigation model substantially reduces associated penalties. These models will now be discussed.

(a) Permissive Models

The permissive model normally contains the following six critical elements:

1. power: power is conferred on treating medical practitioners to administer VE to certain eligible patients;\textsuperscript{121}

2. immunity: immunity against civil, criminal or disciplinary liability is conferred on any persons assisting in the administration of VE in good faith;\textsuperscript{122}

3. safeguards: protective procedures are generally prescribed to require competent requests, to provide information and to obtain psychiatric assessments; these and other safeguards are conditions precedent to exercising the relevant VE power or benefiting from the granted legal

\textsuperscript{119} Lindy Willmott, Ben White and Shih-Ning Then, ‘Withholding and Withdrawing Life-Sustaining Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), \textit{Health Law in Australia} (Lawbook, 2nd ed, 2014) 14.20–14.40. A competent patient is entitled to have a request for medical treatment to be withheld or withdrawn respected by his or her doctor: \textit{Brightwater Care Group Inc v Rossiter} (2009) 40 WAR 84, 92 [32] (Martin CJ); \textit{Hunter and New England Area Health Service v A} (2009) 74 NSWLR 88, 97 [40] (McDougall J). Legislation is therefore not required to enforce such a right.

\textsuperscript{120} See, eg, McGee, ‘Does Withdrawing Life-Sustaining Treatment Cause Death’, above n 27; McGee, ‘Acting To Let Someone Die’, above n 27. See also John Keown who classifies the withholding or withdrawing of treatment as merely prudent medical practice where there is no intention to cause death: John Keown, ‘Against Decriminalising Euthanasia; For Improving Care’ in Emily Jackson and John Keown (eds), \textit{Debating Euthanasia} (Hart Publishing, 2012) 83, 142–5.

\textsuperscript{121} See, eg, Voluntary Euthanasia Bill 2012 (SA) cl 11.

\textsuperscript{122} See, eg, Voluntary Euthanasia Bill 2012 (SA) cl 13.
and disciplinary immunity (the safeguards are discussed further below);\textsuperscript{123}

4. conscientious objections: a conscientious objections clause enables medical practitioners and institutions to decline to administer VE;\textsuperscript{124}

5. avoidances: miscellaneous provisions to prevent contingency clauses in contracts, wills, insurance and annuities from adversely affecting the person’s entitlements on the basis of a request for VE;\textsuperscript{125} and

6. oversight: various mechanisms are established for systematic oversight of the regime, for example a commission or committee that reviews deaths and/or reporting to parliament about how the legislation is being used.\textsuperscript{126}

The ROTTIA once again illustrates the permissive model in use in Australia as it incorporates these six elements.\textsuperscript{127}

As the permissive model actively permits the administration of VE or PAS, the safeguards employed require further discussion. The protective mechanisms in these Bills are generally directed towards ensuring the (1) accuracy of diagnosis and prognosis; (2) quality of the patient’s request including information requirements; and (3) voluntariness of the patient’s request. Quality of request refers to whether the patient has capacity and, even if he or she does, the quality of consideration that the patient has given to the decision. Voluntariness, by contrast, refers to whether the patient’s free will has been exercised to make the decision (in order for one’s will to be overborne or unduly influenced, one must at least have had the legal capacity to make the decision in the first place).

First, the most common legislative device applied to ensure the accuracy of the patient’s diagnosis and prognosis is requiring an independent physician to review the patient’s medical records, consult directly with the patient, and provide a second opinion. Variations of this requirement exist within all Australian Bills conforming to the permissive model.\textsuperscript{128}

Second, information requirements, specialist consultations and cooling-off periods all ensure the quality of the patient’s decision. All Australian Bills make information requirements a condition of accessing VE or PAS and the medical practitioner’s personal immunity from prosecution or civil suit.\textsuperscript{129} Information

\textsuperscript{123} See, eg, Voluntary Euthanasia Bill 2012 (SA) cls 5–6.

\textsuperscript{124} See, eg, Voluntary Euthanasia Bill 2012 (SA) cl 12.

\textsuperscript{125} See, eg, Voluntary Euthanasia Bill 2012 (SA) cl 17. These provisions, however, vary in scope and operation: cf ROTTIA s 18.

\textsuperscript{126} See, eg, Voluntary Euthanasia Bill 2012 (SA) cls 15, 19–20.

\textsuperscript{127} Other examples include Rights of the Terminally Ill Bill 2001 (NSW); Voluntary Euthanasia Bill 2012 (SA); Dying with Dignity Bill 2009 (Tas); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5(m); Voluntary Euthanasia Bill 2000 (WA) cl 7(a).

\textsuperscript{128} See, eg, ROTTIA s 7(1)(c); Rights of the Terminally Ill Bill 2001 (NSW) cl 7(1)(c); Voluntary Euthanasia Bill 2006 (SA) cl 5(2); Dying with Dignity Bill 2001 (Tas) cl 8(1)(c); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5(m); Voluntary Euthanasia Bill 2000 (WA) cl 7(a).

\textsuperscript{129} See, eg, ROTTIA s 7(1)(c); Right of the Terminally Ill Bill 2001 (NSW) cl 7(1)(g); Voluntary Euthanasia Bill 2007 (SA) cl 5(2); Voluntary Euthanasia Bill 2000 (WA) cl 7(b).
requirements enable patients to make a meaningful and autonomous decision by informing them of the nature of their condition, its likely progress, potential treatment options available, and the availability of supplementary support services. Specialist consultations generally require the intervention of psychiatric or palliative care specialists. The principal function of the psychiatric evaluation is to ensure the patient is not adversely affected by a psychological condition affecting their capacity to make the request to receive VE or PAS. Psychiatric specialists ascertain whether the patient exhibits a treatable depressive or other psychiatric illness which may underpin the request for VE or PAS. The psychiatric evaluation, therefore, operates as both an eligibility criterion and patient safeguard. The primary object of palliative care specialists is to ensure the patient is aware of palliative options to mitigate the physical, psychological and existential pain associated with their terminal illness. The provision of cooling-off periods ensure the patient has the opportunity to understand information supplied by the medical practitioner and reconsider their decision. For example, the ROTTIA specified that the certificate of request could not be completed earlier than seven days from the initial request by the patient for their life to be terminated.

Finally, in addition to issues that go to the capacity and quality of the decision, medical practitioners are also required to be satisfied on ‘reasonable grounds’ that the patient’s decision is voluntary and unaffected by duress or undue influence. This is a separate issue from capacity, though it obviously overlaps with the issues discussed above concerning the quality of the actual decision made. We treat voluntariness separately, however, because it is normally a separately expressed requirement of its own in each of the models – whether the patient’s will has been overborne is in principle a different question from that of whether they have taken enough time to think about the decision or have made an adequately informed decision. Voluntariness is really about whether a decision in the true sense of the term has been taken by the patient at all. The requirement of ‘reasonable grounds’ imposes a positive duty on the practitioner to possess objective evidence that the request was voluntary. Supplementing the requirements of expert evaluation, most statutes regulating PAS and VE require a written request, generally within a prescribed form. Writing requirements evidence both the request and that it originated from the patient rather than a third party.

130 See, eg, Voluntary Euthanasia Bill 2000 (WA) cl 7(b).
131 See, eg, Rights of the Terminally Ill Bill 2001 (NSW) cl 7(e).
132 See, eg, Voluntary Euthanasia Bill 2007 (SA) cl 5(3).
133 ROTTIA s 7(1)(i).
134 See, eg, ROTTIA s 7(1)(b).
135 See, eg, ROTTIA ss 7(1)(i)–(j); Rights of the Terminally Ill Bill 2001 (NSW) cl 17; Voluntary Euthanasia Bill 2006 (SA) cl 7; Dying with Dignity Bill 2009 (Tas) cls 8(1)(j)–(k); Voluntary Euthanasia Bill 2010 (WA) cls 10–11.
(b) Defence Models

As stated above, under a defence model, in strict terms, when the defence is made out, this means that the defendant has still committed an offence, but it is an offence for which he or she should not be held criminally responsible. Given this, why adopt such a model? A possible advantage of the defence model is that, by keeping VE or PAS prima facie an offence, the value of human life is considered to be protected, at least symbolically. The model represents the position that, while VE and PAS should not be actively permitted, medical practitioners subject to extraordinary demands, who elect to safely assist patients in terminating their life, should not be penalised. The disadvantage is that anyone who complies with the Act and so has a defence, has still committed an offence (it means that a doctor has effectively committed a murder or manslaughter) – it is just that the law considers it an offence for which the defendant should not be criminally responsible. This disadvantage might explain why this model has only been introduced sparingly within Australia – doctors or other medical practitioners probably do not want to consider themselves as committing offences for which the law will not hold them responsible and so this would make the defence model unpopular. When the defence model was introduced the one time in South Australia, it was seen as a legislative compromise designed to generate consensus regarding the legalisation of VE and PAS – that is, the advantage was privileged over the disadvantage. It was introduced as a way of attempting to respond to the failure of 16 permissive model Bills in that state.\(^\text{136}\) Clause 3 of the Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) would have inserted a defence to a charge of a relevant offence under the Criminal Law Consolidation Act 1935 (SA). It would have been a defence to such a charge if the defendant could prove, on the balance of probabilities, that he or she acted in good faith in the ordinary course of the defendant’s employment, and that his or her conduct was a reasonable response to the patient’s suffering.\(^\text{137}\)

There were other differences between the defence model in the South Australian Bill and the more standard permissive model. In contrast to the permissive models, the Bill merely required the request for VE or PAS to be ‘express’, as opposed to being reduced to writing or communicated within a prescribed form.\(^\text{138}\) Furthermore, there was no requirement for expert consultation by psychiatric or palliative care specialists. The principal protective requirements were that the treating practitioner must be a qualified medical practitioner and the administration of VE or PAS must be a ‘reasonable response’ to the patient’s suffering.

\(^\text{136}\) See generally South Australia, Parliamentary Debates, Legislative Assembly, 10 March 2011, 2849 (Stephanie Key); South Australia, Parliamentary Debates, Legislative Assembly, 28 July 2011, 4726 (Stephanie Key), where it was emphasised that the defensive model was a compromise designed to attain consensus on VE and PAS.

\(^\text{137}\) See Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(3).

\(^\text{138}\) Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(1)(c).
request. Furthermore, unlike the permissive model, oversight and reporting mechanisms were notably absent. The details of whether the practitioner acted in good faith and whether the response in the circumstances was reasonable were to be left to the courts, which meant that parliament could avoid the danger of providing too many procedural requirements to be fulfilled before a practitioner could act on a patient’s request. This was a way of resolving the tension between the need to provide sufficient safeguards on the one hand, and the need to provide workable, practically orientated legislation, on the other.

The defence model adopted in the South Australian Bill contained the following elements:

- **substantive defence**: a person satisfying the relevant criteria incurs no civil, criminal or disciplinary liability; 140
- **exculpating criteria**: these include requiring the relevant person to prove he or she was a treating practitioner; 141 that the person believed the adult to be of sound mind who was suffering from a medical condition which irreversibly rendered the patient’s quality of life intolerable; 142 that the patient expressly requested the VE; 143 and that the conduct was a reasonable response to the patient’s suffering; 144
- **accessorial liability**: a defence was proposed, in certain circumstances, for any person who supported or assisted a medical practitioner in relation to the death of a person; 145

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139 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(1).

140 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(6)(a).

141 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) ss 13B(1)(a), (2)(a).

142 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) ss 13B(1)(b), (2)(b).

143 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) ss 13B(1)(c), (2)(c).

144 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) ss 13B(1)(d), (2)(d). Note that the proposed s 13B(5) expressly states that the court must have regard to parliament’s intention that it is reasonable to terminate a person’s life in exceptional circumstances where the medical condition causes their life to become irreversibly intolerable, including where palliative care cannot relieve the suffering to a level acceptable to the person.

145 To be protected, the medical practitioner must have been duly acquitted under the defence provisions (the proposed s 13B(3)(a)), and the conduct of the person supporting or assisting was in good faith in the ordinary course of their employment and was a reasonable response to the person’s suffering (the proposed s 13B(3)(b)).
• *inchoate liability*: the defences apply to circumstances where death was *intended* or suicide attempted, so it was not necessary to prove the patient in fact died;\(^{146}\) and
• *negating fault elements*: the defence could only be invoked if the conduct occurred in good faith without negligence.\(^{147}\)

(c) *Penalty Mitigation Models*

The penalty mitigation model was only introduced after the enactment of the *Euthanasia Laws Act 1997* (Cth) which withdrew the legislative competence of the Australian territories to enact legislation permitting VE or PAS. There have been two such Bills. The relevant loophole the Bills attempted to exploit was that the *Euthanasia Laws Act 1997* (Cth) deprived the territories of their power to enact legislation which permits, or has the effect of permitting, VE or PAS. The Bills, by imposing minor fines for committing VE according to prescribed procedural safeguards, arguably did not *permit* VE or PAS insofar as the practice remained prohibited, because it was still associated with criminal penalties. Clauses 3, 5 and 6 of the Crimes (Assisted Suicide) Bill 1997 (ACT) are examples.\(^{148}\) The safeguards contained within the penalty mitigation model tend to be significantly less comprehensive than those in the permissive model. The above Australian Capital Territory Bill, for example, prescribed that requests for assistance must be in writing;\(^{149}\) a cooling-off period of 72 hours;\(^{150}\) and an independent medical practitioner must confirm that the patient was in a terminal phase of a terminal illness and suffering severe pain or distress.\(^{151}\) While the imposition of writing requirements, cooling-off periods and limited independent consultation augments patient protection, the penalty mitigation model tends to lack the comprehensive protective frameworks contained within the permissive model.

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146 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been *Criminal Law Consolidation Act 1935* (SA) ss 13B(1)-(3).

147 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been *Criminal Law Consolidation Act 1935* (SA) s 13B(6)(a).

148 The Bill was defeated resoundingly 3:14 (supported only by Michael Moore and the two Australian Greens members): Australian Capital Territory, *Parliamentary Debates, Legislative Assembly*, 5 November 1997, 3673. The Bill lost the support of two VE supporters, Wayne Berry and Simon Corbell, who regarded the Bill as ‘trivialising’ euthanasia: at 3656 (Wayne Berry); reinforcing opposing arguments by causing the pecuniary penalty to be less than a speeding ticket: at 3665 (Simon Corbell); and the associated concern of adverse media and public reactions: at 3656 (Wayne Berry). Another example of the penalty mitigation model is the Criminal Code (Euthanasia) Amendment Bill 1997 (NT) which imposed a $50 fine on medical practitioners performing VE subject to prescribed legislative criteria similar to that discussed under the Crimes (Assisted Suicide) Bill 1997 (ACT). See further Northern Territory, *Parliamentary Debates, Legislative Assembly*, 18 February 1998, 639–45 (John Bailey).

149 Crimes (Assisted Suicide) Bill 1997 (ACT) cls 3 (definition of ‘request’), 5(a).

150 Crimes (Assisted Suicide) Bill 1997 (ACT) cl 5(c).

151 Crimes (Assisted Suicide) Bill 1997 (ACT) cl 5(b).
3 Exclusive and Inclusive Illness Models

It is also possible to categorise the models in terms of the nature of the illness that must be suffered by the person seeking assistance to die. Some Bills (which we call ‘exclusive’ models) only operated if the patient suffered from a terminal illness, or even the ‘terminal phase’ of a terminal illness.152 There were 20 of these exclusive models. Other models (‘inclusive’ models) adopt a broader conception of the illnesses, including, for example, incurable and other chronic illnesses.153 There were nine of these inclusive models. In one South Australian Bill, a defendant would have been entitled to a defence against criminal liability if the defendant could prove, among other things, that the person whose death resulted ‘from the administration of drugs … by the defendant’ was suffering from a ‘qualifying illness’.154 Under that Bill, a ‘qualifying illness’ meant ‘an illness, injury or other medical condition that irreversibly impaired the person’s quality of life so that life had become intolerable to that person’.155 This provision would have allowed somebody who suffered an accident making them a quadriplegic to end their lives if they found life as a quadriplegic intolerable.

4 Nature of ‘Pain’ and ‘Suffering’

Pain and/or suffering156 tends to be an essential eligibility criterion within most proposed Australian regulatory frameworks. Although some similarities exist between Bills, significantly different notions of the ‘pain’ and/or ‘suffering’ that must be endured before a person can be assisted to die are adopted. Distinctions lie in different conceptual requirements such as ‘existential suffering’, how pain and/or suffering is ascertained, and the causal connection between the illness and the relevant pain and/or suffering.157

152 Medical Treatment (Amendment) Bill 1995 (ACT); Rights of the Terminally Ill Bill 2011 (NSW). An extreme example of this model is the Death with Dignity Acts of three states in the United States (Or Rev Stat §§ 127.800–127.995 (1994); Wash Rev Code §§ 70.245.010–70.245.904 (2008); Vt Stat Ann §§ 5281–93 (2013)) which restrict PAS to only imminently lethal medical conditions by requiring the person to be in the terminal phase of a terminal illness and within six months of death.

153 Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic); Rights of the Terminally Ill Bill 2001 (NSW); Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA).

154 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(1)(b).

155 Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA) cl 3, inserting what would have been Criminal Law Consolidation Act 1935 (SA) s 13B(1)(b).

156 We discuss when it is just pain, when it is pain and suffering, and when it is pain or suffering below. We also discuss the distinction between pain and suffering below. In the text, when we refer to “pain” and “suffering”, we are referring to these terms as they are used separately. By contrast, when we refer to ‘pain and suffering’, we are referring to that phrase as used in a statute, and as therefore embodying the requirement that there be both pain and suffering. The same considerations apply to the use of “pain” or “suffering” and ‘pain or suffering’, though we shall also use ‘pain and/or suffering’ to signify these alternatives.

157 Some important academic work by medical practitioners has been undertaken on the concept of suffering that it is outside the scope of the present article: see Eric J Cassel, ‘The Nature of Suffering and the Goals of Medicine’ (1982) 306 New England Journal of Medicine 639.
(a) Defining ‘Pain’ and ‘Suffering’

There is an important distinction between pain and suffering. A person can ‘suffer’ if they experience pain, but need not experience pain in order to ‘suffer’. ‘Suffering’ is broader than pain and can include mental suffering and emotional suffering. In the case of the Bills introduced in Australia so far, the ‘nature’ of the pain and/or suffering required turns upon the label used to describe the ‘suffering’ and whether the terms appear together, either conjunctively or disjunctively, and on whether only one term is used or more than one is used. Many Bills and statutes refer to ‘pain’, ‘distress’ and ‘suffering’; others to ‘pain’ and ‘distress’;\(^\text{158}\) while others refer simply to ‘pain’.\(^\text{159}\) The word ‘and’ means that the patient needs to be considered to be experiencing all or both, as the case may be. Likewise, if only one of the terms is used, especially the narrower term ‘pain’, this might (subject to a point we make in the next paragraph) limit the circumstances in which a request can be made. By contrast, where the word ‘or’ is used along with ‘pain’, ‘suffering’, and ‘distress’, the provisions are more expansive.

On the other hand, considering the substantial overlap between the concepts of ‘pain’, ‘distress’ and ‘suffering’, it is unclear to what extent the use of the single term ‘pain’ is distinguishable from the more expansive ones. For example, it is possible that ‘pain’ could be interpreted to encompass physical, mental and emotional suffering. Alternatively, a narrower understanding of the term might restrict it to physical pain. Whether the expanded or narrow definition is adopted would then depend on the relevant statutory framework.\(^\text{160}\) If both ‘pain’ and ‘suffering’ are used in the same statute, then it is likely that ‘pain’ would be given the narrower reading – for it is a rule of statutory construction that all terms used in the statute be given a meaning, so the word ‘pain’ would arguably not be interpreted in such a wide way if the words ‘suffering’ (and ‘distress’) are also used. But of course any such restriction would be overcome by the use of the other terms that give it its restricted meaning in the first place.

A Victorian Bill provided that ‘intolerable suffering’ means ‘profound suffering and/or distress, whether physical, psychological or existential,

\(^{158}\) See, eg, Rights of the Terminally Ill Bill 2001 (NSW) cl 4; ROTTIA s 4.

\(^{159}\) See, eg, Medical Treatment (Amendment) Bill 1997 (ACT) cl 10, inserting what would have been Medical Treatment Act 1994 (ACT) ss 6A(d), 6B(2)(a)(ii).

\(^{160}\) See, eg, Voluntary Euthanasia Bill 2006 (SA) cl 4(2)(b).

\(^{161}\) As remedial or beneficial legislation, the courts may be more likely to adopt an expansive interpretation consistent with the objects of the legislation, namely providing a systematic framework enabling patients to terminate their suffering. See, eg, Wacal Developments Pty Ltd v Realty Developments Pty Ltd (1978) 140 CLR 503, 519–20 (Mason J); Minister Administering the Crown Lands Act v NSW Aboriginal Land Council (2008) 237 CLR 285, 290–3 [9]–[20] (Kirby J); Butler v Fife Coal Co Ltd [1912] AC 149, 178–9 (Lord Shaw). On this basis, it is arguable that a more expansive interpretation of pain would be more appropriate.
that is intolerable to the patient’. Contrasting existential with physical and psychological suffering might suggest a different meaning of the term, incorporating, for example, a lack of ‘meaning’ within a person’s life, inability to self-actualise or severe despair. That said, even if this broader definition is adopted, ‘existential suffering’ possesses significant overlap with the concept of psychological suffering and, in practice, the two concepts may frequently be indistinguishable. The broadest concept of ‘suffering’ is contained within the Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA). It is defined to include the irreversible impairment of a person’s quality of life. ‘Quality of life’ encompasses all relevant factors which may affect a person’s capacity for pleasure or displeasure.

(b) Degree and Durability of Pain and Suffering

The regulatory frameworks examined adopted diverse formulations of ‘pain’ and ‘suffering’, which are generally defined according to degree and durability. The degree of ‘pain’ and ‘suffering’ the patient must be experiencing varied between Bills and was defined using inexact phrases such as ‘severe’, ‘considerable’, ‘unbearable’ and ‘intolerable’. For example, the Rights of the Terminally Ill Bill 2001 (NSW) requires that a medical practitioner be satisfied the patient is experiencing ‘severe pain or suffering’ without defining the concept of ‘severe’. The Voluntary Euthanasia Bill 2010 (WA) refers to a patient experiencing pain, suffering or debilitation which is ‘considerable’. Other Bills refer to pain the person finds ‘unbearable’, and so is defined by reference to the individual’s subjective experience. ‘Intolerable suffering’ is another phrase used which, again, is defined subjectively as profound suffering or distress which is intolerable to the patient.

The distinction between ‘considerable’, ‘unbearable’, ‘severe’ and ‘intolerable’ pain and/or suffering is a question of degree. A patient experiencing ‘considerable’ pain may not be in ‘severe’ pain and may not be experiencing ‘unbearable’ or ‘intolerable’ pain. ‘Intolerable’ or ‘unbearable’, by contrast, seem to be synonymous. The difference in degree only becomes relevant

162 Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 3 (definition of ‘intolerable suffering’). The concept of ‘intolerable’ or ‘unbearable’ suffering is discussed in detail by H R W Pasman et al, ‘Concept of Unbearable Suffering in Context of Ungranted Requests for Euthanasia: Qualitative Interviews with Patients and Physicians’ (2009) 339 British Medical Journal 1235. The authors discuss the conflict between patients and doctors in understanding what ‘unbearable’ and ‘intolerable’ require.

163 Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) cl 19(1)(b)(ii).

164 Rights of the Terminally Ill Bill 2011 (NSW) cl 7(f). However, other Bills, eg, Medical Treatment (Amendment) Bill 1995 (ACT), which require severe pain or distress, introduce subjective elements by specifying that it cannot be controlled by medical treatment to the person’s satisfaction.

165 Voluntary Euthanasia Bill 2010 (WA) cl 6(1)(f)(i).

166 Voluntary Euthanasia Bill 2012 (SA) cl 4(2)(b).

167 Ibid.

168 Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 3 (definition of ‘intolerable suffering’); Dying with Dignity Bill 2009 (Tas) cl 3 (definition of ‘intolerable suffering’). See also Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) cl 19(1)(b)(ii).
as a procedural criterion where there is an objective arbiter. The Rights of the Terminally Ill Bill 2001 (NSW) implicitly suggests that the question as to whether the patient is suffering ‘severe’ pain will be a matter of medical judgment.\textsuperscript{169} However, contemporary medical practice recognises that the capacity of a person to withstand pain varies between individuals.\textsuperscript{170} More commonly, however, Bills such as the Dying with Dignity Bill 2009 (Tas) and Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) require the patient to make the assessment, stating that the pain must be unacceptable to the patient.\textsuperscript{171} When the patient is the arbiter of the pain, the semantic distinction between differing degrees of suffering dissolves. Some Bills, such as the Voluntary Euthanasia Bill 2010 (WA), are silent in relation to the arbiter of the degree of pain the patient suffers.\textsuperscript{172}

The ‘durability’ of pain or suffering, or both pain and suffering, must be distinguished from the irreversibility or incurability of the illness. An illness may be irreversible or incurable, but painless, though presumably one can ‘suffer from’ an irreversible or incurable illness. Here, though, ‘suffer’ just means to have or experience the illness and must be distinguished from the kind of suffering that accompanies the illness or medical condition, which the use of the word ‘suffering’ is intended to refer to. Durability may be defined as continuous or long-lasting pain or suffering. The requirement of ‘durability’ or repeated requests is also contemplated within statutes with cooling-off periods.\textsuperscript{173}

Incorporated within the concept of durability is pain mitigation. This question is distinct from curability because it relates to pain palliation or, if the symptoms do not cause pain, suffering palliation. The ROTTIA, for example, imposes a

\textsuperscript{169} This is pursuant to its positioning in cl 7(1) of the Bill, which requires the medical practitioner to satisfy several elements prior to administering VE.


\textsuperscript{171} Dying with Dignity Bill 2009 (Tas) cl 3 (definition of ‘intolerable suffering’); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 3 (definition of ‘intolerable suffering’). There may be an ambiguity in the case of the latter Bill. The Bill required the treating doctor to be ‘satisfied on reasonable grounds that the sufferer has a terminal or incurable illness that is causing the sufferer intolerable suffering’: at cl 5(c). On the wording of the Bill, it could mean that the doctor must be reasonably satisfied that the patient has a terminal and incurable illness only, and not also reasonably satisfied that the terminal or incurable illness is causing the patient intolerable suffering (that being an issue that is only determinable by the patient himself or herself). Or it could mean that the doctor must be reasonably satisfied of both. On the first reading, ‘intolerable suffering’ is still given a subjective interpretation – what counts as ‘intolerable’ is determined exclusively by the patient. On the second interpretation, by contrast, ‘intolerable suffering’ must be given an objective meaning. Would a reasonable person in the patient’s position consider the suffering to be intolerable? The wording of the other clauses in the Bill suggest that only the former reading is intended – what counts as intolerable is to be judged by the patient.

\textsuperscript{172} Voluntary Euthanasia Bill 2010 (WA) cl 6(1)(f)(i).

\textsuperscript{173} See, eg, ROTTIA s 7(1)(i); Voluntary Euthanasia Bill 2012 (SA) cl 11(1)(f); Dying with Dignity Bill 2009 (Tas) cl 8(1)(n).
requirement that palliative care must be unable to alleviate pain and/or suffering to levels acceptable to the patient.\textsuperscript{174}

(c) Causality

The various Bills also differ in terms of the required nexus between suffering and/or pain on the one hand, and illness on the other. Some Bills expressly require an objective causal relationship between the illness and the suffering.\textsuperscript{175} For example, under the Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic), the treating doctor must be reasonably satisfied that the sufferer has a terminal or incurable illness that is causing the patient intolerable suffering.\textsuperscript{176} Other Bills merely require the existence of a ‘relationship’ between illness and the pain and/or suffering. For example, the Voluntary Euthanasia Bill 2010 (WA) requires the patient to experience pain, suffering or debilitation that is ‘related to the relevant terminal illness’.\textsuperscript{177}

The concept of ‘causation’ would clearly encompass pain and/or suffering directly deriving from the illness as a causative factor, but, on a broad interpretation, may also incorporate the existential pain a professional athlete may experience on discovering that, by reason of some debilitating illness or disability, they may never compete again. In contrast, and depending on the conception of causality adopted, it would not encompass a request for VE pursuant to significant existential pain deriving from, say, a partner divorcing the patient after he or she contracts the terminal illness.

However, this existential pain may fall within the ambit of the Voluntary Euthanasia Bill 2010 (WA) because there is a relationship between the divorce and the terminal illness, even where the terminal illness was merely connected, and not necessarily a determinative or significantly contributing factor, to the divorce. There may be other examples, such as where a pre-existing psychological illness is exacerbated, but not necessarily caused, by a terminal illness, and the psychiatric disorder is the primary motivation underpinning the request for VE. In jurisdictions adopting a causal criterion, the court is likely to adopt either the ‘but for’ or ‘material contribution’ tests for causation.\textsuperscript{178} Where the ‘but for’ test is adopted, the distinction between requiring a causal relationship rather than a mere relationship becomes more evident. However, if the court adopts the material contribution test, the judiciary may determine that a causal relationship exists notwithstanding that existential, psychological or physical pain derives from a combination of the terminal illness and other related

\textsuperscript{174} ROTTIA s 8(1).
\textsuperscript{175} The Voluntary Euthanasia Bill 1998 (WA) cl 4(2)(b) implies the existence of a relationship of proximity, similar to a causal relationship, through requiring the existence of pain, suffering or debilitation associated with the ‘actual progress of [the] illness or condition’.
\textsuperscript{176} Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5(c).
\textsuperscript{177} Voluntary Euthanasia Bill 2010 (WA) cl 6(1)(f)(ii).
\textsuperscript{178} The ‘but for’ test means that the illness would be the sole cause of the pain and/or suffering. The ‘material contribution test’ means that the illness would be one, but not the only, cause of the pain and/or suffering – there may be other causes as well, and it suffices that the illness only be one of them.
sources. Regardless of which test is selected, in the majority of cases, it is unlikely that the distinction between the requirement for causality and a mere relationship will be determinative.

5 Current and Advance Request Models

The majority of VE Bills adopt a current request model (21 in total), which allows a person to make a request for assistance to die only while he or she has capacity. By contrast, an advance request model (of which there have been eight), where a request continues to operate if the person subsequently loses legal capacity, has been adopted by the South Australian Dignity in Dying Bills introduced in 2001–05, which provide for an advance request to be made by a person who is not yet ‘hopelessly ill’. Finally, some VE Bills have permitted surrogate decision-making.

6 Oversight Mechanisms

Most legislative models provide for oversight of VE and PAS practice. There are two common oversight mechanisms: (a) establishing a monitoring and reporting entity; or (b) utilising an existing entity for monitoring and reporting purposes. In Australia, the vast majority of Bills permitting VE or PAS opt for the second approach and require medical reporting to the coroner, who is responsible for monitoring, evaluating and reporting on the operation of the system.

7 Common Features in Models

The models introduced in Australia exhibit many similarities. The overwhelming majority of proposed frameworks adopt the permissive model –

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179 See, eg, Rights of the Terminally Ill Bill 2001 (NSW) cl 4; ROTTIA s 4. See also, eg, Voluntary Euthanasia Bill 2012 (SA) cl 5; Dying with Dignity Bill 2009 (Tas) cl 5.
180 Dignity in Dying Bill 2001 (SA) cl 6, introduced by Sandra Kanck; Dignity in Dying Bill 2001 (SA) cl 6, introduced by Bob Such; Dignity in Dying Bill 2002 (SA) cl 6; Dignity in Dying Bill 2003 (SA) cl 6(1)(b); Dignity in Dying Bill 2005 (SA) cl 6(1)(b). The primary safeguard in relation to the advance request is that the patient be informed of feasible VE procedures and the risks associated with them (see, eg, Dignity in Dying Bill 2005 (SA) cl 7(1)(c)), as well as in conjunction with witnessing and certification procedures (see, eg, Dignity in Dying Bill 2005 (SA) cls 8–9).
181 See, eg, Medical Treatment (Amendment) Bill 1995 (ACT) cl 19, which would have amended Medical Treatment Act 1994 (ACT) s 13, provided that where an adult is of sound mind, and suffering severe pain in the terminal phase of a terminal illness, they may execute an instrument conferring on another person the power to request the administration of VE in the event that the patient becomes incapacitated.
182 See, eg, Dying with Dignity Bill 2009 (Tas) cl 16(1); Voluntary Euthanasia Bill 2000 (WA) cl 11(1); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 16; ROTTIA ss 14–15. Cf Voluntary Euthanasia Bill 2006 (SA) cl 19, which establishes the Voluntary Euthanasia Monitoring Committee.
35 of the 39 Bills, including all of those that were ‘close to passing’.

In all Australian Bills (and the repealed Northern Territory Act), assistance to die would be available only to an adult who is enduring pain or suffering and/or has a terminal illness. The person is to be competent at the time of the request, and the request must be made voluntarily – that is, even when made by a person who has capacity, it is not made under duress or undue influence. Under some models, assistance to die can be given to a person who no longer has capacity provided the request was made when he or she did have capacity. Rarely, the legislative proposal allows the request to be made under a power of attorney. Generally, the individual was permitted to determine whether his or her suffering satisfied the required pain threshold to receive VE or PAS. Most Australian Bills adopted a broad interpretation of the categories of pain and suffering, frequently including physical, psychological and existential pain.

Most Australian Bills contain consultative requirements which may necessitate obtaining information from independent medical, psychiatric or palliative care specialists. These consultative requirements facilitate specialist assessment about whether the individual is suffering a treatable psychiatric condition, which could vitiate a request for VE or PAS, or acting under duress or undue influence. Most Bills require written requests using a prescribed form, and incorporate cooling-off periods. A number of Bills incorporate

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183 One Bill (2.6 per cent) can be categorised as the defence model (Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA)), and two Bills (5.1 per cent) have adopted the penalty mitigation model (Crimes (Assisted Suicide) Bill 1997 (ACT); Criminal Code (Euthanasia) Amendment Bill 1997 (NT)). The penalty mitigation models have only been introduced within the Australian territories immediately after the enactment of the Euthanasia Laws Act 1997 (Cth) to circumscribe its removal of legislative competency in respect of legalising or decriminalising VE or PAS.

184 See, eg, Dignity in Dying Bill 2001 (SA) cl 6, introduced by Sandra Kanck; Dignity in Dying Bill 2001 (SA) cl 6, introduced by Bob Such; Dignity in Dying Bill 2002 (SA) cl 6; Dignity in Dying Bill 2003 (SA) cl 6(1)(b); Dignity in Dying Bill 2005 (SA) cl 6(1)(b).

185 See, eg, Medical Treatment (Amendment) Bill 1995 (ACT) cl 19, which would have amended Medical Treatment Act 1994 (ACT) s 13.

186 See, eg, Voluntary Euthanasia Bill 2012 (SA) s 4(2)(b); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 3 (definition of ‘intolerable suffering’); Dying with Dignity Bill 2009 (Tas) cl 5 (definition of ‘intolerable suffering’).

187 For broad definitions of the concept of suffering see, eg, Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 3; Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) cl 19(1); Rights of the Terminally Ill Bill 2001 (NSW) cl 4; ROTTIA s 4. However, as noted above, where pain is used on its own, it may well be given an equally broad interpretation. When used alongside ‘suffering’, it may be restricted to physical pain, but the addition of the word suffering will mean that the definition is broad unless the terms appear conjunctively, which would limit the circumstances of suffering to suffering associated with physical pain.

188 See, eg, Voluntary Euthanasia Bill 2007 (SA) cl 5(3); Rights of the Terminally Ill Bill 2001 (NSW) cl 7(1)(e).

189 See, eg, ROTTIA s 7(1)(c)(iv).

190 See, eg, ROTTIA s 7(1)(h).

191 See, eg, Voluntary Euthanasia Bill 2006 (SA) cl 7; ROTTIA ss 7(1)(i)–(j); Dying with Dignity Bill 2009 (Tas) cls 8(1)(i)–(j).

192 See, eg, ROTTIA s 7(1)(i); Voluntary Euthanasia Bill 2000 (WA) cl 8(3); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5(o).
residency requirements restricting the availability of VE, although this was not a feature of the Northern Territory legislation. As an oversight measure, the vast majority of Bills permitting VE or PAS require medical reporting to the coroner, who is responsible for monitoring, evaluating and reporting on the system.

In Part III above, we stated that seven of the Bills introduced into Australia were 'close to passing' (as we have defined that term). Are there any features of these Bills, when compared to those that did not meet this threshold, which might explain why they were able to get so far? For instance, did the provisions concerning safeguards in these Bills have anything in common that would suggest that members of parliament were close to believing that the provisions addressed well-known concerns about these safeguards? Or did the Bills only make lawful VE or PAS in circumstances where a person is terminally ill, thereby limiting the range of circumstances in which a person can avail themselves of the new laws and so making the Bill more palatable for the members of parliament who had to vote on it? Again, were the Bills that were close to passing restricted to PAS, VE, or did they include both? There are certainly common features in these Bills, but none of these features sets them apart from the features of many of the other Bills we have mentioned that were not close to passing. And there were also differences among the Bills on the issues that normally remain controversial, such as whether the Bills were restricted to terminal illnesses only, and whether they regulated only PAS or only VE, or included both. Two of the South Australia Bills that were close to passing, for instance, were not limited to terminal illness. This seems to speak against the idea that a Bill has a greater chance of passing if it is restricted to cases where a patient is terminally ill. Finally, all the Bills that came close to passing contemplated both PAS and VE. There was no restriction exclusively to one or the other, as one might have expected if a more restricted proposal were put forward. There is no sound basis for concluding that the nature of these Bills made them go further than the nature of the Bills that did not come close to passing.

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193 See, eg, Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 5(b); Dying with Dignity Bill 2009 (Tas) cl 9.
194 See, eg, Dying with Dignity Bill 2009 (Tas) cl 16(1); Voluntary Euthanasia Bill 2000 (WA) cl 11(1); Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic) cl 16; ROTTIA ss 14–15. Cf Voluntary Euthanasia Bill 2006 (SA) s 19, which establishes the Voluntary Euthanasia Monitoring Committee.
195 Dignity in Dying Bill 2001 (SA); Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA).
196 By contrast, could it be argued that, within SA, a Bill that is broader has a greater chance of passing than a Bill that is narrower? No, for there are SA Bills with the same requirements that were not close to passing, such as the Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA).
V CONCLUSION

This article has examined two decades of attempted VE reform in Australia. The trends over this period were explored, along with the extent to which Bills progressed (or did not progress) through the relevant houses of parliament. The analysis of reform attempts was also considered in a political context and some tentative conclusions were drawn about why some Bills gained more political support than others. The second half of the article focused on analysing the various models that have been advanced to change the law, including examining them through different lenses (substantive, structural and procedural). This analysis concluded by determining typical approaches to proposed reform in Australia, namely a permissive model that covers both VE and PAS and is limited to competent adults who are terminally or incurably ill and experiencing suffering (variously defined). Multiple safeguards are proposed and there are official oversight mechanisms, generally involving reporting to the coroner.

The authors predict that VE law reform is likely to occur in Australia. There is a convergence of factors that make this issue increasingly difficult for politicians to ignore: high and sustained public support for reform in Australia; an ageing and increasingly informed population seeking choices for their end-of-life experience; the changing legal landscape internationally; and the media’s interest in the topic and, particularly for social media, its agitation for change. These factors are evidenced by an increasing trend of parliamentary activity in this area such as through the introduction of Bills, the release of exposure drafts of Bills and the establishment of select committees. And once the first state or territory enacts legislation, others are likely to follow.

As to when that occurs, no doubt the prevailing political context will be critical. And, in that regard, we make two concluding observations. The first is that who the proponent for reform is may be decisive in whether or not it succeeds. Marshall Perron was the proponent of the only VE Bill ever to have succeeded in Australia, and he was (for much of the relevant time at least) the Chief Minister in the Northern Territory as well as being seen as a popular and charismatic character. Two of the other Bills that we classified as ‘close to passing’ were supported by high-profile politicians including Larissa Giddings and Nicholas McKim (the 2013 Bill in Tasmania) and Jay Weatherill, Pat Conlon and Paul Caica (the 2012 Bill in South Australia). This observation, if correct, has implications for the immediate future now that Richard Di Natale, who has released an exposure draft of a Bill advocating for reform, is leader of the Australian Greens. The second point is that we can be confident that politicians will engage with the issue of VE reform more directly if the public places it on the political agenda, as opposed to merely supporting the concept of reform when their views are sought in opinion polls. Given the increasing extent to which euthanasia reform is becoming part of the political discourse in the lead up to elections, it may be that we are approaching the point where major political parties may be forced to develop policy positions on reform.

Given reform efforts to date, the model described above is likely to be the one enacted in Australia. But despite a broadly consistent approach taken
nationally, there are still important legislative choices to be made. For example, the word ‘suffering’ can encompass different aspects of a person’s experience and can also be judged from different perspectives. The analysis undertaken in this article can be of assistance for legislators and policymakers in identifying and unpacking choices such as these. While the international experience is outside the scope of this article, some of the features of the Australian models are consistent with international models. This points to the need to learn from the experiences of those jurisdictions. There is now an increasing body of empirical evidence as to the operation of these VE and/or PAS regimes and this needs to be considered when deciding whether to undertake reform or not, and the actual design of proposed reforms.\footnote{See, eg, Bregje D 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) 380 The Lancet 908; Kenneth Chambaere et al, ‘Trends in Medical End-of-Life Decision Making in Flanders, Belgium: 1998–2001–2007’ (2011) Medical Decision Making 500; Kenneth Chambaere et al, ‘Physician-Assisted Deaths under the Euthanasia Law in Belgium: A Population-Based Survey’ (2010) 182 Canadian Medical Association Journal 895; Luc Deliens et al, ‘End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey’ (2000) 356 The Lancet 1806; Paul van der Maas et al, ‘Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995’ (1996) 335 New England Journal of Medicine 1699; Paul J van der Mass, ‘Euthanasia and Other Medical Decisions Concerning the End of Life’ (1991) 338 The Lancet 669.}

The enactment of legislation that provides state imprimatur for a health professional (or another) to end a person’s life (or provide assistance for a person to take their own life) is a significant step, and should be recognised as such. Concerns about the effect of such a shift on the community and particularly the vulnerable within our community have been an important part of the debate for many decades. It is not the purpose of this article to engage with the merit or otherwise of these arguments but one of the key considerations when proposing law reform is to consider carefully how and if a model for VE and/or PAS addresses these issues. To assist with those deliberations, we offer the analysis in this article of the various Bills that have been introduced into Australian parliaments to date. The authors hope that this analysis will inform community debate, too frequently littered with inaccurate claims about what is or has been proposed when VE or PAS Bills are drafted. We also hope that this article will assist in cultivating a more sophisticated understanding of the various regulatory models, and the options that are available to parliaments when considering legislative reform.
## APPENDIX: LEGISLATIVE REFORM ATTEMPTS IN AUSTRALIA

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Name</th>
<th>Date Introduced</th>
<th>Who Introduced</th>
<th>Where Introduced</th>
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This table expands a similar table included in White and Willmott, above n 24.
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<td>Bob Such (Independent)</td>
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<td>16 October 2008</td>
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<td>Laresa Giddings (Australian Labor Party)</td>
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<td>Who Introduced</td>
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<td>28 May 2008</td>
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<td>Robin Chapple (Australian Greens)</td>
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As Victorian MPs debate assisted dying, it is vital they examine the evidence, not just the rhetoric

September 20, 2017 5.41am AEST

Assisted dying in Australia is no longer a matter of "if" but "when". Will the "when" be 2017 through the Voluntary Assisted Dying Bill likely to be tabled in the Victorian parliament this week?

The politics of assisted dying are notoriously unpredictable, and how our politicians ultimately vote may turn on last-minute lobbying. However, a robust process to develop the bill, coupled with government and high-profile political support, means reform is a real possibility.

As with previous Australian assisted dying bills, Victorian parliamentarians have been offered a conscience vote. As politicians ponder how they will respond, interest groups on both sides of the debate are lobbying fiercely. MPs are being provided with a range of conflicting information about how assisted dying regimes operate overseas and the risks or benefits of these regimes.

How can politicians sift through and assess these competing claims?

Claims about facts or about morals

A starting point is to distinguish between claims that something should or should not happen (a moral claim about right and wrong), and claims that something is or is not happening (a factual or empirical claim). This distinction matters, because what justifies each type of claim is different.

For example, a claim that the bill should not be enacted because it is wrong for doctors to be involved in deliberately bringing about the death of a patient is a moral claim. This moral claim is based on values – that killing a person is always wrong, and/or it is wrong for doctors to be involved in such a practice.

Politicians should ask those making such claims what values they are relying on. This allows them to assess if those values are justifiable in contemporary Australia, recognising that our society respects a...
plurality of viewpoints.

On the other hand, a factual (or empirical) claim depends on evidence. For example, a claim that vulnerable people will be at risk if the bill is enacted is a factual claim. This claim should be supported by evidence, and politicians should ask the claimant for that evidence.

**Is the evidence reliable?**

If no evidence is provided for a factual or empirical claim, it should be ignored. If evidence is provided, the question then becomes: how reliable is it? There are established ways to evaluate evidence, as shown by the pyramid below.

Key considerations are how high up the pyramid of quality the evidence is, and whether it has been robustly tested. An example of low-quality evidence is anecdotal evidence, which hasn’t been independently verified, about a small number of cases in an overseas assisted dying regime.

At the other end of the spectrum, high-quality evidence could be a peer-reviewed systematic review that analyses all existing research to determine what sorts of people are receiving assistance to die in a particular country.

Politicians must also support their claims

In putting forward their views on assisted dying legislation, politicians are also making claims. This means the arguments outlined above apply to them too.
Politicians making a moral claim can rely on different values and so reasonably reach different conclusions on the permissibility of assisted dying. If so, they should be transparent about this, making clear their values and why they believe in them.

Importantly, they should not confuse the issue by cloaking value claims as empirical or factual claims. For example, a politician should not claim that safeguards cannot stop inappropriate use of assisted dying regimes (a factual claim) if their real concern is a principled one (based on values) that killing is always wrong.

Likewise, with empirical claims, politicians must not only test the evidence that is presented to them, they must also satisfy themselves of the reliability of the evidence they are relying on.

Fortunately, there is a significant body of reliable evidence that examines how assisted dying regimes in other countries work that can inform these assessments. We invite politicians to critique this evidence for themselves, but here we tackle two empirical claims that are commonly made in the debate.

**Two common empirical claims**

The first claim is that safeguards cannot protect the vulnerable in society. But a reliable body of peer-reviewed evidence now demonstrates that assisted dying regimes are not disproportionately used by vulnerable groups. The available body of peer-reviewed research was further tested by the courts in Canada, and upheld by the Supreme Court, which concluded that it was possible to design a regime that adequately protects the vulnerable.

Those making claims contrary to this established body of reliable evidence need to provide their high-quality evidence in support of their position.

The second common claim is that the law will inevitably expand over time to allow new and broader groups to have access to assisted dying. But this factual claim doesn’t reflect what has happened elsewhere. There have been virtually no changes in the regimes that permit assisted dying overseas.

The best comparison for the proposed Victorian model is Oregon, as it permits only physician-assisted suicide (a doctor prescribes medication to a person, who must then take it themselves). Oregon’s law has not changed in the 20 years it has been in operation.

A limited exception to this trend is Belgium. In 2014, it extended its laws to permit assisted dying for competent terminally ill people under the age of 18 in restricted circumstances. But this expansion of law has been very limited, with only two young people using it in the three years since.

As Victorian MPs debate assisted dying, it is vital they examine the evidence.
As Victorian MPs debate assisted dying, it is vital they examine the evidence, then test how reliable that evidence is.

Important issues are at stake, and lazy debate and discussion should not be permitted.

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Four reasons Victorian MPs say ‘no’ to assisted dying, and why they’re misleading

November 14, 2017 6.16pm AEDT

Victoria’s upper house has resumed its debate on the Voluntary Assisted Dying bill. The bill is now at the committee stage and a vote is expected as soon as Thursday (it needs 21 votes to pass).

At the conclusion of its last sitting, the Legislative Council voted 22:18 in favour of the legislation. Of the 18 members who voted “no”, 15 gave speeches articulating reasons for their view. We examined those speeches and identified four major themes. These were: the bill doesn’t have adequate safeguards to protect the vulnerable; legalising assisted dying presents a slippery slope; palliative care services must be improved first; and a doctor’s duty is to treat, not to kill.

Some of these arguments are misleading and they all require close scrutiny.

1. Insufficient safeguards

The most frequently cited reason for opposing the bill was the inability of safeguards to adequately protect the vulnerable. Liberal Bernie Finn expressed concern that:

“There is no regard to treatable depression or other mental illness that may be driving a
request to seek suicide, so long as the patient has decision-making capacity. […]

Rachel Carling-Jenkins of Cory Bernardi’s Australian Conservatives noted the bill:

[…] has no detail on how an assessing doctor will satisfy themselves that the person has informed consent in the regime.

And the Liberal David McLean Davis said he was voting against the bill as it didn’t adequately address issues of “pressure and duress”. He said:

[…] I am very concerned that there will be those who seek to inherit, those who seek to take advantage of a vulnerable person.

Concerns that vulnerable people are at risk under such laws have been rejected in top peer-reviewed journals such as The Lancet and the New England Journal of Medicine as well as by the Canadian courts, who have cross-examined evidence testing the findings of this research. Justice Smith of the Supreme Court of British Columbia concluded that:

the empirical evidence gathered in the two jurisdictions [Netherlands and Oregon] does not support the hypothesis that physician-assisted death has imposed a particular risk to socially vulnerable populations.

Further, the Victorian bill does address “treatable depression” in the sense that a person can only access assisted dying if they are assessed to have mental capacity to make the decision. If the doctor is unsure about this – for example because of the patient’s depression – the doctor must refer the person to a health professional with appropriate skills to assess capacity.

Read more: Victoria may soon have assisted dying laws for terminally ill patients

The concern about doctors not being confident of informed consent is also surprising. As part of everyday practice, doctors are aware of their legal obligation to inform patients about treatment, and the need to obtain consent for it. The bill also contains a detailed list of information that must be provided to someone seeking assistance including the person’s diagnosis and prognosis, possible treatment options, palliative care options, the potential risks of taking the substance and the expected outcome of doing so.

2. The slippery slope

The slippery slope argument contends that even though the Victorian model is currently a conservative one, that doesn’t mean it won’t evolve over time. Labor’s Nazih Elasmar argued that
But this argument is also misleading. The Victorian bill is modelled on the Oregon Death with Dignity Act which has not been amended since it was enacted 20 years ago. It is disingenuous to suggest a broadening of the law is the "norm". In this regard, the Netherlands and Belgium are not "perfect examples".

**Read more: In places where it’s legal, how many people are ending their lives using euthanasia?**

3. **Palliative care should improve instead**

In terms of palliative care, there were two inter-related arguments. First, that we should be focusing on increased funding to palliative care to widen its reach, instead of introducing assisted dying.

Liberal Joshua Morris stated that for “palliative care not to be appropriately funded in our state [...] is nothing short of shameful” and that provision of palliative care “must be in place before a bill of this type is considered”.

The second argument is that offering people assisted dying but not palliative care, as Labor’s Daniel Mulino said, “is not a real choice”.

But access to assistance in dying is a separate and distinct issue. Chair of Victoria’s advisory panel for the assisted dying legislation, Professor Brian Owler, has said palliative care is the “main game” when treating patients approaching the end of their lives. This will always remain so.

Funding for palliative care should be increased so that palliative care services are available to all who need it. The government can, at the same time, increase funding for palliative care and pass legislation allowing assistance to die. We are advocates for palliative care and would welcome that outcome.

As for the issue of choice, it makes no sense to suggest an otherwise eligible person should not have...
assistance to die because he or she does not have access to palliative care. The proponents of this argument are effectively saying it is better to have no options rather than one option at the end of life, which cannot be right.

Read more: Assisted dying is one thing, but governments must ensure palliative care is available to all who need it

4. Doctors should do no harm

This argument holds that an assisted dying bill will undermine the nature of the doctor-patient relationship, which is based on trust. Arguments in this theme also contend assisting patients to die is the very antithesis of what doctors do. Nazih Elasmar referred to the Hippocratic oath, noting that it says “first, do no harm”.

It’s important to note that for a person to be eligible for assisted dying under the Victorian bill, the time of healing has passed. The person is terminally ill and will inevitably die.

Secondly, many in our community including health professionals do not regard assisted dying as a “harm”. A recent Tribunal decision has accepted this view.

What counts as harm depends on context. For example, we do not normally think surgeons are violating the Hippocratic oath when they cut into our skin during life-saving surgery, yet cutting into our skin is a form of harm. We accept this harm because it is outweighed by the fact the surgery is life-saving. We can similarly argue helping people die more comfortably is not a form of harm, but is actually a benefit.

Thirdly, it is important to acknowledge that every day doctors, patients and families make decisions to withhold or withdraw treatment that will result in a patient’s death. Pain relief is also provided knowing this can accelerate death. These actions are not thought to undermine the doctor-patient relationship.

As the debate over the bill continues in Victoria’s Legislative Council, we repeat our earlier call that all MPs interrogate their positions, including the biases that underpin them, to be intellectually rigorous. Debates must be being based on reliable evidence.
How should Australia regulate voluntary euthanasia and assisted suicide?

Ben White and Lindy Willmott

This article invites consideration of how Australia should regulate voluntary euthanasia and assisted suicide. It attempts to pose this question as neutrally as possible, acknowledging that both prohibition and legalisation of such conduct involve decisions about regulation. It begins by charting the wider field of law at the end of life, before considering the repeated, but ultimately unsuccessful, attempts at law reform in Australia. The situation in Australia is contrasted with permissive jurisdictions overseas where voluntary euthanasia and/or assisted suicide are lawful. The authors consider the arguments for and against legalisation of such conduct along with the available empirical evidence as to what happens in practice both in Australia and overseas. The article concludes by outlining a framework for deliberating on how Australia should regulate voluntary euthanasia and assisted suicide. It asks a threshold question of whether such conduct should be criminal acts (as they presently are), the answer to which then leads to a range of possible regulatory options.

INTRODUCTION

Voluntary euthanasia and assisted suicide 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 voluntary euthanasia and assisted suicide 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 article, 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

1 Ben White, LLB (Hons) (QUT), DPhil (Oxon), Professor, Director, Health Law Research Centre, Faculty of Law, Queensland University of Technology; Lindy Willmott, BCom, LLB (Hons) (UQ), LLM (Cantab), PhD (QUT), Professor, Director, Health Law Research Centre, Faculty of Law, Queensland University of Technology. This article is an edited version of a background paper commissioned by Australia21 (for which the authors acknowledge receipt of a small honorarium). The authors acknowledge the input of Australia21 during the drafting process but are, of course, responsible for the final content of this article.

Correspondence to: bp.white@qut.edu.au.

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

3 See eg 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 at 414-415.

4 In the New South Wales Legislative Council on 23 October 2012, Cate Faehrmann (Australian Greens) signalled the introduction of the Rights of the Terminally Ill Bill into Parliament in 2013.
The issue of how we, as a society, regulate voluntary euthanasia and assisted suicide 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, voluntary euthanasia and assisted suicide are issues that are of significant interest to the public and, as considered in this article, 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 must be made about whether to provide life-sustaining treatment, or allow the 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.

The purpose of this article is to provide a basis from which to start an informed and rational dialogue in Australia about voluntary euthanasia and assisted suicide. 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. The article begins by describing the wider field of law at the end of life, before considering the repeated, but ultimately unsuccessful, attempts at law reform in Australia. The situation in Australia is contrasted with permissive jurisdictions overseas where voluntary euthanasia and/or assisted suicide are lawful. The article considers the arguments for and against legalisation of such conduct along with the available empirical evidence as to what happens in practice both in Australia and overseas. The article concludes by outlining a framework for deliberating on how Australia should regulate voluntary euthanasia and assisted suicide.

It is not the purpose in this article to persuade. Rather, it attempts to address the issues as neutrally as possible and to canvass both sides of the argument in an even-handed manner. The authors hope that this exercise places the reader in a position to consider the question posed by the title of this article: How should Australia regulate voluntary euthanasia and assisted suicide? In line with the approach taken here, this question does not imply a view as to whether the existing law should remain the same, or be amended. Voluntary euthanasia and assisted suicide are currently regulated (by the criminal law) and would also be the subject of regulation (in varying ways) if such practices were legalised.

DEFINITIONS AND SCOPE OF ARTICLE

It is important to be clear about the meaning of the terms used in this article 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. Table 1 lists the terminology used in the article.

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6 According to media reports, a voluntary euthanasia Bill will be introduced into the Tasmanian Parliament by Lara Giddings (Tasmanian Premier) and Nick McKim (leader of the Australian Greens in Tasmania): Arndt D, "Assisted Death Debate Reigned", The Examiner (4 July 2012).


6 See below at 420.
TABLE 1 Terminology used in the article

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<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Example</th>
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<tr>
<td>Euthanasia</td>
<td>For the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person.</td>
<td>A doctor injects a patient with a lethal substance to relieve that person from unbearable physical pain.</td>
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<tr>
<td>Voluntary euthanasia</td>
<td>Euthanasia is performed at the request of the person whose life is ended, and that person is competent.</td>
<td>A doctor injects a competent patient, at their request, with a lethal substance to relieve that person from unbearable physical pain.</td>
</tr>
<tr>
<td>Competent</td>
<td>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.</td>
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<tr>
<td>Non-voluntary euthanasia</td>
<td>Euthanasia is performed and the person is not competent.</td>
<td>A doctor injects a patient in a post-coma unresponsive state (sometimes referred to as a persistent vegetative state) with a lethal substance.</td>
</tr>
<tr>
<td>Involuntary euthanasia</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Withholding or withdrawing life-sustaining treatment*</td>
<td>Treatment that is necessary to keep a person alive is not provided or is stopped.</td>
<td>Withdrawing 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 her or him off the ventilator because there is no prospect of recovery. Withholding 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.</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>A competent person dies after being provided by another with the means or knowledge to kill herself or himself.</td>
<td>A friend or relative obtains a lethal substance (such as Nembutal) and provides it to another to take.</td>
</tr>
<tr>
<td>Physician-assisted suicide</td>
<td>Assisted suicide where a doctor acts as the assistant.</td>
<td>A doctor provides a person with a prescription to obtain a lethal dose of a substance.</td>
</tr>
</tbody>
</table>

* This is sometimes referred to as “passive euthanasia” as the death arises from not giving life-sustaining treatment.

The scope of this article also requires clarification. It considers only the arguments that relate to voluntary euthanasia and assisted suicide so far as they apply to requests from a competent adult for death or assistance to die. There are two main reasons for limiting the article in this way. First, 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 voluntary euthanasia and assisted suicide, as has the vast majority of public debate. Accordingly, although some may argue that euthanasia and assisted suicide should extend to other situations, such issues are not explored here. As such, this article does not consider euthanasia and assisted suicide 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 they have lost competence;
- individuals who are not competent (adults or minors) and are therefore unable to make an informed choice about whether to end their lives; and
compotent minors who seek euthanasia or assistance to die.

CURRENT AUSTRALIAN LEGAL LANDSCAPE AT THE END OF LIFE

Voluntary euthanasia and assisted suicide are unlawful in all States and Territories in Australia.\(^7\) 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.\(^8\) (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 her or his actions even if he or she is motivated by compassion or if the deceased consented to her or his own death.\(^9\)

Withholding or withdrawing life-sustaining treatment can be lawful

While taking active steps to end a person’s life (or assist them to do so themselves) is unlawful, the law does permit life-sustaining treatment to be withheld or withdrawn in certain circumstances.\(^10\) One situation is where a person who is competent to make her or his 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.\(^11\)

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.\(^12\) 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.\(^13\) 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.\(^14\) Thirdly, parents can make this decision for their children who do not yet have decision-making competence. The relevant criterion for such a decision is the child’s best interests.\(^15\)

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,

\(^7\) See generally Stewart C, “Euthanasia and Assisted Suicide” in White B, McDonald F and Willmott L (eds), Health Law in Australia (Thomson Reuters, Sydney, 2010) at [12.10]-[12.200].


\(^11\) Willmott, White and Then, n 10 at [13.30]-[13.40].


\(^15\) Willmott, White and Then, n 10 at [13.280]-[13.290].
he or she is not required to provide it even if it is needed for the patient to stay alive. 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 voluntary euthanasia 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 her or his substitute decision-maker, or because the treatment is not in the patient’s best interests and so need not be provided. By contrast, voluntary euthanasia involves taking active steps to end another’s life and so is in breach of the criminal law.

**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. 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 (eg, opioids suppressing respiration) although many argue that properly administered palliative care does not do this.

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.

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. While the statement of law may be clear, its operation in practice is not.

**Legislative reform attempts in Australia**

Australia has witnessed continual and numerous attempts to reform the law governing voluntary euthanasia and assisted suicide. 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 a Labor Member of Parliament. Table 6 in the Appendix lists legislative attempts to reform the law regarding voluntary euthanasia and/or assisted suicide of which the current authors 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 voluntary euthanasia and assisted suicide, 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 voluntary euthanasia and assisted suicide, 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). Three key factors that were
significant in how the politicians voted were party alliances, gender and religious affiliation. 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. 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 (eg,
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 voluntary euthanasia and assisted suicide debate, particularly if politicians are
granted a conscience vote as is often the case for topics such as these.

**LEGISLATIVE SCHEMES THAT PERMIT VOLUNTARY EUTHANASIA AND/OR ASSISTED
SUICIDE**

Although reform has not occurred in Australia (except for a brief period in the Northern Territory),
legislation permits voluntary euthanasia and/or assisted suicide 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, assisted suicide is permitted in some circumstances because of the narrower reach of the
crime of assisted suicide in that country, and this is explained further below. This section provides a
brief overview of the legislative models that currently operate, as well as the legislation that was
enacted and operated (albeit briefly) in the Northern Territory prior to its repeal by the Commonwealth
Parliament. As the focus here is on the more detailed regulation that occurs through legislative reform,
this article does not examine where reform has occurred through judicial means (eg in Montana),
although this is considered later in the article.

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

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

Table 7 in the Appendix provides some further detail about aspects of the six statutes and facilitates
comparisons across jurisdictions. Some observations are also made here about key features of these
legislative regimes. First, the statutes differ in relation to the kind of activity which is regulated –
either voluntary euthanasia or assisted suicide or both. Voluntary euthanasia and assisted suicide are
permitted in The Netherlands, Belgium and Luxembourg, and were permitted under the Northern
Territory regime. Only assisting a suicide can be lawful in Oregon and Washington.

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


25 See below at 431-432. Judicial reform also occurred in Colombia in 1997, although a recent media article has reported that a
Bill has been passed in Colombia to regulate the practice of euthanasia in some circumstances: O’Gorman J, “Colombian Senate
Approves Regulation of Euthanasia”, Colombia Reports (9 August 2012), http://www.colombiareports.com/columbia-news/
* 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.

** In Oregon, the legislation resulted from a voter-initiated referendum. For a discussion of the legal challenges to this legislation, see Stewart, n 7 at [12.210].

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

Secondly, there is significant divergence in terms of eligibility requirements, that is, what must be present before a person will qualify for voluntary euthanasia or assisted suicide under the particular regime. Such requirements relate to the person’s competence, age and 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 her or his life, while in The Netherlands, Belgium and Luxembourg, a person’s advance statement 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.

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 her or his 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 her or his own interests, and where the parents or guardians agree with the decision.
Switzerland

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

Article 114 provides:
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 provides:
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 voluntary euthanasia as it involves a person who “causes” the death of another, while Art 115 is about assisting another to bring about her or his own death. The effect of Art 114 is that voluntary euthanasia 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 assisted suicide 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 her or his life to relieve that pain and suffering, and seeks assistance to achieve that goal.

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 assisted suicide. 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.

ARGUMENTS FOR AND AGAINST REFORM

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

Finding a consensus of ethical values

Before rehearsing the arguments for and against voluntary euthanasia and assisted suicide, an attempt is made 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.

• 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.

• 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.30

• 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.

• 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.

• 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.

• 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. It is acknowledged, 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.

**Key arguments in favour of legalising voluntary euthanasia and assisted suicide**

**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 her or his 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 her or his 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 her or his 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, eg, feed them, bathe them and assist them with toileting, and may prefer to end their lives rather than continue to live in this fashion.31 A competent person who forms that view should have the right to end her or his life.

**Voluntary euthanasia or assisted suicide 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 existential32 and some physical pain cannot be alleviated and may

30 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 article to explore those contrasting views.

31 See eg 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”: Rothschild A, “Just When You Thought the Euthanasia Debate had Died” (2008) 5 Bioethical Inquiry 69 at 69-70.

32 By existential pain, the authors mean pain which is not necessarily connected with physical pain. The term refers to emotional or psychological pain and/or suffering.
result in a request from an individual for her or his life to end. As a society, we should not prevent a competent person, who is experiencing unrelenting pain or suffering, from ending her or his life.\textsuperscript{33}

**Current regulatory framework does not work: Voluntary euthanasia and assisted suicide currently occurs**

**Evidence that lives are ended unlawfully**

There is a clear body of evidence that demonstrates that voluntary euthanasia and assisted suicide occur despite being unlawful.\textsuperscript{34} 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.\textsuperscript{35} 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.\textsuperscript{36} Further, the palliative practice of “terminal sedation”\textsuperscript{37} – where a patient is kept under deep continuous sedation to manage pain, while artificial nutrition and hydration is withdrawn or withheld ultimately leading to death – can give rise to legal ambiguity and has sometimes been equated to “slow euthanasia”.\textsuperscript{38}

**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 voluntary euthanasia and assisted suicide allows for the creation of appropriate safeguards and oversight to ensure, eg, 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.

**The current law is incoherent**

As considered earlier in the article, some decisions are lawful even though they result in a person’s death.\textsuperscript{39} Withholding and withdrawing life-sustaining treatment can be lawful, eg, 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 as a result are

\begin{itemize}
\item \textsuperscript{33} 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. Campbell T, “Euthanasia as a Human Right” in McLean S (ed), First Do No Harm: Law, Ethics and Healthcare (Ashgate, Aldershot, 2008) p 455.
\item \textsuperscript{35} See above at 414.
\item \textsuperscript{38} 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.
\item \textsuperscript{39} See above at 413-414.
\end{itemize}
lawful, yet others (namely voluntary euthanasia and assisted suicide) are not. 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.

Public opinion is in favour of legalising voluntary euthanasia and assisted suicide

There is a longstanding history of strong public support for the legalisation of voluntary euthanasia and assisted suicide 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.41

The current law is discriminatory

The prohibition on voluntary euthanasia and assisted suicide 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 assisted suicide is lawful, while others may not.

Legalisng voluntary euthanasia and assisted suicide will expand options for individuals who want to die, but currently are unable to end their own lives or access assistance to die.

Key arguments against legalising voluntary euthanasia and assisted suicide

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 her or his 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.42

The Catholic Church’s Declaration of Euthanasia states that the practice of voluntary euthanasia and assisted suicide is a violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.43

The importance of human life is also recognised by our common law. In the landmark English case of Airedale NHS Trust v Bland [1993] AC 789, 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

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40 Rothschild, n 31 at 73-74; Doyal L, “The Futility of Opposing the Legislation of Non-voluntary and Voluntary Euthanasia” in McLean, n 33, p 470.

41 The Australia Institute, “Survey Results – Attitudes to Voluntary Euthanasia” (2011), https://www.tai.org.au/index.php?q=node%2F19&pubid=822&act=display viewed 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 Sikora J and Lewins F, “Attitudes Concerning Euthanasia: Australia at the Turn of the 21st Century” (2007) 16 Health Sociology Review 68.


accepted that the “sanctity of life” formed part of the English legal system (at 859). The Australian courts have also recognised the state’s interest in preserving human life.

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

**If voluntary euthanasia or assisted suicide 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 Table 7 in the Appendix, all statutes that have provided for voluntary euthanasia or assisted suicide 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 her or his life who relies heavily on others for all aspects of living may be pressured to end her or his 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.

**If voluntary euthanasia or assisted suicide 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 (eg, 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 voluntary euthanasia and assisted suicide are available to some members of our society.

**The improvements in palliative care make the need for voluntary euthanasia and assisted suicide obsolete**

The advances in medical knowledge over the past decade, particularly in the field of palliative care, mean that the debate about voluntary euthanasia and assisted suicide 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 voluntary euthanasia or assisted suicide is now obsolete.

**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 her or his 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.

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*See eg Hunter and New England Area Health Service v A (2009) 74 NSWLR 88 at [5]-[16], and most recently a reference by the majority of the High Court in Patel v The Queen (2012) 86 ALJR 954; [2012] HCA 29 at [87] to “the value the law places on human life”.*
If voluntary euthanasia or assisted suicide 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 the 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 being provided with assistance to manage their condition, they may be encouraged by their doctor to seek assistance to end their lives.

The role of human dignity in this debate

Before leaving this discussion of the arguments in favour of and against voluntary euthanasia and assisted suicide, a note about “human dignity” is necessary. Views are likely to differ regarding precisely what is encompassed by this term. Nevertheless, it is frequently cited as a reason that voluntary euthanasia or assisted suicide 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 voluntary euthanasia or assisted suicide 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 voluntary euthanasia and assisted suicide. Accordingly, neither voluntary euthanasia nor assisted suicide 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 voluntary euthanasia and assisted suicide. Instead, in the 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.

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 voluntary euthanasia and/or assisted suicide 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 voluntary euthanasia and assisted suicide.

The first proposition is that making voluntary euthanasia and assisted suicide illegal is an effective deterrent to them occurring. In this section, reference is made to some of the available evidence of current practice regarding voluntary euthanasia and assisted suicide in Australia, namely that the unlawful practices of voluntary euthanasia and assisted suicide currently occur. The authors 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. Rather, the authors put forward this information about the extent of compliance or not with the law as relevant evidence to inform deliberations of how voluntary euthanasia and assisted suicide should be regulated.

46 Keown J, “Defending the Council of Europe’s Opposition to Euthanasia” in McLean, n 33, p 483.
The second proposition is that in jurisdictions where voluntary euthanasia and assisted suicide are legal, there will be a slide into other (unacceptable) practices such as involuntary and non-voluntary euthanasia, or voluntary euthanasia and assisted suicide 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. The authors consider some of the data regarding the practice of voluntary euthanasia and/or assisted suicide in The Netherlands, Belgium, Switzerland and Oregon to see the extent to which these concerns have been realised. (The situation in Luxembourg or Washington is not examined due to the relatively limited time that their regimes have been in operation.)

What happens in Australia?

As the practice of voluntary euthanasia and assisted suicide 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 et al which concluded that in 1995-1996, 1.8% of all deaths in Australia occurred due to voluntary euthanasia and 0.1% were due to physician-assisted suicide. 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 to “ending life without patient’s explicit request”: Kuhse et al noted it was significantly higher in Australia (3.5%) than in The Netherlands (0.7%, at the comparable time of 1995).

A qualitative study by Magnusson has also documented sustained unlawful conduct relating to voluntary euthanasia and assisted suicide. His book, entitled The Euthanasia Underground, details the involvement of 49 people in deaths through euthanasia (voluntary and otherwise) and assisted suicide. 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.

In addition to this empirical research, there is a body of anecdotal evidence that voluntary euthanasia and assisted suicide occur 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. The letter formed part of a campaign to legalise assisted suicide. 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.

While there is not comprehensive evidence in relation to the extent to which voluntary euthanasia and assisted suicide occur 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.

What happens in The Netherlands, Belgium, Switzerland and Oregon?

A vast body of literature exists about current practices in jurisdictions that permit voluntary euthanasia and/or assisted suicide. 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

47 See above at 421.
49 Kuhse et al, n 48 at 195-196.
50 Magnusson, n 34.
51 Douglas et al, n 36.
53 Syme, n 34.
54 See eg the prosecution of Daryl Stephens, a 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): Weber D, “Doctor Releases Book on Woman’s Death”, PM (8 October 2002), http://www.abc.net.au/pn/stories/stories/6006378.htm viewed 19 August 2012.
comprehensive reviews of law and practice that are conducted from time to time. However, the bulk of the literature is comprised of articles 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 on empirical research that has been conducted in permissive jurisdictions, providing data on the extent to which voluntary euthanasia and assisted suicide occur. Some commentators express concern in this writing that permissive jurisdictions, and most notably The Netherlands, have witnessed an expansion in voluntary euthanasia and assisted suicide practices which has led to the vulnerable in our society being placed at risk. The literature includes concerns about the difficulties of ensuring that the safeguards embodied in the legislation are observed, and that the practice of voluntary euthanasia and assisted suicide 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 are in direct conflict with that evidence.

For any jurisdiction contemplating how best to regulate voluntary euthanasia and assisted suicide, 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. 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 permissive jurisdictions, particularly about the risk to which the vulnerable in our society will be exposed, are justified.

For the purpose of this analysis, the authors are not able to undertake a comprehensive review of the body of literature that is in the public domain in this area. Instead, a snapshot of current practice is provided, drawing on the recent review of empirical research undertaken by the Royal Society of Canada Expert Panel on End-of-life Decision-making.

The 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:

- 1973: Case law recognised that a doctor could lawfully shorten a person’s life to prevent serious and irremediable suffering (although voluntary euthanasia and assisted suicide were punishable in all circumstances). Despite this concession, in this case, the doctor was found guilty (although he did not receive a harsh penalty). The law, as a result of this case, therefore remained unclear.

55 Recently eg 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), http://www.demos.co.uk/publications/thecommissiononassisteddying viewed 20 August 2012; and Schüllken et al, n 45, 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 2012: Quebec, Select Committee, Dying with Dignity Report (2012), http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html viewed 10 September 2012.


57 See eg Downie J, Chambare K and Bernheim J, “Pereira’s Attack on Legalizing Euthanasia or Assisted Suicide: Smoke and Mirrors” (2012) 19 Current Oncology 133.

58 For comment on the difficulty inherent in interpreting available data, see Shariff M, “Assisted Death and the Slippery Slope – Finding Clarity Amid Advocacy, Convergence, and Complexity” (2012) 19 Current Oncology 143.

59 Schüllken et al, n 45 at 61-65.

60 This summary was based on information provided in Schüllken et al, n 45 at 51-57.
How should Australia regulate voluntary euthanasia and assisted suicide?

- 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.
- 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, 2005 and 2010 and they resulted in the data in Table 3.

### TABLE 3 Deaths due to voluntary euthanasia and assisted suicide as a percentage of total deaths in The Netherlands

<table>
<thead>
<tr>
<th>Annual number of deaths</th>
<th>1990</th>
<th>1995</th>
<th>2001</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>128,824</td>
<td>135,675</td>
<td>140,377</td>
<td>136,402</td>
<td>136,056</td>
</tr>
<tr>
<td>Voluntary euthanasia</td>
<td>1.7%</td>
<td>2.4%</td>
<td>2.6%</td>
<td>1.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Life-terminating acts without explicit request of the patient*</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2.7%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>2.2%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

* The circumstances in which such acts occur are explained in Schüklenk et al, n 45 at 62 as follows: “[T]hey 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”.

### 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.

The figures in Table 4 allow comparisons in practice between 1998 (when voluntary euthanasia was illegal) and 2007 (when voluntary euthanasia was legal). 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.

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For information about the authors of these studies and where they are reported, see Lewy, n 26, p 29.


The information in this table, while sourced from these five surveys, was drawn primarily from Schüklenk et al, n 45 at 61-62, as well as from Onwuteaka-Philipsen et al, n 62.

These statistics were obtained from Lewy, n 26, p 77.

The information in this table was drawn from Schüklenk et al, n 45 at 62.

---
TABLE 4 Deaths due to voluntary euthanasia and assisted suicide as a percentage of total deaths in Belgium

<table>
<thead>
<tr>
<th></th>
<th>1998 %</th>
<th>2007 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary euthanasia</td>
<td>1.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>0.12</td>
<td>0.07</td>
</tr>
<tr>
<td>Life-terminating acts without explicit request of the patient</td>
<td>3.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>4.42</td>
<td>3.77</td>
</tr>
</tbody>
</table>

Switzerland

It will be recalled that law reform has not occurred in Switzerland to permit voluntary euthanasia or assisted suicide. However, assisted suicide 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. Dignitas has reported that it has assisted 15 Australians to die between the years of 2003 and 2011.

Oregon

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

An interesting observation from the 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:

- 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;

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67 Dignitas, n 29.
68 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 assisted suicide legislative model, and the legislation in Oregon has operated since 1998, only the data from Oregon are considered in this article. Suffice it to say that in Washington in 2010, medication was dispensed to 87 individuals, and 51 deaths took place after ingesting the medication: Schüklenk et al, n 45 at 63, drawing on official data.
69 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): Schüklenk et al, n 45 at 63, drawing on official data.
70 These statistics were obtained from Lewy, n 26, p 134.
71 The points below were extracted from an analysis of the summary report in Lewy, n 26, pp 134-136.
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.

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

A FRAMEWORK FOR CONSIDERING REGULATORY OPTIONS FOR VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE

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 law should take on voluntary euthanasia and assisted suicide. It starts by asking whether voluntary euthanasia and assisted suicide 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 voluntary euthanasia and assisted suicide 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.

Should voluntary euthanasia and/or assisted suicide be criminal acts?

A threshold question is whether voluntary euthanasia and/or assisted suicide should be criminal acts. Commentators have identified a number of functions of criminal law. Two that have particular significance here are the punishment of an offender in order 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 voluntary euthanasia and assisted suicide 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 voluntary euthanasia or assisted suicide being a criminal act but not both. Where a distinction is made between these two courses of action, it is generally to permit assisted suicide but not voluntary euthanasia. 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, eg, 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.

If voluntary euthanasia and/or assisted suicide should be criminal acts

Culpability of voluntary euthanasia and assisted suicide

If voluntary euthanasia and/or assisted suicide 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, voluntary euthanasia and assisted suicide 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. 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 imprisonment. 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.

Another option is for the criminal law to treat voluntary euthanasia and assisted suicide 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 voluntary euthanasia and assisted suicide 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, eg, 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 voluntary euthanasia and assisted suicide 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.

73 Otlowski M, “Mercy Killing Cases in the Australian Criminal Justice System” (1993) 17 Crim LJ 10; Bartels L and Otlowski M, “A Right to Die? Euthanasia and the Law in Australia” (2010) 17 JLM 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: see Weber, n 54.

74 Bartels and Otlowski, n 73.

**Sentencing reform**

The sentences that can be imposed for voluntary euthanasia and assisted suicide vary depending on the crime of which the person has been convicted and the State or Territory in which he or she lives.\(^{76}\) 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 assisted suicide varies from 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.\(^{77}\)

Some may consider the current approach to sentencing cases of voluntary euthanasia and assisted suicide 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 of diversionary programs from the mainstream criminal justice system represent more appropriate sentencing options.

Sentencing reform could be achieved through legislation, eg reducing the maximum sentence or, alternatively, imposing a mandatory minimum sentence. It could also be achieved through judicial means, eg, 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 voluntary euthanasia 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. Assisted suicide 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 assisted suicide.

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 assisted suicide\(^{78}\) while in South Australia and Victoria, a murder charge is not open but rather only the crime of manslaughter.\(^{79}\)

**Prosecutorial guidelines**

A third legal option for reform is to develop prosecutorial guidelines that deal specifically with when voluntary euthanasia and assisted suicide will and will not be prosecuted.\(^{80}\) Prosecutors in Australia have a discretion not to charge or prosecute a person where they conclude that doing so would not be

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\(^{76}\) Bartels and Otlowski, n 73 at 534-535.

\(^{77}\) Bartels and Otlowski, n 73.

\(^{78}\) Crimes Act 1900 (NSW), ss 31B, 31C.

\(^{79}\) Criminal Law Consolidation Act 1935 (SA), s 13A; Crimes Act 1958 (Vic), s 6B.

in the public interest. In England and Wales, the Director of Public Prosecutions has developed a policy specifically dealing with assisted suicide and when it will and will not be in the public interest to prosecute such cases.81

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.82

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.

**If voluntary euthanasia and/or assisted suicide should not be criminal acts**

The alternative position is now considered where voluntary euthanasia and assisted suicide 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 voluntary euthanasia, assisted suicide 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 voluntary euthanasia or assisted suicide may occur only in relation to a person who is competent to make their own decisions and, as outlined above, this article deals only with voluntary euthanasia and assisted suicide in this context.83

- **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, eg, against an individual with disabilities who may not be able to satisfy a terminal illness requirement but who considers her or his 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 voluntary euthanasia or assisted suicide. 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 the involvement of doctors can harm the doctor-patient relationship and erode trust and the ethic of

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

83 See above at 412.
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 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 voluntary euthanasia and assisted suicide are not criminal acts. The first is that the law that prohibits voluntary euthanasia and assisted suicide 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 voluntary euthanasia and assisted suicide.

**Invalidity of laws prohibiting voluntary euthanasia and assisted suicide**

One option for legal change is to judicially challenge the validity of criminal laws so far as they prohibit voluntary euthanasia and assisted suicide. 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*. 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.

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 voluntary euthanasia and assisted suicide was incompatible with the *Human Rights Act 1998* (UK).

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. 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 voluntary euthanasia or assisted suicide lawful, but to create a defence that doctors (or others) may rely upon to avoid criminal responsibility. This can occur...

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85 The Supreme Court decision is currently being appealed by Canada’s federal government: *Appeal Court Upholds BC Woman’s Exemption from Doctor-assisted Suicide Ban* (10 August 2012), [http://www.canada.com/health/Appeal+Court+upholds+womans+exemption+from+doctorassisted+suicide/7071822/story.html](http://www.canada.com/health/Appeal+Court+upholds+womans+exemption+from+doctorassisted+suicide/7071822/story.html) viewed 19 August 2012.

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

87 *R (on the application of Nicklinson) v Ministry of Justice* [2012] EWHC 2381 at [86].
through judicial decision. This 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 her or his 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 the doctor.\(^{88}\)

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.\(^{89}\) However, a defence governing voluntary euthanasia and assisted suicide 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 (SA). Under the Bill, a defence to homicide\(^ {90}\) was created for a treating doctor to administer drugs where he or she believed on reasonable grounds that the life of an adult of sound mind was intolerable to that person. Such action had to be at the request of the person and be regarded as a “reasonable response to the suffering”. Of note is that the Bill expressly provided that the onus of proof rested on the doctor on the balance of probabilities to demonstrate that he or she fell within the protection provided by the defence. This criminal defence model is also consistent with how assisted suicide is regulated in Switzerland with people being allowed to assist another to die, provided they are acting with unselfish motives.\(^ {91}\)

As noted above, this model (whether it is achieved through judicial or legislative reform) does not make voluntary euthanasia and assisted suicide 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 voluntary euthanasia or assisted suicide. 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.\(^ {92}\)

Statutory framework to regulate the practice

A final reform option, and one favoured most by voluntary euthanasia and assisted suicide 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.\(^ {93}\)

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 voluntary euthanasia and assisted suicide are lawful which is accompanied by some oversight mechanism.

**What should happen next?**

This article has drawn together some of the key issues in the vast body of literature dealing with law, practice and opinion relating to voluntary euthanasia and assisted suicide. It outlined the broader legal landscape at the end of life, the attempts to make these practices lawful in Australia, and the situation

\(^{88}\) Baxter v Montana 354 Mont 234 (2009). Judicial reform also occurred in Colombia: see above n 25.

\(^{89}\) R (on the application of Nicklinson) v Ministry of Justice [2012] EWHC 2381.

\(^{90}\) The Bill also creates defences for assisted suicide and other offences that might conceivably be charged in this context.

\(^{91}\) See above at 417.

\(^{92}\) R (on the application of Nicklinson) v Ministry of Justice [2012] EWHC 2381 at [86].

\(^{93}\) See above at 415-416.
in those jurisdictions where voluntary euthanasia and/or assisted suicide 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. It has attempted to approach this
exercise in a balanced way that acknowledges the complexity of these issues and the diversity of
views held.

While an article like this cannot be comprehensive, it provides a departure point for a
conversation by interested parties about the future of how voluntary euthanasia and assisted suicide
should be regulated. Part of that conversation will include identifying what further research and
information will be needed to properly consider this issue. This article has suggested at various places
where further work is needed to inform consideration of these issues.

It is hoped 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. Voluntary
euthanasia and assisted suicide 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. The
authors 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.

How should Australia regulate voluntary euthanasia and assisted suicide?

(2012) 20 JLM 410 433
## APPENDIX

### TABLE 6 Legislative reform attempts in Australia

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Name of Bill</th>
<th>Date introduced</th>
<th>Who introduced</th>
<th>Where introduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>Medical Treatment (Amendment) Bill 1995</td>
<td>20 September 1995</td>
<td>Michael Moore (Independent)</td>
<td>Legislative Assembly</td>
</tr>
<tr>
<td></td>
<td>Euthanasia Referendum Bill 1997</td>
<td>18 June 1997</td>
<td>Michael Moore (Independent)</td>
<td>Legislative Assembly</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Rights of the Terminally Ill Bill 2001</td>
<td>29 November 2001</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Trial (Referendum) Bill 2002</td>
<td>9 April 2002 (Notice of motion)</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Trial (Referendum) Bill 2003</td>
<td>17 September 2003</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2003</td>
<td>30 April 2003 (Notice of motion)</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2010</td>
<td>22 September 2010 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2010</td>
<td>19 October 2010 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2011</td>
<td>2 August 2011 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
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<tr>
<td>South Australia</td>
<td>Voluntary Euthanasia Bill 1995</td>
<td>9 March 1995</td>
<td>John Quirke (ALP)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 1996</td>
<td>6 November 1996</td>
<td>Anne Levy (ALP)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2001</td>
<td>14 March 2001</td>
<td>Sandra Kanck (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2001</td>
<td>15 March 2001</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2003</td>
<td>24 September 2003</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2005</td>
<td>16 February 2005</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2006</td>
<td>14 March 2007</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2007</td>
<td>31 May 2007</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2008</td>
<td>16 October 2008</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008</td>
<td>12 November 2008</td>
<td>Mark Parnell (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2010</td>
<td>24 June 2010</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
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<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010</td>
<td>16 September 2010</td>
<td>Stephanie Key (ALP)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010</td>
<td>29 September 2010</td>
<td>Mark Parnell (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Name of Bill</td>
<td>Date introduced</td>
<td>Who introduced</td>
<td>Where introduced</td>
</tr>
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<td>--------------</td>
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</tr>
<tr>
<td>South Australia continued</td>
<td>Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011</td>
<td>10 March 2011</td>
<td>Stephanie Key (ALP)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2012</td>
<td>1 March 2012</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Dying with Dignity Bill 2009</td>
<td>26 May 2009</td>
<td>Nicholas McKim (Australian Greens)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td>Victoria</td>
<td>Medical Treatment (Physician Assisted Dying) Bill 2008</td>
<td>28 May 2008</td>
<td>Colleen Hartland (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Voluntary Euthanasia Bill 1997</td>
<td>16 October 1997</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 1998</td>
<td>20 August 1998</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2000</td>
<td>10 May 2000</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2000</td>
<td>19 October 2000</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2002</td>
<td>18 September 2002</td>
<td>Robin Chapple (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2010</td>
<td>20 May 2010</td>
<td>Robin Chapple (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>Commonwealth</td>
<td>Euthanasia Laws Bill 1996**</td>
<td>9 September 1996</td>
<td>Kevin Andrews (Liberal Party)</td>
<td>House of Representatives</td>
</tr>
<tr>
<td></td>
<td>Euthanasia Laws (Repeal) Bill 2004</td>
<td>3 March 2004</td>
<td>Lyn Allison (Australian Democrats)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Australian Territories Rights of the Terminally Ill Bill 2007</td>
<td>8 February 2007</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008</td>
<td>14 February 2008</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2008</td>
<td>17 September 2008</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010</td>
<td>29 September 2010</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
</tbody>
</table>

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

** 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).
<table>
<thead>
<tr>
<th>Overview of the regulation</th>
<th>Northern Territory</th>
<th>Netherlands</th>
<th>Belgium</th>
<th>Luxembourg</th>
<th>Oregon</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of activity that is regulated</td>
<td>Voluntary euthanasia and assisted suicide</td>
<td>Voluntary euthanasia and assisted suicide</td>
<td>Voluntary euthanasia*</td>
<td>Voluntary euthanasia and assisted suicide</td>
<td>Assisted suicide</td>
<td>Assisted suicide</td>
</tr>
</tbody>
</table>

### Eligibility requirements

<table>
<thead>
<tr>
<th>Must be an adult?</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation extends to:</td>
<td>(a) Minor between 16 and 18 who has a reasonable understanding of own interests (where parents or guardians involved in decision-making process)</td>
<td>(b) Minor between 12 and 16 who has a reasonable understanding of own interests (where parents or guardians agree).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Must be competent at time death occurs?</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation is not limited to competent individuals.</td>
<td>Legislation is not limited to competent individuals.</td>
<td>An advance directive requesting euthanasia that was made when a person was competent can also be acted upon.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Must person have a terminal illness?</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is pain and/or suffering required?</th>
<th>Northern Territory</th>
<th>Netherlands</th>
<th>Belgium</th>
<th>Luxembourg</th>
<th>Oregon</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><em>Illness is causing “severe pain or suffering”.</em></td>
<td><em>Suffering must be “lasting and unbearable”.</em></td>
<td><em>Patient must be in a “medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated”.</em></td>
<td><em>Patient must show “constant and unbearable physical or mental suffering without prospects of improvement”.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Must person be a resident in the jurisdiction?</th>
<th>No</th>
<th>No**</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Safeguards</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement of health professionals</td>
<td>2 doctors and a psychiatrist</td>
<td>2 doctors</td>
<td>2 doctors (unless not expected to die in near future and, if so, 3 doctors)</td>
<td>2 doctors</td>
<td>2 doctors</td>
<td>2 doctors</td>
</tr>
<tr>
<td>Validity of request</td>
<td>2 doctors must be satisfied that request made “freely, voluntarily and after due consideration”.</td>
<td>2 doctors must be satisfied that the “request ... was voluntary and well-considered”.</td>
<td>Doctor to be satisfied that the “request is voluntary, well-considered and repeated, and is not the result of any external pressure”.</td>
<td>Doctor to be satisfied that the “request is made voluntarily, after reflection and, if necessary, repeated, and does not result from external pressure”.</td>
<td>2 doctors satisfied that request is made voluntarily.</td>
<td>2 doctors satisfied that request is made voluntarily.</td>
</tr>
<tr>
<td>Patient must be professionally informed</td>
<td>Patient informed of the nature and likely course of illness and medical treatment and other support (including counselling and psychiatric support) available.</td>
<td>Patient informed of the situation he was in and about his prospects.</td>
<td>Patient informed about health condition, life expectancy, the possible palliative and therapeutic courses of action and their consequences.</td>
<td>Patient informed about state of health and life expectancy, therapeutic and palliative possibilities and their consequences.</td>
<td>Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control).</td>
<td>Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control).</td>
</tr>
<tr>
<td>Cooling-off period</td>
<td>Northern Territory</td>
<td>Netherlands</td>
<td>Belgium</td>
<td>Luxembourg</td>
<td>Oregon</td>
<td>Washington</td>
</tr>
<tr>
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</tr>
<tr>
<td>Yes</td>
<td>At least 7 days between advising doctor of decision and signing of certificate; and 2 days from signing the certificate.</td>
<td>[Legislation is silent]</td>
<td>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).</td>
<td>Doctor to “hold several interviews with the patient, at reasonable intervals having regard to the evolution of the patient’s condition”.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

| 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, the 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. |

*Although the Belgian legislation does not expressly permit assisted suicide, the prevailing view is that it is covered by the regime: see above n 26.

** Compare the Netherlands Ministry for Foreign Affairs which has stated that it would be “impossible” for a non-resident to receive voluntary euthanasia or assisted suicide 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.
The right to choose an assisted death: Time for legislation?

Report following a Roundtable in Brisbane, January 2013
“How should Australia regulate voluntary euthanasia and assisted suicide?”

Bob Douglas, Lindy Willmott and Ben White
The fact that a peaceful, assisted death is illegal, while much worse alternatives are legally available and much more easily accessible, is disgraceful.

Having been in that suffering, terminal position myself, I understand the debilitating, helpless and inescapable nature of such a situation for patients. No person should have to endure a quality of life which causes them intolerable suffering and distress.

It is important to note that for each person dying there are friends, relatives and carers who are also affected by such a painful and undignified death.

Jessica Sparks is a law and journalism student. She has cystic fibrosis, and at 16 was diagnosed with end-stage lung disease, placed on a breathing machine and told death was imminent. Fortunately she received a double-lung transplant after surviving for a year.
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31 Acknowledgements
Australia21 is a non-profit body, committed to an analysis of complex issues, which bear on Australia’s future. During 2012, the Board was approached with the suggestion that the issues of voluntary euthanasia and assisted suicide would benefit from Australia21’s multidisciplinary approach to the exploration of complex policy issues.

We convened a steering group and obtained funds from private donors to explore this issue. A background paper was published on the topic “How should Australia regulate voluntary euthanasia and assisted suicide?” by two senior legal academics from the Queensland University of Technology, Professors Ben White and Lindy Willmott. This paper formed the basis for a roundtable involving a diverse group of doctors, lawyers, former politicians, ethicists, big picture thinkers and activists, including people supporting and opposed to law reform on this topic. There was a constructive dialogue at an all day meeting in Brisbane on 31 January 2013.

This report has two parts. The first part describes the roundtable and some of the key concerns among the participants. It presents the diversity of views on this topic and the background to the arguments that have been used both for and against assisted dying.

No attempt was made to reach consensus between those supporting and opposing reform on this issue but rather the goal was to facilitate a respectful understanding between the two groups.

The second part of the report describes what the authors, writing for Australia21, have concluded from this rich exchange of ideas and concerns, from the transcript of the discussion which included summative statements by all of the participants at the end of the day, and from published literature. Australia21 hopes that by distributing this report, Australian legislators will be encouraged to engage in this debate with a clearer understanding of the concerns on both sides of the argument.

Australia21’s purpose in this report is not to propose a definitive legislative solution to assisted dying – there is already a wealth of documented and evaluated experience on this matter – but to broaden understanding of the difficulties which current Australian law causes for patients and carers alike, and to explain why the authors have concluded that legislative action is now needed.
Executive Summary

The legal framework that operates at the end of life in Australia needs to be reformed.

- Voluntary euthanasia and assisted suicide are currently unlawful.
- Both activities nevertheless occur not infrequently in Australia, in part because palliative care cannot relieve physical and psychological pain and suffering in all cases.
- In this respect, the law is deficient. The law is also unfair because it doesn’t treat people equally. Some people can be helped to die on their own terms as a result of their knowledge and/or connections while some are able to hasten their death by the refusal of life-sustaining treatment. But others do not have access to the means for their life to end.
- A very substantial majority of Australians have repeatedly expressed in public opinion polls their desire for law reform on these matters. Many are concerned at what they see is happening to their loved ones as they reach the end of their lives, and want the confidence that when their time comes they will be able to exercise choice in relation to assisted dying.
- The most consistent reason advanced not to change the law is the need to protect the vulnerable. There is a concern that if the law allows voluntary euthanasia and assisted suicide for some people, it will be expanded and abused, including pressures being placed on highly dependent people and those with disabilities to agree to euthanasia.
- But there is now a large body of experience in a number of international jurisdictions following the legalisation of voluntary euthanasia and/or assisted suicide. This shows that appropriate safeguards can be implemented to protect vulnerable people and prevent the abuse that opponents of assisted dying have feared. It reveals that assisted dying meets a real need among a small minority of people at the end of their lives. It also provides reassurance to people with terminal and incurable disease that they will not be left to suffer the indignities and discomfort of a nasty death.
- Australia is an increasingly secular society. Strong opposition to assisted death by religious groups that is based on their belief in divine sanctity of all human life is not a justification for denying choice for those who do not share that belief.
- It is now time for Australian legislators to respond to this concern and this experience by legislating to enhance the quality of death for those Australians who seek assisted dying.
We note:

a) For the reasons outlined in Part 2 of this report, voluntary euthanasia and assisted suicide should no longer attract criminal sanctions;

b) Every Member of Parliament (except in the Territories) has the power to introduce a private member’s bill on voluntary euthanasia or assisted suicide;

c) Voluntary euthanasia and assisted suicide bills have generally been decided in Australia by a conscience vote;

d) Federal Parliament withdrew powers to legislate on voluntary euthanasia and assisted suicide from Australian Territories in 1997; and

e) Since 1997, a large body of international evidence has accrued from a number of jurisdictions that have successfully legislated to support voluntary euthanasia and/or assisted suicide.

Accordingly, Australia21 recommends:

a) State governments should develop legislation now to permit and regulate voluntary euthanasia and assisted suicide in defined and limited circumstances;

b) The Federal Parliament should restore powers that were withdrawn from the Territories so these parliaments may do the same; and

c) Until the above happens, each Member of Parliament should consider exercising his or her right to introduce a private member’s bill on voluntary euthanasia and assisted suicide.
Mr Neil Francis
is Foundation Chair and CEO (now retired) of national voluntary euthanasia law reform group YourLastRight.com, past President and CEO of Dying With Dignity Victoria, and past President of the World Federation of Right To Die Societies.

Late last year, YourLastRight.com commissioned national public opinion research, conducted by Newspoll. The survey of more than 2,500 Australians confirmed ongoing very high public support for legal access to physician-assisted dying in the face of intolerable end-of-life suffering that cannot be relieved. (2) Respondents were strongly in favour of this development across age groups, religious affiliation and political affiliation. (see over)

But the study went further. It uncovered that more than a quarter (29%) of Australians said they would change their vote if their otherwise most likely candidate or party stance on assisted dying law reform is opposed to their own stance.

A politician whose stance is opposed to assisted dying law reform will lose considerably more votes at a general election (23%) than a politician who supports reform (6%). A majority of lost votes for “opposed” election candidates applies across all major political parties.

The study also found that voluntary euthanasia law reform was more personally important to voters than other major national issues like the carbon tax, the national high-speed broadband network and gay marriage, and that the views of voluntary euthanasia law reform supporters are on average more deeply held than are views of opponents.

The findings unravel the “truism”, long-held by most politicians: the belief that they will be clobbered at the polls if they undertake law reform. The exact opposite may be true.
Newspoll Survey Results on Public Desire for Reform in 2012

The question asked was: “Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?”

Age group
(doctor can provide a lethal dose)

Religion
(doctor can provide a lethal dose)

Party voting intention
(doctor can provide a lethal dose)
In 2012, Australia21 commissioned a background paper entitled “How should Australia regulate voluntary euthanasia and assisted suicide?” (1) This paper provided a non-partisan analysis of assisted dying and included a review of:

- The current legal landscape in Australia in relation to medical decisions at the end of life including withholding and withdrawing life-sustaining treatment, the provision of palliative medication that may hasten death, as well as euthanasia and assisted suicide;
- Legislative reform attempts in Australia;
- Evidence on what currently happens in Australia;
- Current law and practice in overseas jurisdictions where voluntary euthanasia and/or assisted suicide are lawful;
- Arguments for and against reform; and
- Possible frameworks for regulating voluntary euthanasia and/or assisted suicide.

Invitations to the roundtable were extended to a number of former and current politicians, ethicists, lawyers, palliative care physicians, representatives of the AMA, nurses, young students and strong advocates as well as strong opponents of voluntary euthanasia and assisted suicide. All participants were invited to respond to the background paper with a series of personal dotpoints that were circulated to all participants prior to the roundtable discussion.

The agenda for the day included open discussions on the following questions:

- What happens at present when seriously ill and dying patients request voluntary euthanasia or assisted suicide?
- What is the evidence that Australians wish for a change in regulation on this matter?
- What are the main arguments in favour of and against legalising voluntary euthanasia and assisted suicide?
- What can we learn from international experience that is pertinent to the current Australian situation?
- What are the political realities surrounding legalisation and/or other regulatory changes on this topic?
- If voluntary euthanasia and assisted suicide were to be legalised in Australia, what regulations and constraints would be required to protect the vulnerable?

At the conclusion of the roundtable, summative statements were made by each participant and these were included in a transcript of the discussion that was circulated to all participants and provided the basis for Part 1 of this report.
The right to choose an assisted death

Areas of broad agreement

Discussions throughout the day revealed broad agreement among participants on a number of key issues:

- The law should be coherent;
- Every person who is dying should have access to high quality palliative care and all health professionals should be aware of the role that palliative care can play;
- Advance care planning has an important role to play in end of life decisions and this should be widely available and understood;
- Every competent person has a right to refuse treatment that they do not want;
- Palliative care cannot deal with all physical, existential or psychological pain and suffering that is experienced by people who are dying;
- Doctors who practise in an ethical and compassionate way should not be exposed to legal risk (though there was not consensus on what constitutes ethical and compassionate practice with respect to voluntary euthanasia and assisted suicide).

On the desirability of changing the current law on voluntary euthanasia and assisted suicide, several different themes emerged. Some of those themes support change and others, that the legal framework should not change. Some of these themes are illustrated by specific comments from participants.

Terminology

Terminology is important in this area to ensure a common understanding of the issues being discussed. This report adopts the terminology which was set out in the background paper.\(^1\)

The discussion in the roundtable and the recommendations in this report refer to voluntary euthanasia and physician-assisted suicide.

euthanasia: for the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person

voluntary euthanasia: euthanasia is performed at the request of the person whose life is ended, and that person is competent

non-voluntary euthanasia: euthanasia is performed and the person is not competent

involuntary euthanasia: euthanasia is performed and the patient is competent but has not expressed the wish to die or has expressed a wish that he or she not die

withholding or withdrawing life-sustaining treatment: treatment that is necessary to keep a person alive is not provided or is stopped

assisted suicide: a competent person dies after being provided by another with the means or knowledge to kill himself or herself

physician-assisted suicide: assisted suicide where a doctor acts as the assistant by providing the lethal treatment that the person self-administers.

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assisted suicide: a competent person dies after being provided by another with the means or knowledge to kill himself or herself

physician-assisted suicide: assisted suicide where a doctor acts as the assistant by providing the lethal treatment that the person self-administers.
Themes/perspectives in support of reform:

1. Competent adults should be able to make decisions about their own life and death. Increasingly, older or terminally ill people want the security of knowing that they can obtain assistance to end their life if they judge that it has become too burdensome and insufferable or meaningless.

2. Some people are dying in physical, psychological and/or existential pain in a way that should not be tolerated in a humane and compassionate society.

3. The law is unsatisfactory and, in important respects, incoherent.
   • There is uncertainty about what it means to “assist” someone to die, whether a person will be prosecuted if they do so and, if they are prosecuted and found guilty, whether they will be imprisoned.
   • Legal liability for doctors can depend on their intention when treating their patient – did they intend to relieve symptoms or end the patient’s life? Although voluntary euthanasia is illegal in all states and territories in Australia, doctors not infrequently prescribe heavy sedation to patients with intractable pain to relieve their symptoms, even if doing so risks hastening the patient’s death. If their intention is to relieve symptoms, doctors are legally protected by the “doctrine of double effect” even if they foresee the possibility that the sedation will shorten a patient’s life.
   • While there is recognition under the law that a patient can end their life by requesting suspension of unwanted life-sustaining treatment (such as a respirator), a request for active steps to end their life cannot be legally respected.

4. Lives are currently being ended despite existing prohibitions on voluntary euthanasia and assisted suicide.
   • Some individuals take their own lives by suicide (e.g. by violent means or, more often recently, by importing illegal drugs from overseas).
   • Some individuals (including family members and doctors who act outside the protection of the doctrine of double effect) take active steps to end a person’s life.

5. Providing requested assistance to die should be part of how those doctors, who are willing to do so, can care compassionately for suffering patients.
Dying may be associated with intolerable suffering and there may be a crescendo of suffering as death approaches. A doctor’s duty is to relieve suffering. Some suffering will only be relieved by death.

A doctor’s duty is to respect his patient’s autonomy. Some patients rationally and persistently request assistance to die. Palliative care cannot relieve pain and suffering of all dying patients.

There is a serious lack of appreciation of the importance of psychological and existential suffering at the end of life, and an undue emphasis on physical pain in the debate.

The current law is opaque, ambiguous, hypocritical and unenforceable.

Dr Rodney Syme is a medical practitioner with a 38 year history of active participation in physician-assisted dying.
The issue of voluntary euthanasia and assisted suicide should be withdrawn from the context of the criminal law entirely, with interventions from lawyers, courts, judges excluded virtually completely. The law is a blunt instrument at the best of times but particularly when dealing with sensitive issues such as life and death.

The whole issue is morally complex and sensitive and it is impossible to regulate all of the personal and subjective variables at play in voluntary euthanasia and assisted suicide.

The presumption must be that the patient particularly, as well as their doctor and perhaps with advice from a well-established religious moral tradition, are in the best position to make these kinds of deeply personal decisions.

I support the right to refuse or withdraw life-sustaining treatment.
Themes/perspectives opposing reform:

1. There is a risk that if voluntary euthanasia and/or assisted suicide are legally permitted, the current culture of our society in terms of care and concern for the disadvantaged and people with disabilities will change.
   - There is a risk that there would be a change in societal thinking that would place vulnerable individuals and people with disabilities at risk. Those who need support and care may feel under a duty to “do the right thing” by family and society and accept euthanasia.
   - The increasing focus on individual autonomy and rights, exemplified by legalising voluntary euthanasia and assisted suicide, is undesirable. As a community, we need to focus more on society than the individual. While reform would permit a small number of individuals to exercise a right they consider to be important, this will not result in the overall good for society, which should be responsible for caring for those who are sick and dying.

2. Legalising voluntary euthanasia and assisted suicide will result in a significant and undesirable change in the doctor/patient relationship.
   - Doctors should not be the “takers” of life but rather the “defenders” of life.
   - Doctors have a duty to the “weakest” of their patients, and this duty would be corrupted by introducing a culture of mercy killing.
   - Assisting a patient to die may be regarded by inexperienced and less skilled doctors as an easier option than to work through issues that may underpin a patient’s request to die.
   - Doctors, nurses and other health professionals may feel pressured to be involved in ending life, or referring patients to others who will, contrary to their conscience.

3. The “non-compliance with legislative safeguards” argument: Even if voluntary euthanasia and/or assisted suicide legislation contained adequate safeguards such as limiting the regime to competent adults who are terminally ill and who voluntarily request assistance to die, in practice such safeguards would not be adhered to. The practice would extend, for example, to vulnerable individuals who may feel under emotional pressure to end their lives.

4. The “inevitable expansion of criteria” argument: Even if voluntary euthanasia and/or assisted suicide legislation were limited to competent adults, in due course such legislation would be amended to extend to incompetent adults, or even competent but very sick adults who do not wish their lives to end.

5. A fifth issue – which was not discussed at the roundtable – but is an important aspect of the debate for some is a religious belief in the divinely authorised sanctity of human life. There is a prohibition by some religious groups of all acts that end human life and these groups have been active in opposing legalisation of assisted dying.
If you are bringing in the machinery of mercy killing, you are corrupting two basic elements: firstly the social contract between the state and its most vulnerable citizens, who will not be claiming the right to die but will be accepting the duty to die. Secondly a change would corrupt the relationship between doctors and their patients.

If you allow doctors to prescribe medicines with the intention of causing death, you have radically changed the nature of the doctor’s role and his/her relationship with the patient.

A culture of mercy killing would also transform the social contract between the state and its most vulnerable citizens – or what former Governor-General Bill Hayden called society’s “unproductive burdens”.

I draw your attention to a key conclusion from the 1994 House of Lords inquiry into medical ethics:

“It would be virtually impossible to ensure that all acts of euthanasia were truly voluntary... We were also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death... The committee believed that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death but should assure them of our care and support in life.”

For such people, the so-called “right to die” would be felt more as a “duty to die”; to do the right thing by family and society.
End-of-life issues are, by their nature, complex, personal and sensitive, but they are made all the harder if the wishes of the person concerned are not properly understood or set out.

The general reluctance in our society to discuss end-of-life issues translates into a failure by many to prepare properly for the end of life.

There is a need for more discussion, debate and community-wide research to ensure that the complex issues relating to dementia are fully considered.\(^{14}\)

It is clear that, even if voluntary euthanasia were to be legalised, it would be wrong to end the life of an individual who does not have the capacity to make the decision and who has not expressed previous wishes.
While the AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide, the organisation currently believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person’s life.

This does not include the discontinuation of futile treatment or the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

The AMA strongly advocates for the right of a competent patient to make fully informed health care decisions, including the right to refuse treatment. The AMA recognises that this may include life-sustaining treatment as well as palliative care.

The AMA strongly promotes advance care planning as a process of supporting patient self-determination, including the development of advance directives and the identification of surrogate decision-makers such as Enduring Powers of Attorney (or similar), as a means to ensure that the patient’s values and goals of care are known. Advance care plans are prepared by the competent patient to assist in decision-making if he or she loses the capacity to make treatment decisions in the future.

While the need for access to voluntary euthanasia and assisted suicide may be a simple issue for patients, it is more complex and ambiguous for doctors and carers. The ambiguity has led to significant variation in the kind of end-of-life care that takes place.

If there is to be any progress on this issue there has to be legal protection for doctors. It may be law reform, legalisation, or it may be case law.
Most (but not all) of the roundtable participants considered that the current legal situation is unsatisfactory for many patients and/or their professional carers. Australia21 and the authors of this report agree that legislative change is now needed.

Patients in the terminal phase of their lives not infrequently ask their doctor for help to die. Sometimes, this is simply a cry for help and when symptoms are alleviated (e.g., with pain relieving medication), the patient changes their mind. For some, pathological depression can be alleviated with modern psychoactive drugs and counselling. But while palliative care can assist with physical, psychological and existential problems, it cannot adequately manage all suffering in all patients. Some patients genuinely, persistently and rationally request help to end their lives.

If the patient’s life is being prolonged by medical means such as respirators, the law allows those life support measures to be turned off at the request of a competent patient. Furthermore, if there is unrelieved pain, doctors can (and do) respond to a patient’s (or family’s) request for the provision of drugs in sufficiently high doses to relieve symptoms. In this situation, the doctor may foresee that symptomatic relief could shorten life, but provided the doctor’s intention is to relieve symptoms, the provision of such medication is lawful. But if the doctor’s intent is to shorten life rather than to relieve symptoms, the action may constitute murder. This is an untenable situation for a compassionate doctor who agrees that the situation is hopeless and that the patient’s request is genuine and reasonable.

National polling suggests that this is an issue on which Australians want reform. There is now extensive international experience to encourage and guide such reform.
There are a number of compelling reasons why Australia supports the view that the law needs to change.

1. The Australian community wants change
Repeated polling has been carried out for 25 years by professional pollsters, and the public has consistently reported overwhelming support in favour of reform. The question usually explores whether a person supports allowing a doctor to assist a person to end their lives if experiencing unrelievable and incurable suffering. In addition to the Newspoll survey reported on page 8, an opinion poll conducted by The Australia Institute in 2012 asked the following question:

If a person is experiencing unrelievable and incurable suffering (physical and/or mental) should a doctor be allowed to help them end their life?
Of the 1400 people surveyed, 71% agreed with the proposition, 12% of people disagreed and 17% were unsure.

2. The law has failed
For the reasons described below, the current legal framework of prohibition has failed.

a) Deaths are currently occurring contrary to the law
Research among Australian doctors caring for seriously ill patients has documented current practices in some detail. According to that research, voluntary, involuntary and non-voluntary euthanasia all occur in Australia in defiance of the law. Some doctors have admitted publicly that they have acted with intent to end the patient’s life but, despite this admission, they have not been prosecuted.
Kuhse et al concluded that in 1995-1996, 1.8% of all deaths in Australia occurred as a result of voluntary euthanasia and 0.1% were due to physician-assisted suicide. Despite these actions being unlawful in Australia, the incidence was broadly comparable with that in permissive jurisdictions. Other research demonstrates that some doctors who treat terminally ill patients intend to shorten life (rather than only relieve pain) when they administer pain relieving medication, and so will be acting unlawfully.

b) The current law is incoherent or illogical
There are a number of aspects of the law in relation to the end of life care which are incoherent or illogical:
• Withdrawal or withholding of life-sustaining treatment that results in a person’s death may be lawful, but the provision of a lethal dose intended to cause death is not;
• Terminal sedation may be lawful, but can also be unlawful depending on the doctor’s intention when giving the medication;
• Suicide is legal, but assisting someone to commit suicide is illegal;
• There is a lack of clarity about what is meant by “assisting” someone to die;
• Even in a clear case where a person has “assisted” another to die, some individuals are prosecuted and jailed for providing that assistance, and others are not.

c) The law fails the principle of “equality before the law”
The Rule of Law requires that law must apply equally to all, but this is not the case in this field. Whereas some may be able to end their own life, another person’s disability may prevent them from doing so. Further, a person who is ill and relying on life-sustaining treatment to survive [such as a respirator] may lawfully ask for that equipment to be turned off. Another person who is equally ill, but suffering from a different condition which does not require such treatment, cannot be assisted to die.
At present, there are some who can access voluntary euthanasia and assisted suicide despite it being unlawful. Those people are generally able to do so because they possess some privilege. It may be privilege in terms of education or it may be in relation to contacts and connections one has within the medical or veterinary professions. The operation of the law cannot be justified if a privileged few are able to receive assistance to die, but others cannot.
d) Non-compliance with the law brings the law into disrepute

Repeated breaches of the law, particularly where they are made public and not prosecuted, undermine the Rule of Law. This becomes even more problematic for the Rule of Law, if that non-action in the face of illegality is a position that is generally endorsed by a large majority of the community.

3. Some terminally ill patients feel forced to choose an unsatisfactory death

For some people in the terminal stages of their life, pain or other suffering are relentless and these individuals may take steps to end their own lives. This ending can be violent and painful for the person and traumatic for their family and friends. Many people are attending workshops to seek information on how they can take their own lives when the time is right, in a peaceful way. But for others, the only current alternative is violent.

4. Palliative care cannot address all suffering

The palliative care movement has developed to assist patients with terminal illness when approaching the end of their life. It provides medical support for the relief of symptoms and also nursing, social and spiritual support for the relief of existential suffering. But palliative care, despite its accomplishments, is unable to meet the needs of all patients as they approach the end of their lives. While palliative care can assist with physical, psychological and existential pain, it cannot manage all suffering in all cases.
Palliative care usually has adopted a confrontational position against voluntary euthanasia, recognising its work as supporting living before death rather than assisting death. Other factors are its historical association with Christian (Catholic) concern to preserve life; and a sense that support for euthanasia is a criticism of palliative care expertise.

The process of dying, as palliative physicians come to understand it, is an evolving one, subject to change. Evaluation of the needs of a terminally ill patient requires time and a comprehensive approach, taking in the history and the context of the patient and attending family.

Sometimes a wish to die does stem from “intolerable suffering”, but just what makes a situation “intolerable” may be very individual. Awful pain can usually be addressed; anger, despair, isolation, a concern about finance may all impinge on the scene and are more difficult. Family members usually want to support whatever decision a patient has made, but may also be in contention. One needs time to build understanding about the realities of the whole situation.

I am clearly in favour of decriminalisation of assisted death but I worry about euthanasia being regarded as a “quick fix”.

It calls for the same full appreciation as palliative care physicians seek to bring to their work. Most of us want the right to have a say, but it is appropriate to ask that all death decisions be considered in the light of a full understanding of complex realities, and of close others whom it will affect.

Emeritus Professor
Ian Maddocks AM

is Senior Australian of the Year 2013. He was the first President of the Australian Association for Hospice and Palliative Care (now known as Palliative Care Australia) and first President of the Australian and New Zealand Society for Palliative Medicine. Now aged 81, he continues daily care for the terminally ill.
Undoubtedly, euthanasia occurs now in various guises in Australia and is likely to continue to occur outside any regulatory guidelines if euthanasia or assisted suicide are decriminalised or legalised.

There is convincing evidence that the majority of Australians are in favour of legalised assisted death.

There is no convincing evidence that the legalisation of euthanasia and/or assisted suicide in the Netherlands and Oregon has caused any significant societal harm.

There is overwhelming evidence that the vast majority of requests for euthanasia are simply “cries for help”. This is not to deny the validity of a very small number of requests, but this is a fairly well-established fact accepted by those on both sides of the euthanasia debate.

I am agnostic about the benefits of legislative change. I don’t accept that we will have a much better society if it happens, nor do I think it is going to be catastrophic as some opponents of change suggest.

But if we do have legislative change, I think it will have a substantial effect on the national psyche and that the effect could be both positive and negative.
1. Safeguards to protect the vulnerable are working well internationally

Since the House of Lords Select Committee on Medical Ethics expressed its view in 1994(5) that it would be virtually impossible to devise safeguards to prevent abuse of legalised euthanasia, the issue of safeguards has dominated the Australian debate. The concern is that people who are dependent on others may feel a responsibility to seek death, or worse, may be coerced into using it to relieve society or relatives of the burden of caring for them.

Different legislative approaches to safeguards exist in the Netherlands, Belgium and Oregon and these regimes have been in place for long enough to assess their impact. Extensive evaluative data about their operation have been analysed and these, along with considerations such as the need to protect the vulnerable in society, have been considered in detail in many international publications and inquiries(7, 8, 9, 10) and, more recently, in a discussion paper in Tasmania.(11) The experience shows that guidelines to protect the vulnerable and ensure that assisted dying is reserved for the group in whose interest it is legislated, are generally operating effectively.

Such data have sometimes been interpreted differently by those who support and oppose legalisation(14), but discussion at the roundtable supported (though not unanimously) the view that legislation in jurisdictions that have legalised voluntary euthanasia and/or assisted suicide is generally operating without evidence of the kinds of abuses that opponents and the 1994 report of the House of Lords had feared.

Australia21 agrees. It takes the view that the available evidence demonstrates safeguards can be designed to ensure that only “eligible” patients (eg. competent adults who voluntarily request assistance to die and are terminally ill) can receive legal assistance to die, and to ensure that certain conditions (including, for example, the provision of information, obtaining a second opinion and a cooling off period) are satisfied before that assistance is provided.

2. Religious belief in divinely authorised sanctity of human life should not bind others

Strong opposition to assisted death has been mounted by some religious groups on the basis that human life is sacred and divinely given and that therefore killing is divinely prohibited. (3, 4) This issue was not discussed at the roundtable, but was considered in the background paper.

Australia is increasingly a secular society and it is difficult to defend law and policy that reflects divine understandings of the value of human life. There is now wide acceptance that human life is not an absolute good and that notions of compassion and autonomy can carry greater weight in some circumstances. Further, some religious groups are moving away from more traditional positions and agitating for a more humane approach to assisted dying.

The polling data presented on page 8 of this report confirms that strong support for reform spans religious denominations.

Australia21 firmly asserts the right of people to hold and practise religious beliefs. An important concern raised at the roundtable was to ensure doctors, nurses and other health professionals are not required to participate in voluntary euthanasia or assisted suicide contrary to their conscience. However, respect for those beliefs should not bind others who have different beliefs and values, and religious teachings should certainly not be regarded, in our secular society, as a basis for developing law and policy.

We have demonstrated why we think the law must change. Legislation to legalise assisted dying should be enacted unless there are compelling reasons not to do so. The two major arguments against reform are: 1) concerns that the vulnerable in our community will be placed at greater risk, and 2) the theological view that the divinely conferred sanctity of human life should prevent the intentional taking of life. Neither of these arguments is, in our view, sufficient to resist reform.
I have cared for terminally ill patients who have strongly expressed their wish for help to die. Around 7% of patients with advanced cancer make persistent requests for help to die. While I support patient-centred care and patient autonomy, family and broader concerns can temper these.

There are situations in which a strong consensus can be formed between the terminally ill patient, their loved ones, and their carers, that voluntary euthanasia is reasonable and desired. Compassionate clinicians can experience enormous pressure to grant a dying person’s wish for a hastened death. In these circumstances, I believe clinicians should have protection from prosecution for the most serious crime of murder.

Voluntary euthanasia is ethically distinct from murder, because of respect for autonomy and compassion (rather than sinister motives), yet parliamentarians have been reluctant to distinguish them in law.
Dr Philip Nitschke

In 1996, Philip Nitschke became the first physician in the world to administer a legal lethal voluntary injection to four terminally ill patients under the Northern Territory’s Rights of the Terminally Ill Act. When the law was overturned nine months later, Philip founded Exit International; an international end of life choices group with a focus on practical strategies. Philip has written extensively on voluntary euthanasia and is the author of two books: Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill (Penguin, 2005) and The Peaceful Pill Handbook (Exit International USA, 2013).

In the intervening 16 years since the Northern Territory Rights of the Terminally Ill Act came and went, the debate on voluntary euthanasia has been extended beyond those who are terminally ill, to include the well elderly for whom rational suicide is one of many end of life options.

This new cohort consider end of life planning in the form of rational suicide as an insurance policy should their health take a turn for the worse. As the baby boomer generation ages, the shift away from a medicalised approach to death and dying can be expected to accelerate, making way for a more democratic model of DIY [do it yourself] methods which are predicated upon widely-held notions of independence, control and self-sufficiency.

My focus in recent years has been the provision of information about forms of access to Nembutal – the best end of life drug – as well as the use of inert gases (such as nitrogen and helium). These technologies serve to de-couple end of life decision-making from a hitherto medicalised model of death and dying controlled by the medical profession.

On the legislative front, there remain two key unresolved issues. The first of these concerns section 122 of the Australian Constitution which allows the Government of Australia to make laws for its territories. This section constitutes a loophole by which the laws of the democratically elected government of the Northern Territory (and the Australian Capital Territory) can be overturned. The preparedness of the Australian Parliament to exploit this Constitutional weakness remains a significant impediment to voluntary euthanasia law reform nationally.

The second area of legislative concern is the mismatch between the lawfulness of suicide and the illegality of assisted suicide. The legal nexus between suicide and assisted suicide needs examination. The fact that countries such as the UK have seen fit to publish guidelines on assisted suicide (without actually changing the law) suggests that Australia could, as a first tentative step, make similar considerations with a view to adopting similar guidelines.
Existing legal understandings that allow various medical end-of-life decisions, but prohibit “voluntary euthanasia” are unfair and unjust. They treat patients experiencing similar intolerable pain and suffering arbitrarily, in discriminatory ways.

A patient who needs life-support can lawfully refuse it, thereby bringing about her/his own death, with the assistance of a doctor. A patient not needing life support cannot lawfully draw on the assistance of doctors to end their lives.

Legislation to allow voluntary euthanasia would place all incurably and/or terminally ill patients on an equal footing; it will allow for openness and oversight and may well – as various overseas studies have shown – reduce (rather than increase) the incidence of non-voluntary and involuntary euthanasia in Australia.
Selected references


Hon Bob Brown is a medical doctor, environmentalist, former Senator and former Parliamentary Leader of the Australian Greens.

Legislation is much more likely to succeed if it requires the patient, not the doctor, to self-administer the lethal drug.

The strongest opposition in the political arena comes from palliative care advocates who, wrongly, tell politicians that given enough funding, palliative care will be able to make every dying person content. This opposition is most unreasonable when it comes from Catholic palliative care doctors, cardinals and ethicists.

Ideally, bills for voluntary euthanasia should be hosted by members from each of the political parties in that parliament and should involve a conscience vote.
Roundtable Participants

Mr Paul Barratt AO  
Chair, Australia21

The Hon Emeritus  
Professor Peter Baume AC  
Former Health Minister and University Chancellor

Mr Jack Boyd  
Law/Commerce Student

Dr Bob Brown  
Former Leader, Australian Greens

Professor Colleen Cartwright  
Professor of Aged Care, Southern Cross University

Dr Paul Collins  
Historian, Writer and Broadcaster

Dr Richard Denniss  
Director, The Australia Institute

Emeritus Professor Bob Douglas AO  
Retired Epidemiologist (Chair)

Dr Charles Douglas  
Surgeon and Ethicist

Mr Richard Eckersley  
Director, Australia21 and Social Researcher

Mr Neil Francis  
Former Chair and CEO, YourLastRight.com

Dr Roger Hunt  
Palliative Care Physician

Dr Helga Kuhse  
Ethicist, Monash University

Dr Yvonne Luxford  
CEO, Palliative Care Australia

Emeritus Professor Ian Maddocks AM  
Senior Australian of the Year, Palliative Care Physician  
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Dr Alex Markwell  
President, AMA Queensland, Emergency Physician

Mr Richard Mills  
President, Dying with Dignity NSW

Dr Philip Nitschke  
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Professor Malcolm Parker  
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Mr Marshall Perron  
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Dr Romaine Rutnam  
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Ms Jessica Sparks  
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Dr Rodney Syme  
Medical Practitioner, Writer on Assisted Dying

Dr David Van Gend  
General Practitioner, Senior Lecturer in Palliative Care, University of Queensland

Professor Ben White  
Professor of Law, Health Law Research Centre, QUT

Professor Lindy Willmott  
Professor of Law, Health Law Research Centre, QUT

Mr Ian Wood  
Retired Pharmacist, Co-Founder, Christians Supporting Choice for Voluntary Euthanasia
Voluntary euthanasia goes on every day — but without supervision, without advice from colleagues, and without rules.

Involuntary euthanasia occurs in intensive care units now.

Access to most goods is unequal in society and this is likely to be the case with voluntary euthanasia (and access to good quality palliative care).

The ethical principle of autonomy of the individual is not accepted by some people and some cultures positively reject the principle.

Religious belief does play a role here. People who want voluntary euthanasia are worse off (in regard to voluntary euthanasia) in hospital (or in a nursing home) than they are at home.

It is legal now to kill oneself but the legal methods are all messy.
Australia21 gratefully acknowledges financial support for this project from Mr Richard Eckersley, the estate of Ms Jan Lee Martin, Mrs Joan Douglas, the Health Law Research Centre at the Queensland University of Technology (QUT), Mr Robert Albert, Mr John Newsom, Dr and Mrs David Evans, Mrs Elizabeth Alpers, Dr Romaine Rutnam and Dr Tony Adams.

The steering committee for this project included Mr Paul Barratt AO, Mr Richard Eckersley, Mr Marshall Perron, Professor Peter Baume AC, Dr Charles Douglas, Mr Richard Mills, Professor Lindy Willmott, Professor Ben White and Professor Bob Douglas AO.

We are also particularly grateful for use of facilities at QUT, to the Vice Chancellor, Professor Peter Coaldrake AO, who hosted a reception for participants, and to Ms Amy Henderson and her staff at QUT for logistic support.
If there are terminally and incurably ill patients who wish to end their suffering by accelerating inevitable death and if there are sympathetic doctors who are willing to help them to die with dignity, then the law should not forbid it.

The law does forbid it and that is why I have been on a bit of a campaign to change that.

Currently the message that the Australian community is being given by its politicians is as follows:

“When you get really ill and near-death, go to the palliative care unit and they will do their best to help you but there is a chance they cannot. If you don’t want to go down that path then you can go and kill yourself and there is no law against suicide. We don’t want you to but no one can stop you. You can go and hang yourself or shoot yourself. That is okay. But if you want to have the family around for the hugs and tears and say goodbye, it is very hard to do that when you’re going to hang yourself from the ceiling fan.”

Why can we not die in a peaceful tranquil way in the company of loved ones?
PROSECUTORIAL GUIDELINES FOR VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE: AUTONOMY, PUBLIC CONFIDENCE AND HIGH QUALITY DECISION-MAKING

Ben White* and Jocelyn Downie†

[This article proposes offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. A similar policy has been produced in England and Wales but we consider it to be deficient in a number of respects, including that it lacks a set of coherent guiding principles. In light of these concerns, we outline an approach to constructing alternative guidelines that begins with identifying three guiding principles that we argue are appropriate for this purpose: respect for autonomy; the need for high quality prosecutorial decision-making; and the importance of public confidence in that decision-making.]

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Euthanasia and assisted suicide remain the subject of ongoing debate in Australia. Public interest has been sparked by a series of recent prosecutions, most notably those of Shirley Justins and Caren Jenning in connection with the death of Graeme Wylie.\(^1\) Other recent prosecutions that have attracted attention include those of Ann Leith\(^2\) and Victor Rijn\(^3\) in Victoria, Merin Nielsen in Queensland,\(^4\) and David Mathers in New South Wales.\(^5\) A promi-

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\(^1\) The cases associated with Graeme Wylie’s death are discussed further below at Part VIIA.

\(^2\) See Adrian Lowe and Steve Butcher, ‘No Conviction for Euthanasia Drug’, *The Age* (Melbourne), 16 April 2010, 3.


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A significant part of the debate in this area has been directed to the need for reform and those efforts to date have focused on legislative change. For example, there have been a number of Bills recently introduced or considered in South Australia,6 Western Australia7 and New South Wales8 seeking to liberalise the law.9 There have also been reports of a forthcoming Bill being prepared in Tasmania, which has the support of the Premier of that state,10 and there have been attempts at the Commonwealth level to repeal the laws that preclude territory governments from legislating in relation to euthanasia.11

One issue that has not yet received sufficient attention in the Australian context, however, is the use of discretion as to when cases of euthanasia and assisted suicide should be prosecuted.12 Examination of the role that prosecutorial discretion might play in such cases is timely given recent developments in England and Wales and Canada. In 2010, after a period of public consulta-
tion, the Director of Public Prosecutions (‘DPP’) in England and Wales released its Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, which provides offence-specific guidance for how prosecutors will approach their decision of whether or not to prosecute. In Canada, both the reports of the Royal Society of Canada Expert Panel on End-of-Life Decision-Making and the all-party Select Committee of the Quebec National Assembly included the adoption of prosecutorial guidelines as part of their recommendations for reform in this area.

The purpose of this article is to develop offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. We acknowledge the threshold issue of whether such guidelines are an appropriate vehicle for reform, but there is not scope in this article to make the case for this. It is sufficient for our purposes to point to developments in England and Wales and Canada, which make it timely for Australian jurisdictions to consider this issue, and to offer our guidelines as a principled approach for those contemplating this model.

We propose that our guidelines would supplement the existing general prosecution guidelines and we begin by outlining the way in which these guidelines in the various Australian states and territories operate in relation to the prosecution of offences generally. We then turn to consider the position in the England and Wales and how the offence-specific policy there came to be produced. Although a useful starting point, we conclude that this policy is deficient in a number of respects, including that it lacks a set of coherent guiding principles. In light of these concerns, we outline an approach to constructing alternative guidelines that begins with identifying three guiding principles that we argue are appropriate for this purpose: respect for autonomy; the need for high quality prosecutorial decision-making; and the importance of public confidence in that decision-making. Using those principles, we then construct our own guidelines for how prosecutorial discretion should

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be exercised in cases of voluntary euthanasia and assisted suicide. For ease of reference, our proposed guidelines are set out in full in the Appendix.

II PROSECUTORIAL GUIDELINES IN AUSTRALIA

The criminal offences that principally arise in the context of euthanasia and assisted suicide are murder, manslaughter, and aiding, abetting or counselling suicide. It is no defence that the accused’s conduct was motivated by compassion, nor is a person excused from criminal responsibility because a victim consented to his or her own death. However, the commission of one of the above offences is not of itself sufficient to lead to prosecution. All of the

15 See Cameron Stewart, ‘Euthanasia and Assisted Suicide’ in Ben White, Fiona McDonald and Lindy Willmott (eds), Health Law in Australia (Lawbook, 2010) 415, 416–33 [12.10]–[12.160]. See also Bartels and Otlowski, above n 9, 534–5. For a wider discussion of the relevant criminal law position in Australia, see Simon Bronitt and Bernadette McSherry, Principles of Criminal Law (Lawbook, 3rd ed, 2010) 503–42 [9.05]–[9.175] (unlawful killing); see especially 512–22 [9.40]–[9.95] (euthanasia and unlawful killing), 546–9 [9.190]–[9.205] (offences related to suicide). There may also be other relevant offences, including: the misuse of drugs under various state health regulations contrary to, eg, the Poisons and Therapeutic Goods Act 1966 (NSW); using a carriage service for suicide-related material contrary to ss 474.29A–474.29B of the Criminal Code Act 1995 (Cth) sch (‘Criminal Code’); or importing ‘border controlled drugs’ contrary to Criminal Code s 314.4.

16 Motive is immaterial to the determination of criminal responsibility in these cases. In relation to three Australian states with criminal codes, see Criminal Code Act 1899 (Qld) sch 1 s 23(3); Criminal Code Act 1924 (Tas) sch 1 s 13(4); Criminal Code Act Compilation Act 1913 (WA) sch s 23(2). In relation to the common law, see, eg, Airedale NHS Trust v Bland [1993] AC 789, 892 (Lord Mustill). For a discussion of the irrelevance of motive in this context, see Margaret Otlowski, Voluntary Euthanasia and the Common Law (Oxford University Press, first published 1997, 2000 ed) 21–2.

17 In relation to the common law, see R v Cato [1976] 1 WLR 110, 117 (Lord Widgery CJ); Otlowski, Voluntary Euthanasia and the Common Law, above n 16, 20–1. In relation to the Code states, see Criminal Code Act 1983 (NT) s 26(3); Criminal Code Act 1899 (Qld) sch 1 s 284; Criminal Code Act 1924 (Tas) sch 1 s 53(a); Criminal Code Act Compilation Act 1913 (WA) sch s 261. On this point, we anticipate a possible argument that our proposed guidelines could be subject to an administrative law challenge on the basis that they are based on an autonomous choice by the deceased for his or her life to end and this is inconsistent with the prohibition on consenting to one’s own death. However, we consider that our proposed guidelines would withstand such a challenge because the guidelines do not infringe on the criteria for when criminal responsibility as a matter of law is established. Instead, the proposed voluntary euthanasia and assisted suicide guidelines are relevant only to assessments as to whether it is in the public interest for that conduct to be prosecuted and a discretion to be exercised accordingly. We also note that the public interest factor of autonomous choice in the proposed guidelines would not be the sole criterion for the exercise of prosecutorial discretion as DPPs would also have to apply the other public interest considerations as set out in the general prosecution guidelines.
state and territory DPPs have issued guidelines that govern the exercise of prosecutorial discretion generally and made them publicly available. In all but one jurisdiction (Tasmania), the production of these guidelines is expressly authorised by the statute that creates the office of the DPP. These guidelines set out the test that the DPP will apply in considering whether to prosecute an accused. Although the approach is formulated in different ways in the various jurisdictions, there are broadly two considerations:


19 *Director of Public Prosecutions Act 1990* (ACT) s 12; *Director of Public Prosecutions Act 1986* (NSW) ss 13–15 (the present guidelines are issued pursuant to s 13); *Director of Public Prosecutions Act 1990* (NT) s 25; *Director of Public Prosecutions Act 1984* (Qld) s 11; *Director of Public Prosecutions Act 1991* (SA) s 11; *Public Prosecutions Act 1994* (Vic) s 26 (note also that issuing guidelines is a ’special decision’ as defined in s 3(1) and so must occur on the advice of a ’Director’s Committee’: s 22(2)); *Director of Public Prosecutions Act 1991* (WA) s 24. There is no equivalent provision in *Director of Public Prosecutions Act 1973* (Tas). Although not considered in this article, note also that in some jurisdictions, the Attorney-General is able to give directions or provide guidelines to the Director of Public Prosecution as to how his or her functions are to be carried out: see, eg, *Director of Public Prosecutions Act 1990* (ACT) s 20; *Director of Public Prosecutions Act 1986* (NSW) s 26; *Director of Public Prosecutions Act 1990* (NT) s 28.

20 For example, some jurisdictions expressly include the reasonable prospect of securing a conviction as part of the wider public interest test (see, eg Director of Public Prosecutions for Western Australia, *Statement of Prosecution Policy and Guidelines*, above n 18, 7 [24]) while other jurisdictions frame these two considerations in different ways (see, eg, Office of the
1 Is there sufficient evidence such that there is a reasonable prospect of securing a conviction?

2 If so, is it in the public interest that a prosecution occur?

The second consideration is the significant one for this article. The various Australian prosecution guidelines identify a range of factors that may be relevant to determining whether a prosecution is in the public interest. These factors include: the seriousness of the alleged offence;\(^{21}\) any mitigating or aggravating circumstances;\(^{22}\) the characteristics of the accused, the victim and any witnesses (such as age, physical or mental health, or disability);\(^{23}\) the degree of the accused’s culpability in relation to the offence;\(^{24}\) antecedents and background of the accused;\(^{25}\) the prevalence of this type of offence and the need for deterrence;\(^{26}\) the level of public concern about the offence;\(^{27}\) the attitude of the victim to prosecution;\(^{28}\) the level of cooperation from the accused;\(^{29}\) the need to maintain confidence in Parliament, the courts and the law;\(^{30}\) the likely sentence if the accused is convicted;\(^{31}\) and the likely length and cost of trial.\(^{32}\) Although some of these factors may have particular applicability to cases involving voluntary euthanasia and assisted suicide, none of the prosecution guidelines in Australia include specific criteria to consider when determining whether a prosecution should occur in such cases.\(^{33}\)

21 See, eg, Director of Public Prosecutions Victoria, *Director’s Policy: The Prosecutorial Discretion*, above n 18, 4 [2.1.10(a)].

22 See, eg, ibid 4 [2.1.10(b)].

23 See, eg, ibid 4 [2.1.10(c)].

24 See, eg, ibid 4 [2.1.10(f)].

25 See, eg, ibid 4 [2.1.10(d)].

26 See, eg, ibid 4 [2.1.10(j)].

27 See, eg, ibid 4 [2.1.10(l)].

28 See, eg, ibid 5 [2.1.10(n)].

29 See, eg, ibid 5 [2.1.10(p)].

30 See, eg, ibid 5 [2.1.10(q)].

31 See, eg, ibid 5 [2.1.10(o)].

32 See, eg, ibid 5 [2.1.10(o)].

33 Note, however, that the Attorney-General of the ACT has issued a direction entitled *Director of Public Prosecutions Direction 2006 (No 2) (ACT)*, which clarifies that health professionals will not be prosecuted for withholding or withdrawing life-sustaining treatment that has been
III The Assisted Suicide Policy in England and Wales

The position is different in England and Wales, as they have recently produced a prosecutorial policy dealing with assisted suicide (the policy does not cover voluntary euthanasia). This occurred after the final judicial decision of the House of Lords in July 2009: R (Purdy) v Director of Public Prosecutions ('Purdy'). Ms Purdy suffered from primary progressive multiple sclerosis and wished to obtain assistance from her husband to travel to a jurisdiction where assisted suicide was lawful so that she might die. She was, however, concerned that her husband might be prosecuted and so requested information from the DPP as to the factors he would consider when deciding whether to consent to the initiation of a prosecution for assisted suicide. This consent is specifically required by s 2(4) of the Suicide Act 1961. The DPP declined to provide that information and Ms Purdy challenged that decision. The House of Lords concluded that Ms Purdy was entitled to know what factors the DPP would consider when deciding whether to prosecute and directed him to promulgate an offence-specific policy to this effect.

In reaching this conclusion, the House of Lords considered that Ms Purdy’s right to respect for her private life under art 8(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms (‘Convention’) was engaged. A failure to provide an offence-specific policy setting out the factors that will be used to determine whether a prosecution is in the public interest interfered with that right in a manner that was not ‘in accordance with law’ as required by art 8(2) of the Convention. Matters of

34 See Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13.
36 9 & 10 Eliz 2, c 60.
40 Ibid 395–6 [54]–[55] (Lord Hope), 398 [64] (Baroness Hale), 405 [85] (Lord Brown), 407–8 [100]–[101] (Lord Neuberger); see also at 390–91 [40]–[43] (Lord Hope) (discussing art 8(2)), 391 [44]–[53] (Lord Hope) (discussing the Director’s discretion).
significance in reaching this conclusion included the recognised inadequacy of the general Code for Crown Prosecutors\(^{41}\) in providing guidance for prosecution decisions in cases of this type\(^{42}\) and the disparity between the prohibition on assisted suicide and the general practice in terms of prosecutions actually brought.\(^{43}\) Greater clarity was needed as to how this discretion was to be exercised for Ms Purdy to be able to make decisions about how she lived her life.\(^{44}\)

In September 2009, the DPP produced an interim policy setting out proposed factors for and against prosecution of cases of assisted suicide.\(^{45}\) That policy was then the subject of a wide public consultation process that included the participation of over 4800 individuals and organisations.\(^{46}\) In February 2010, after considering the results of that consultation exercise, the DPP published its final Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide.\(^{47}\) In determining whether a prosecution is in the public interest, the policy sets out 16 factors that favour prosecution and six factors that tend against it (see tables below).

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\(^{42}\) See, eg, Purdy [2010] 1 AC 345, 398 [64] (Baroness Hale).

\(^{43}\) See, eg, ibid 395 [54] (Lord Hope).

\(^{44}\) See, eg, ibid 386 [27], 391 [43], 395 [55] (Lord Hope).

\(^{45}\) Crown Prosecution Service (England and Wales), Interim Policy for Prosecutors in respect of Cases of Assisted Suicide (September 2009) <http://www.cps.gov.uk/consultations/as_policy.pdf> (‘Interim Policy on Assisted Suicide’).


\(^{47}\) Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13. Note also that the Isle of Man has recently followed suit and issued guidelines in similar terms: see ‘Suicide Policy Same as UK’, Isle of Man News: Isle of Man Examiner (online), 28 September 2011 <http://www.iomtoday.co.im/news/isle-of-man-news/suicide_policy_same_as_uk_1_3814031>.
Public Interest Factors Tending in Favour of Prosecution under the
England and Wales Assisted Suicide Policy

1. The victim was under 18 years of age.
2. The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.
3. The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
4. The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
5. The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
6. The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim.
7. The suspect pressured the victim to commit suicide.
8. The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
9. The suspect had a history of violence or abuse against the victim.
10. The victim was physically able to undertake the act that constituted the assistance him or herself.
11. The suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.
12. The suspect gave encouragement or assistance to more than one victim who were not known to each other.
13. The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.

48 Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, 5–6 [43].

49 The policy later clarifies that a ‘common sense approach’ should be taken in relation to this factor. Some benefit may accrue to the suspect from the victim’s death but the critical element is the suspect’s motive; ibid 6 [44].
14 The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.

15 The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.

16 The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

Public Interest Factors Tending against Prosecution under the England and Wales Assisted Suicide Policy

1 The victim had reached a voluntary, clear, settled and informed decision to commit suicide.

2 The suspect was wholly motivated by compassion.

3 The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.

4 The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.

5 The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.

6 The suspect reported the victim’s suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

50 Ibid 7 [45].
There is a growing body of academic work that examines the England and Wales policy. There is not scope in this paper to rehearse that literature, nor is it our goal to undertake a detailed critique of the policy. However, to contextualise our own attempt at drafting guidelines, we feel compelled to make four brief observations about them. These observations inform our alternative approach and lead to points of disagreement and thereafter divergence of our guidelines from the England and Wales policy.

The first observation is that the policy does not appear to be founded on a set of coherent guiding principles. This seemed to be confirmed by evidence given by the DPP responsible for developing the policy, Keir Starmer QC, to the privately established Commission on Assisted Dying. In response to a question about what the ‘underlying principle’ was for the policy, he noted that a ‘schematic approach’ had been avoided on the basis that such an approach would risk, ‘unless it’s very carefully constructed, undermining


52 More information is available at: Commission on Assisted Dying, About the Commission on Assisted Dying (17 August 2010) <http://www.commissiononassisteddying.co.uk/about-the-commission-for-assisted-dying>.
Parliament’s intention that this should be an offence.\textsuperscript{53} The role of the DPP was instead, he explained, to exercise discretion on a case-by-case basis.\textsuperscript{54} The risk of that approach, however, is that the policy may not be conceptually sound and may lead to undesirable outcomes in practice. Consider, for example, the factor in favour of prosecution that the suspect was aware that the deceased intended to commit suicide in a public place where people may be present. It is clear that this factor is different in character to the others in the policy and seems to be aimed at different considerations. We ultimately omitted this factor from our guidelines because it did not flow from the guiding principles we established as relevant to our approach. We were also concerned that it may inadvertently capture places where we would argue it could be appropriate for voluntary euthanasia or assisted suicide to occur, such as a hospital room which, at least sometimes, is a ‘public place’. Nevertheless, depending on one’s starting point, such a factor could be regarded as appropriate. However, without a clear articulation of relevant guiding principles, it is unclear whether this is so and what purpose this factor is serving.\textsuperscript{55}

The second observation is linked to the first and concerns how the authors of the policy failed to articulate the significance of, and the relationships between, the various factors in the policy.\textsuperscript{56} For example, as we outline below when constructing our approach, some factors are considerations in their own right. An illustration from the policy is that ‘the victim had not reached a


\textsuperscript{54} Ibid.

\textsuperscript{55} It could reflect an attempt to prevent harm to third parties who witness the assisted suicide or voluntary euthanasia. However, for such an objective, the language would be both under- and over-inclusive. That is, it could capture individuals in a public place, such as a hospital room, where no innocent third parties will be harmed, and it could also fail to capture individuals in a private place, where third parties will be harmed by discovering the body. Location seems to be a poor proxy for some consequences one might legitimately seek to prevent.

\textsuperscript{56} A similar critique is made in relation to the various elements of the ‘public interest’ test contained in the general Code for Crown Prosecutors: see John Rogers, ‘Restructuring the Exercise of Prosecutorial Discretion in England’ (2006) 26 Oxford Journal of Legal Studies 775, 793–4. The latest incarnation of this test is contained in Crown Prosecution Service (England and Wales), Code for Crown Prosecutors, above n 41, 10–15 [4.10]–[4.20]. The interim policy did suggest some factors be given greater weighting than others: Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide, above n 45, 4 [20], 5 [22]. This was ultimately removed to make the policy ‘clearer and more accessible’: Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide: Summary of Responses, above n 46, 18 [4.7], 21 [5.6], 32 [8.5], 34 [9.5].
voluntary, clear, settled and informed decision to commit suicide.\footnote{Crown Prosecution Service (England and Wales), \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, above n 13, 5 [43(3)].} By contrast, other factors might best be described as ‘evidential’, that is, they are evidence as to when other factors in the policy will be substantiated or not. A relevant example is that ‘the suspect pressured the victim to commit suicide’\footnote{Ibid 6 [43(7)].} as this is evidence that goes to the factor mentioned earlier, namely the voluntary nature of the decision. This distinction matters as consistent and considered decision-making requires an understanding of the role and significance of the relevant factors in a process of deliberation. We acknowledge that the policy does note that assessing the public interest is not a numerical exercise and that prosecutors ‘must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment’.\footnote{Ibid 5 [39].} However, we consider this sort of guidance to still fall short of articulating in a meaningful way how the factors are to be used in the decision-making process.

The third observation is that the policy applies only to assisted suicide and does not deal with voluntary euthanasia.\footnote{Voluntary euthanasia is where a person performs an act that intentionally ends the life of another person. This is done in response to a competent request by that second person who considers his or her life is no longer worth living. Assisted suicide is where a competent person dies after being provided by another with the means or knowledge to kill him or herself. For a discussion of various terminology in this area, see Ben White and Lindy Willmott, \textit{Background Paper: How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?} (Australia 21, 2012) 7–8.} Although this arose because of the way in which the policy was produced in response to the \textit{Purdy} decision, we consider that differentiating between voluntary euthanasia and assisted suicide is not justifiable for four reasons. First, to differentiate discriminates on the basis of disability. If the policy does not include voluntary euthanasia, a person whose disability or illness means that he or she is not capable of ending life on his or her own (and so requires another to do the final act that ends life) may be deprived of that assistance because of concerns about prosecution.\footnote{Otlowski, \textit{Voluntary Euthanasia and the Common Law}, above n 16, 194–5.} Second, given that we argue for guidelines grounded in respect for autonomy, both assisted suicide and voluntary euthanasia are justified (even though the final agent of death is different as between assisted suicide and voluntary euthanasia). Third, an assumption that sometimes underpins treating assisted suicide differently from voluntary euthanasia is that the
former is always less serious than the latter.\textsuperscript{62} But this is not always the case,\textsuperscript{63} and including both in the guidelines allows prosecutors to assess whether a prosecution is appropriate in the circumstances of each case. And, as noted below, this assessment would occur not only having regard to the offence-specific guidelines but also the general prosecutorial guidelines which take into account factors such as the level of culpability of the accused. Finally, we accept that some people may say that they would experience an emotional difference between assisting another person to commit suicide and participating in voluntary euthanasia.\textsuperscript{64} However, different emotional reactions do not provide a foundation for a claim of there being a morally significant distinction — particularly a distinction to be used as the basis for public policy. Otherwise, of course, the fact that some people experience withholding treatment differently from withdrawing treatment could justify permitting one and not the other. In the context of public policy grounded in respect for autonomy, in most circumstances, the emotional difference could justify a person, such as a medical or other health professional, not being forced to provide both assisted suicide and voluntary euthanasia (autonomy is often constrained where its exercise would result in harm to others)\textsuperscript{65} but it could not justify a difference in public policy with respect to the permissibility of one and not the other.\textsuperscript{66}

The final observation is concerned with the emphasis the England and Wales policy places on the conduct of the suspect being characterised as non-professional, ‘compassionately-motivated, one-off assistance’.\textsuperscript{67} Related to this, the policy specifically discourages the involvement of medical and other health professionals as well as individuals belonging to organisations that facilitate assisted suicide. Such an approach gives rise to concerns that


\textsuperscript{63} For example, we would argue that a case of coerced assisted suicide where the will of a person was overborn should be treated more seriously than a case involving a competent request for voluntary euthanasia.


\textsuperscript{65} See Otlowski, \emph{Voluntary Euthanasia and the Common Law}, above n 16, 195 (‘doctors should not be required to abdicate their autonomy in favour of that of the patient’).

\textsuperscript{66} See, eg, Dan W Brock, 'Voluntary Active Euthanasia' (1992) 22(2) Hastings Center Report 10, 10.

\textsuperscript{67} Crown Prosecution Service (England and Wales), \emph{Interim Policy on Assisted Suicide: Summary of Responses}, above n 46, 10 [2.7]. See also Commission on Assisted Dying, \emph{Transcript of Evidence from Keir Starmer QC}, above n 53, 8–9, 11; Williams, above n 51, 192–3; Mullock, above n 51, 453–60, who note the significant weight given to this consideration.
assessments of the deceased’s competence, without the relevant expertise and experience, may be incorrect.\(^{68}\) Also of concern is the fact that amateur attempts to assist the deceased to die may lead to him or her dying in pain or discomfort, or experiencing the indignity in death that the deceased was seeking to avoid.\(^{69}\) Further, precluding the involvement of medical and other health professionals may also reduce opportunities for the deceased to make a decision about whether to die in light of complete and accurate information about his or her prognosis and treatment options.\(^{70}\) For these reasons, our proposed guidelines do not treat acting in a professional capacity in and of itself as a factor in favour of prosecution. We note finally that this aspect of the England and Wales policy is currently the subject of a legal challenge by a man who wishes to end his life but whose family will not assist him. ‘Martin’ is challenging the policy seeking that it be amended to permit professionals to assist him to die.\(^{71}\)

IV PROPOSED VOLUNTARY EUThANASIA AND ASSISTED SUICIDE GUIDELINES: INTRODUCTION

Turning from the experience in England and Wales, and informed by our above critique of its policy, we now set out our proposed guidelines for when prosecutions should or should not occur in relation to voluntary euthanasia and assisted suicide. Although we are not able to undertake a detailed review of the England and Wales policy in this paper, we consider there are sufficient concerns about that model to warrant starting anew and designing a set of guidelines for the Australian context, albeit informed by the experience in England and Wales. As part of that process, we start from first principles and

\(^{68}\) Lewis, above n 51, 129. Although there are aspects of assessing whether decision-making is competent and voluntary that do not require medical expertise (for example, the impact of family dynamics), medical involvement in capacity assessments is likely to reduce error: Ost, above n 51, 534–7.

\(^{69}\) Lewis, above n 51, 129–30; Seale, above n 51; Ost, above n 51, 533–4; Mullock, above n 51, 452–3; Commission on Assisted Dying, ‘The Current Legal Status of Assisted Dying is Inadequate and Incoherent…’; above n 51, 98–9.

\(^{70}\) Ost, above n 51, 537.

\(^{71}\) Clare Dyer, ‘Nicklinson’s Widow Is Refused Right to Appeal to Higher Court’ (2012) 345 British Medical Journal e6690. ‘Martin’ received leave to appeal against the English High Court’s conclusion in R (on the application of Nicklinson) v Ministry of Justice [2012] EWHC 2381 (16 August 2012) that the DPP was not required to clarify his policy as requested. ‘Martin’s’ case was heard along with the related case of Tony Nicklinson (who challenged the law rather than the DPP policy). Nicklinson was unsuccessful before the High Court and his widow (Nicklinson had subsequently died) was denied leave to appeal.
identify three guiding principles for constructing these guidelines: respecting autonomous choice; promoting high quality decision-making by prosecutors; and ensuring public confidence in the decisions of prosecutors. Each of these principles is discussed in more detail below.

Having identified those principles, we are then in a position to determine the content of the guidelines, which we have organised into six components. The first component states that a public interest factor that tends in favour of, or against, prosecution is whether the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end. The second and third components of the guidelines deal with how the nature of the deceased’s choice (if any) is to be established: what are the elements of an autonomous choice in the context of voluntary euthanasia and assisted suicide; and what is the evidence that is directly relevant to determining whether those elements are present or not. For example, one element of an autonomous choice is that it was made voluntarily, and direct evidence of whether that is the case or not might include whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect.

The fourth component is comprised of factors that do not constitute direct evidence of whether the elements of an autonomous choice are present or not, but that nevertheless give confidence or raise doubts as to the nature of the choice. An example of this is where the suspect has a financial interest in the death of the deceased. While in such cases, as a matter of fact, it is still possible to show that an autonomous choice has been made, the presence of this factor creates a real risk that this may not be the case. Recognition of such ‘confidence factors’ in the guidelines is important in individual cases but also in the longer term for ensuring the public has confidence in these decisions and that these guidelines do not foster situations where non-autonomous choices are acted upon.

These four components comprise the decision-making content of the offence-specific guidelines, and explain how a DPP should use each component in his or her decision-making. Although this is explained further below when each component is considered in more detail, we have briefly indicated here the role played by each of the components and how they relate to each other. This is important in light of the objection expressed earlier in relation to the England and Wales policy that it fails to articulate the significance of, and the relationships between, the various factors in that policy. We anticipate the suggestion that in practice, such decision-making may not be as nuanced and orderly as the approach we have proposed here. Nevertheless, deficits in practice do not detract from the importance of conceptual clarity in decision-
making and there is merit in attempting to articulate how decisions should be made in a principled way.

The final two components relate more to process issues of decision-making than the content of those decisions. The fifth component requires that decisions whether or not to prosecute under the guidelines must be made by the DPP himself or herself. The sixth component establishes a reporting structure for decisions whether or not to prosecute. Reporting should occur in relation to individual decisions but systematic data should also be kept and published to ensure the system is working.

Turning finally to the scope and operation of the proposed guidelines, they are intended to supplement, and not to exclude, the operation of the general prosecutorial guidelines. Directors of public prosecutions would be required to apply the broader public interest considerations in the general guidelines as well as the additional public interest factor identified as significant for these specific offences set out below.\textsuperscript{72} Our guidelines also apply only where the deceased was capable of making an autonomous choice for his or her life to end. This includes competent adults and competent minors as discussed below.\textsuperscript{73} Given the centrality of autonomy in these guidelines, it is not appropriate that they govern those who are incompetent. Finally, for the reasons outlined above,\textsuperscript{74} the guidelines apply to both voluntary euthanasia and assisted suicide. We note though that the operation of the general prosecutorial guidelines may be significant in terms of how these two situations are treated. As noted above,\textsuperscript{75} some of the factors in the general guidelines to be considered in assessing whether prosecution is in the public interest include the seriousness of the alleged offence and the degree of culpability of the accused. It may be that in particular cases of voluntary euthanasia the greater level of participation by the accused in the deceased’s death points more towards prosecution than if he or she had only assisted the deceased’s suicide, but that will not always be the case and allowing the guidelines to deal with both situations allows this discretion to be exercised in light of the facts of each case.

\textsuperscript{72} This is also the approach taken in England and Wales: Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, 4–5 [38].

\textsuperscript{73} See below Part VIIA.

\textsuperscript{74} See above Part III.

\textsuperscript{75} See above Part II.
V Three Guiding Principles

In drafting the proposed prosecutorial guidelines, we were guided by three principles:

1. the critical factor that tends against prosecution is if the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end;

2. the decision-making pursuant to the prosecutorial discretion in this area needs to be of high quality; and

3. the decision-making pursuant to that discretion needs to attract public confidence.

A An Autonomous Choice

Support for autonomy as an appropriate value underpinning these guidelines can be found in law and public opinion. First, the principle of respect for autonomy is a fundamental tenet of Australian law. The High Court has consistently recognised the significance of autonomy in the common law and this is most notably seen in the recent case of *Stuart v Kirkland-Veenstra*. In that case, where the High Court declined to recognise a duty of care owed by police officers to prevent a person from committing suicide, Gummow, Hayne

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76 Support can, of course, also be found in ethics. We do not, however, rely upon an ethical argument for respect for autonomy here. This is in part because we believe that the argument grounded in law and public opinion is sufficient and it can be made without introducing the complexity and controversy associated with competing ethical theories about autonomy. Contrast, for example, Immanuel Kant, *Fundamental Principles of the Metaphysic of Morals* (T K Abbott trans, Prometheus Books, 1987) [trans of: *Grundlegung zur Metaphysik der Sitten* (first published 1785)]; John Stuart Mill, *On Liberty* (David Bromwich and George Kateb eds, Yale University Press, first published 1859, 2003 ed); Susan Sherwin, ‘Relational Autonomy and Global Threats’ in Jocelyn Downie and Jennifer L Llewellyn (eds), *Being Relational: Reflections on Relational Theory and Health Law* (UBC Press, 2012) 13. While we believe that the case can be made for autonomy as a core value and respect for autonomy as a core principle within an ethical foundation for the law, we leave that discussion for other venues. We believe that it is necessary and sufficient to ground the guidelines proposed in this article in the conventional understanding of autonomy that underpins the law more generally. The guidelines can and should evolve inasmuch as the law evolves in relation to changing conceptions of autonomy within moral philosophy. But we do not see the project in this article as contributing to or driving such change.

and Heydon JJ concluded that such a duty would ‘mark a significant departure from an underlying value of the common law which gives primacy to personal autonomy.’ These judges considered that personal autonomy is ‘a value that informs much of the common law’ and permits the individual to decide whether to engage in conduct that may cause harm to himself or herself.

Other support in law for the principle of respect for autonomy comes from the cases that deal with a closely related field: refusals of medical treatment. For example, in *Brightwater Care Group (Inc) v Rossiter*, Martin CJ referred to the ‘common law principle of autonomy and self-determination’ and also noted that the principle is ‘well established at common law’.

Public opinion provides another basis for adopting respect for autonomy as a guiding principle for the prosecution guidelines. While there have been a number of surveys that found that public opinion favours legalising voluntary euthanasia and assisted suicide (at least in certain circumstances), these surveys have not explored why those views are held. There is some evidence, however, that much of the high level of public support for reform in this area is motivated by the commitment to the value of autonomy. Sikora and Lewins examined 12 large representative surveys conducted between 1993 and 2002 on the issue of assisted suicide and analysed views on its acceptability in four different factual situations. By examining the responses of participants in these different situations, the authors were able to discern the weight given by participants to the various dominant ethical perspectives as identified in the euthanasia literature. They concluded that ‘a large proportion of the population accepts all forms of voluntary euthanasia, which points to the strong

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79 Ibid 248 [88].
80 Ibid 248 [89], citing *Agar v Hyde* (2000) 201 CLR 552, 583–4 [88]–[90] (Gaudron, McHugh, Gummow and Hayne JJ). The judges also endorsed the view of Lord Hope in *Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360, 379–80: ‘[o]n the whole people are entitled to act as they please, even if this will inevitably lead to their own death or injury’.
81 (2009) 40 WAR 84, 95 [48].
85 The three dominant themes considered were utilitarianism, individualism/commitment to autonomy and a commitment to Christian doctrine; ibid 69–71.
commitment to individual autonomy as the underpinning motivation \(^{86}\) and that the ‘pattern of responses indicates that the commitment to individual autonomy may lead many Australians, close to 50% in these surveys, to approve of active voluntary euthanasia in any circumstance. \(^{87}\)

In light of its recognition by Australian law and its role in public opinion, we consider that respect for autonomy is an appropriate guiding principle to inform our approach to drafting guidelines that outline when prosecution may or may not be in the public interest. Therefore, as argued below, we consider that the critical factor that tends against prosecution in such cases is if the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

**B High Quality Decision-Making**

A decision whether or not to prosecute cases potentially involving voluntary euthanasia and assisted suicide is significant. Most obviously, whether a prosecution occurs in relation to a death is significant for the deceased. For example, a choice not to prosecute on public interest grounds means the taking of the deceased’s life does not, in all of the circumstances, warrant criminal sanctions. While in some instances such an outcome would be as the deceased had hoped, in other circumstances such a decision could be regarded as a failure to acknowledge the wrongful nature of the death. A decision whether to prosecute is also significant for the deceased’s family and friends who, for example, may be seeking public acknowledgement of the loss and harm they have suffered. \(^{88}\) The decision is also significant for the suspect (who may also be a member of the deceased’s family or a friend). A decision to prosecute imposes the ‘harms of prosecution’ \(^{89}\) on the suspect and he or she also faces the prospect of conviction for a serious criminal offence, potentially murder, which in some Australian states carries a mandatory life sentence. \(^{90}\) Finally, it is significant for society as a whole: the ending of another person’s

\(^{86}\) Ibid 77.

\(^{87}\) Ibid.

\(^{88}\) For a discussion of some of the harm caused by the unlawful killing of a family member, see Tracey Booth, ‘Voices after the Killing: Hearing the Stories of Family Victims in New South Wales’ (2001) 10 Griffith Law Review 25.


\(^{90}\) See, eg, Criminal Law Consolidation Act 1935 (SA) s 11; Criminal Code Act 1899 (Qld) sch 1 s 305.
life matters for the community and so determining the appropriate criminal law response is important. It is therefore critical that decisions whether or not to prosecute in such cases be of high quality. For the purposes of this article, we consider that high quality decision-making requires a process that is rigorous, transparent and accountable, and which results in outcomes that accurately reflect conceptually sound criteria (which we put forward in our proposed guidelines). The importance of high quality decision-making is particularly significant given that such decisions are not susceptible to judicial review in Australia.

The production of clear guidelines dealing with the exercise of prosecutorial discretion in relation to cases of voluntary euthanasia and assisted suicide is one way to promote high quality decision-making. As was discussed in Purdy, clear guidelines provide a basis for ensuring decisions whether to prosecute are made predictably and consistently. This is a function of prosecution guidelines generally and this claim can also be made in relation to those designed for specific offences. Making the guidelines publicly available also helps promote high quality decision-making as prosecutorial decisions (even in the absence of reasons for those decisions as discussed below) can then attract some level of scrutiny that can be referenced against those criteria.

The terms of the guidelines themselves can also establish ways in which high quality decision-making in this area can be promoted. One is by ensuring there is rigour in the decision-making process, and the requirement to

92 Maxwell v The Queen (1996) 184 CLR 501, 512–14 (Dawson and McHugh JJ), 534–5 (Gaudron and Gummow JJ). Note, however, that the courts do retain power to intervene to prevent an abuse of process or ensure a fair trial: at 512–14 (Dawson and McHugh JJ), 535 (Gaudron and Gummow JJ). See also Barton v The Queen (1980) 147 CLR 75, 90–1, 96 (Gibbs ACJ and Mason J); Likiardopoulos v The Queen [2012] HCA 37 (14 September 2012) [1]–[5] (French CJ), [37] (Gummow, Hayne, Crennan, Kiefel and Bell JJ).
94 See, eg, Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, iii; Office of the Director of Public Prosecutions (Qld), Director’s Guidelines, above n 18, 1.
95 See below Part XA.
produce reasons for decisions can help to achieve that. Another is by advocating an open approach to the exercise of the prosecutorial discretion and making those reasons for decisions publicly available so that decision-making is transparent and accountable to the community. Developing monitoring systems of longer-term trends to ensure the efficacy of the guidelines and decision-making pursuant to them can also ensure that the discretion is being exercised to a high standard. The terms of the guidelines can also support high quality decision-making by requiring that the DPP himself or herself decide whether a prosecution should occur or not.

C Public Confidence in the Exercise of Prosecutorial Discretion

The third guiding principle that informs our proposed guidelines is that they, and the decisions made pursuant to them by DPPs, need to retain public confidence. As noted above, these are significant decisions in a difficult area and so it is important that the public has confidence in how they are made. Although this guiding principle is related to the previous one, for example in that high quality decision-making can attract public confidence, these principles are distinct and so warrant separate consideration. Public confidence could be had in decision-making that is not of a high standard, and high quality decision-making will not always attract public confidence.

One way in which public confidence in prosecutorial decision-making can be earned is through openness. As noted above, the public availability of the

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98 Ashworth, above n 96, 605–6. This is why the current DPP in England and Wales, Keir Starmer QC, states that he makes publicly available reasons for decisions not to prosecute in cases that are already in the public domain: Commission on Assisted Dying, Transcript of Evidence from Keir Starmer QC, above n 53, 5. See also ibid.
99 While not gathered in relation to prosecutorial guidelines of the sort advocated for in this article, the systemic data collected in the Netherlands have, for example, highlighted issues of concern that have then been able to be addressed through changes to law and practice. See, eg, the discussion of changing reporting requirements and rates in Judith A C Rietjens et al, “Two Decades of Research on Euthanasia from the Netherlands: What Have We Learnt and What Questions Remain?” (2009) 6 Bioethical Inquiry 271, 279.
100 Daw and Solomon, above n 51, 742, 750–1; Some of the Australian state and territory prosecutorial guidelines explicitly recognise that wrongly exercising prosecutorial discretion undermines public confidence in the criminal justice system: South Australian Office of the Director of Public Prosecutions, Prosecution Policy, above n 18, 3; Office of the Director of Public Prosecutions (Tas), The Role of an Independent Prosecutor and Guidelines for the Exercise of the Discretion to Prosecute, above n 18, 2; Director of Public Prosecutions Victoria, Director’s Policy: The Prosecutorial Discretion, above n 18, 1 [2.1.1].
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guidelines can make decision-making more transparent which can engender public confidence in the exercise of prosecutorial discretion.101 There is also scope for the guidelines to impose requirements designed to promote public confidence. Openness in decision-making by making the reasons for decisions publicly available enables the public to scrutinise the exercise of the discretion which, if being exercised appropriately, will attract public confidence.102 A similar argument applies to making systemic data about how the guidelines are being used publicly available.103 Requiring the DPP to be the ultimate decision-maker in these cases can also promote public confidence in the guidelines.

Of course, one could argue that all decisions should be made well and should attract public confidence and that the guiding principles of high quality decision-making and public confidence in the exercise of this discretion should apply not only in relation to the offences being discussed in this article, but to all offences. Indeed, many of the factors identified above could be applied or adapted to other offences, particularly those of a serious nature. However, because of the nature of the conduct at issue and the novelty of the approach (effectively allowing that some instances of assisted suicide and voluntary euthanasia do not warrant prosecution), decisions as to whether or not prosecuting a case involving voluntary euthanasia or assisted suicide is in the public interest can give rise to a particularly high level of community

101 Ashworth, above n 96, 605–6; Commission on Assisted Dying, Transcript of Evidence from Keir Starmer QC, above n 53, 5.
103 For example, the public availability of data about the Netherlands, Belgium, Oregon and Washington State as to the practice of voluntary euthanasia and assisted suicide has made it possible for the public to see that claims about slippery slopes and risks to vulnerable groups (such as the poor, the elderly, people from ethnic backgrounds and people with disabilities) are demonstrably false. See, eg, Rietjens et al, above n 99; Kenneth Chambare et al, “Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998–2001–2007” (2011) 31 Medical Decision Making 500. See also Oregon Health Authority, Death with Dignity Act, Oregon.gov <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx>; Washington State Department of Health, Death with Dignity Act <http://www.doh.wa.gov/dwda/>. Of course there are authors who argue that there is empirical evidence of slippery slopes and risks to vulnerable groups. See, eg, John Keown, Euthanasia, Ethics and Public Policy: An Argument against Legalization (Cambridge University Press, 2002) pt 3; Emily Jackson and John Keown, Debating Euthanasia (Hart Publishing, 2011) 118–36.
interest and sometimes concern. \textsuperscript{104} We therefore believe it to be especially important to explicitly articulate these guiding principles here.

VI **AUTONOMOUS CHOICE**

As outlined above, respect for autonomy is one of the guiding principles we used when constructing the proposed prosecutorial guidelines. And whereas high quality decision-making and public confidence are directed at least in part to procedural matters, respect for autonomy makes a greater contribution to determining the content of the guidelines. Accordingly, we place autonomy at the centre of our approach and include whether the deceased’s death occurred as a result of an autonomous choice by him or her as the first component of our guidelines and the sole additional public interest factor they contribute. As noted above, this does not preclude consideration of the broader public interest factors contained in the general prosecutorial guidelines. Rather, these proposed guidelines add a further factor for DPPs to consider that is specifically tailored for this context.

1 **Autonomous Choice: An Additional Public Interest Factor**

1.1 An additional public interest factor that tends in favour of prosecution is that the deceased’s death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

1.2 An additional public interest factor that tends against prosecution is that the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

VII **ELEMENTS AND DIRECT EVIDENCE OF AN AUTONOMOUS CHOICE**

This section considers the second and third components of the proposed guidelines. The second component identifies the elements of an autonomous choice while the third component sets out an inclusive list of the direct evidence that may be relevant to assessing whether those elements have been satisfied or not.

\textsuperscript{104} For evidence of this high level of community interest and concern in England and Wales, see Crown Prosecution Service (England and Wales), \textit{Interim Policy on Assisted Suicide: Summary of Responses}, above n 46, 6 [1.14].
The three elements that need to be satisfied for the deceased's death to have occurred as a result of his or her autonomous choice are:

1. the deceased was competent to make the decision to end his or her life;
2. the decision was made voluntarily by the deceased; and
3. the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

These elements are derived from the law that applies to when medical treatment is refused. Although not entirely apposite to cases of voluntary euthanasia and assisted suicide, this is a useful departure point and this was the approach taken by the England and Wales policy.\(^{105}\)

### A Competence

Applying the law that governs refusal of treatment, a person will be judged competent if he or she has the necessary capacity to make a decision and is then able to communicate that decision.\(^{106}\) McDougall J in Hunter and New England Area Health Service v A ('Hunter') described the test at common law for when an adult will be found to lack capacity as where he or she:

1. is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or
2. is unable to use and weigh the information as part of the process of making the decision.\(^{107}\)

Adults are presumed to be capable of making their own decisions.\(^{108}\) The competence required to make a decision is said to be commensurate with its significance so that a decision with grave consequences, such as one which

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105 Crown Prosecution Service (England and Wales), *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide*, above n 13, 5 [43(2)–(3)], 7 [45(1)]. See also the discussion of the relevant Australian (and some foreign) cases in this area in *Justins v The Queen* (2010) 79 NSWLR 544, 601–4 [350]–[362] (Johnson J).

106 *R (Burke) v General Medical Council* [2005] QB 424, 440 [41] (Munby J); this aspect of the judgment was confirmed on appeal: *R (Burke) v General Medical Council* [2006] QB 273, 290 [10] (Lord Phillips MR, Waller and Wall LJ).


results in death, requires a higher level of capacity than other decisions.\textsuperscript{109} Children are not presumed to have capacity but are capable of making decisions if they possess ‘a sufficient understanding and intelligence to enable him or her to understand fully what is proposed’ (‘Gillick competence’).\textsuperscript{110}

Evidence that is relevant to determining whether a deceased was competent or not includes whether he or she had a recent capacity assessment undertaken by an appropriately qualified medical or other health professional. Also relevant is whether the deceased was in need of assistance to make decisions about other aspects of his or her life. Although capacity is specific to the particular decision to be made, findings of incompetence in other realms can sometimes shed light on whether the deceased had capacity to choose for his or her life to end.

Before leaving this issue, we note the attempt by the trial judge in \textit{R v Justins} (considered on appeal in \textit{Justins v The Queen})\textsuperscript{111} to set out a test for capacity to commit suicide. In this case, the accused, Justins, placed a bottle of Nembutal and a glass on a table in front of her de facto partner, Wylie, because she believed he wanted to die. She gave evidence that she said: ‘This will relieve your pain, Graeme. If you drink this you will die.’\textsuperscript{112} He poured himself a glass from the bottle and drank it knowing he would die. Wylie had previously attempted suicide and had expressed interest in ending his own life and sought assistance to do so. There were doubts, however, as to whether Wylie had capacity to make this decision. He had been diagnosed with Alzheimer’s disease three years earlier and there was a range of evidence that his mental capacity had diminished. A critical issue for the jury was whether Wylie had capacity at the time of his death. A lack of capacity would suggest that Justins caused the death whereas the presence of capacity would suggest that drinking the Nembutal was instead truly Wylie’s act. The trial judge

\begin{footnotes}
\item[109] \textit{Re B} (Adult: Refusal of Medical Treatment) [2002] 2 All ER 449, 458 [31] (Dame Butler-Sloss P), quoting \textit{Re T} (Adult: Refusal of Treatment) [1993] Fam 95, 113 (Lord Donaldson MR).
\item[110] \textit{Gillick v West Norfolk and Wisbech Area Health Authority} [1986] 1 AC 112, 188–9 (Lord Scarman), adopted in Australia in \textit{Secretary, Department of Health and Community Services (NT) v JWB} (1992) 175 CLR 218, 238–9 (Mason CJ, Dawson, Toohey and Gaudron JJ), 311 (McHugh J) (‘Marion’s Case’). Note, however, that the courts retain the power to override a decision of a Gillick-competent child to refuse medical treatment: see Ben Mathews, ‘Children and Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), \textit{Health Law in Australia} (Lawbook, 2010) 114, 133–5 [5.160], 139–40 [5.210].
\item[111] \textit{R v Justins} [2008] NSWSC 1194 (12 November 2008), revd \textit{Justins v The Queen} (2010) 79 NSWLR 544. For further discussion of this case, see Faunce and Townsend, above n 12.
\end{footnotes}
directed the jury that to have ‘capacity to commit suicide’, a person must be able to do all of the following:

1. know the extent of his illness and its prognosis;
2. understand the nature of the act of suicide and its consequences;
3. comprehend the benefits and disadvantages of the alternatives (life and death);
4. be able to weigh the benefits and advantages and decide between them; and
5. be able to communicate that decision.113

The jury acquitted Justins of murder but found her guilty of manslaughter by gross criminal negligence. The New South Wales Court of Criminal Appeal quashed the conviction and ordered a new trial.114 One ground of appeal on which Justins was successful was that the trial judge misdirected himself in relation to the issue of capacity and erred by stating these five elements as requirements of law.115 Instead, these elements (which emerged from the expert evidence) were only factual matters for the jury to consider when determining whether Wylie had capacity. As a result, this case does not establish or endorse a legal test for when an adult has capacity to commit suicide.116 We do note, however, that the approach suggested by the trial judge is broadly consistent with the law that governs when a person may refuse treatment as set out above.

B Voluntariness

Again building on the law that governs refusal of medical treatment, a decision to commit suicide must also be free of undue influence.117 It is worth

113 Ibid 549–50 [25] (Spigelman CJ). Note also that the direction stated: ‘It must be his independent decision, even though taken with the advice of others’: at 549 [25], which reflects the voluntariness element discussed below.

114 That second trial did not go ahead as the Crown instead accepted a guilty plea to aiding and abetting suicide (which it had refused to accept at Justins’ trial). Justins received no further punishment having already served her sentence for the more serious charge of manslaughter: R v Justins [2011] NSWSC 568 (26 May 2011).


116 Indeed Simpson J specifically stated that it would be inappropriate in the context of this appeal to define what constitutes capacity to commit suicide: ibid 585 [269] (Simpson J).

117 Re T (Adult: Refusal of Treatment) [1993] Fam 95, 121 (Staughton LJ); Hunter (2009) 74 NSWLR 88, 94 [26] (McDougall J).
noting though that not all influence will be undue. So, provided that the
decision remains that of the person in question, it is legitimate for others,
such as family, friends and doctors, to provide advice and even seek to
persuade the person to change her or his mind.\textsuperscript{118} Evidence relevant to the
voluntary nature of the decision includes whether there was any pressure
placed on the deceased in his or her decision-making, whether the suggestion
for taking such steps originally came from the deceased, and whether there
was a clear and unequivocal request from the deceased for assisted suicide or
voluntary euthanasia.

\textbf{C. Received or Offered Sufficient Information}

Our proposed guidelines require that the deceased had received or was
offered sufficient information about the decision to end his or her life includ-
ing, where appropriate, information from qualified medical or other health
professionals. This would include information about the diagnosis, prognosis
and treatment options for a person’s illness or disability (if any); other care
options including palliative care; the nature of possible methods of voluntary
euthanasia or assisted suicide and associated risks; and the consequences of
alternative courses of action. Since \textit{Rogers v Whitaker},\textsuperscript{119} Australian law has
recognised that medical and other health professionals have a duty to offer all
information that would be considered significant in the circumstances by
either a reasonable person or the particular individual concerned. The High
Court’s reasoning was based on autonomy: a person can only make a mean-
ingful choice to undertake treatment or not with relevant information about
what that treatment involves and its potential risks.\textsuperscript{120} So recognition of the
need for an autonomous decision requires that either the deceased has
received such information or been offered it.

While it is clear how a decision by a person who has received the relevant
information supports respect for autonomy, further explanation is needed in

\textsuperscript{118} See \textit{Re T (Adult: Refusal of Treatment)} [1993] Fam 95, 121, in which the English Court of
Appeal found that a woman’s refusal of treatment was not binding on the treating team,
Staughton LJ considered that influence will be undue only if there is ‘such a degree of external
influence as to persuade the patient to depart from her own wishes, to an extent that the law
regards it as undue.’

\textsuperscript{119} (1992) 175 CLR 479.

\textsuperscript{120} Ibid 487, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). The civil liability
legislation in Queensland, Tasmania and Victoria includes provisions dealing with this duty
to warn in terms that reflect the common law position: \textit{Civil Liability Act 2003} (Qld) s 21;
\textit{Civil Liability Act 2002} (Tas) s 21; \textit{Wrongs Act 1958} (Vic) s 50.
relation to why the guidelines also recognise as sufficient the offering of relevant information. This issue has received some attention in Australia in a series of cases dealing with refusals of life-sustaining treatment. McDougall J in Hunter considered that a refusal of treatment did not need to be informed to be effective, whereas Martin CJ in Brightwater Care Group (Inc) v Rossiter disagreed. Kourakis J in H Ltd v J preferred the approach taken in Hunter but qualified this by saying that another specific legal duty could require that a refusal of treatment be informed. There is not scope in this paper to engage properly in this debate or to resolve these conflicting judicial authorities. For our purposes, it is sufficient to note our preference for the Hunter position and to adopt the view that a person is able to refuse life-sustaining treatment without having received information about that decision. To require that a person must have received information to be able to refuse treatment is inconsistent with the widely endorsed position that treatment may be refused for irrational reasons or no reason at all. We consider a similar approach should be taken here and note this is supported by comments in Justins v The Queen to the effect that a person may be regarded as having capacity to commit suicide even if doing so on a basis that is ill-informed or not supported by a reason. So while it is desirable that a decision by a deceased to end his or her life is an informed one from a policy perspective, compelling receipt of (as opposed to offering) information is inconsistent both with that broad legal framework and with permitting a person to make autonomous decisions to refuse information.

Evidence as to whether the deceased had received or been offered sufficient information will include the steps taken to ensure this occurred including, where appropriate, whether qualified medical or other health professionals were involved. Also relevant would be the nature of the information received by, or offered to, the deceased such as whether it included relevant information about the diagnosis, prognosis and treatment options for a person's illness or disability (if any), other care options including palliative

121 (2009) 74 NSWLR 88, 98 [40].
122 (2009) 40 WAR 84, 92 [30].
124 This point is discussed further in Lindy Willmott, Ben White and Shih-Ning Then, ‘Withholding and Withdrawing Life-Sustaining Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), Health Law in Australia (Lawbook, 2010) 449, 455–7 [13.40].
125 See, eg, Re T (Adult: Refusal of Treatment) [1993] Fam 95, 102, 113 (Lord Donaldson MR).
126 Justins v The Queen (2010) 79 NSWLR 544, 604 [363]–[365] (Johnson J); see also at 585 [269] (Simpson J).
care, the nature of possible methods of voluntary euthanasia or assisted suicide and associated risks, and the consequences of alternative courses of action. Further evidence that is relevant to the sufficiency of information offered to the deceased or received by him or her is whether any of that information was misleading or inaccurate, and whether it was in a form that the deceased could understand.

D Guidelines

Accordingly, the prosecutorial guidelines should outline the elements of an autonomous choice and an inclusive discussion of the direct evidence that may be relevant to determining whether those elements are satisfied.

2 Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

2.1 the deceased was competent to make the decision to end his or her life;
2.2 the decision was made voluntarily by the deceased; and
2.3 the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

3 Direct Evidence in relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased’s death occurred as a result of an autonomous choice by him or her include whether:

3.1 the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (competence);
3.2 the deceased needed assistance to make decisions about other aspects of his or her life (competence);
3.3 there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntariness);
3.4 the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntariness);
3.5 the suspect or others took steps to ensure that the deceased’s decision was not brought about by pressure or coercion (voluntariness);
3.6 the suspect or others took steps to ensure that the deceased had received, or was offered, sufficient and accurate information about the decision including, where appropriate, information from qualified medical or other health professionals (sufficient information).

VIII Confidence regarding whether Death Occurred as a Result of Autonomous Choice

The proposed guidelines also include factors that are relevant to a prosecutor’s confidence about whether the death that occurred was as a result of an autonomous choice by the deceased (confidence factors). The role of these factors is different from those mentioned in the previous section where the goal was to identify matters that could be used as direct evidence in relation to whether the three elements of an autonomous choice discussed above were satisfied. The factors in this section do not have that same direct probative value and so cannot be used in that way.

Two examples of confidence factors are where the suspect has an interest of his or her own that conflicts with the interest of the deceased in making an autonomous choice about death (conflict of interest), and where there is a history of violence or abuse towards the deceased by the suspect. These factors are not direct evidence of an absence of autonomy and it is possible that decisions that occur in the presence of such factors could still be autonomous and therefore not appropriate for prosecution. To illustrate, a DPP who was firmly satisfied that a deceased had made an autonomous choice to die, in spite of the existence of potentially negative confidence factors, would be justified under our guidelines in not prosecuting. Nevertheless, the presence of these circumstances can give rise to real doubts that such a choice has been made. This risk is sufficient to justify addressing them in the guidelines. One of the guiding principles for constructing these guidelines is the importance of public confidence in prosecutorial decision-making. If circumstances that cause us to doubt there was an autonomous choice are specifically addressed, confidence can be had by the public that prosecutorial discretion is only being exercised to decline to prosecute in clear cases of autonomous decision-making.

Also included in this section are confidence factors that are indirectly about autonomy. An example is whether a suspect reported the deceased’s death to the police and cooperated with its investigation. Such action is not directly about whether the death occurred as a result of an autonomous choice. However, reporting and cooperation by a suspect can suggest that his or her behaviour is more likely to be consistent with the non-prosecution
factors in the guidelines than if the suspect concealed his or her involvement. Given that those non-prosecution factors are based on the deceased making an autonomous choice, these factors can still, albeit indirectly, give rise to confidence or doubts as to the nature of any choice made by the deceased.

These confidence factors have two functions in the guidelines. The first is that factors which give rise to doubts about whether the deceased made an autonomous choice for his or her life to end act as triggers for further investigation or scrutiny of the circumstances in which the death occurred. The presence of these confidence factors is a warning that should prompt a DPP to review even more closely the direct evidence in relation to the elements of an autonomous choice in the case at hand. We note that confidence factors can also provide reassurance that the deceased chose to die but we are not proposing that this should lead to a reduced level of scrutiny. The second function for confidence factors is that they must be used by DPPs in their deliberations when weighing the direct evidence of the elements of an autonomous choice set out above. To illustrate, the existence of a troubling conflict of interest is an important part of the context in which DPPs would assess the available direct evidence about whether the deceased was making a competent and voluntary decision. We now consider the four confidence factors we include in our proposed guidelines.

A History of Violence or Abuse

A history of violence or abuse by the suspect towards the deceased gives rise to real concerns about whether the deceased made an autonomous choice for his or her life to end. Such abuse need not be physical in nature and can include emotional or psychological abuse. While it is possible for a decision to end one’s life to be made autonomously despite that history, the existence of this type of relationship between the suspect and deceased casts doubt over this and poses a risk that the decision was not autonomous. Accordingly, the guidelines identify this factor as one that should trigger very close scrutiny of the circumstances in which the death occurred. A DPP should weigh any available evidence as to whether the deceased made an autonomous choice in

light of this history. Part of this may include accessing information or advice about the dynamics of such relationships and the impact that any violence or abuse may have had on the deceased's ability to make his or her own choices.

B Settled Decision

A confidence factor that may point the other way is that the deceased's decision appeared to be a settled one. One way this could be demonstrated is through repeated requests by the deceased for his or her life to end. We note that the settled nature of a decision is not an element of an autonomous choice: it is not part of the law that governs the refusal of medical treatment discussed above. Nevertheless, if a decision appears to be a settled one, then a prosecutor, and indeed the public, could have greater confidence that the choice was autonomous. However, as noted above, we are not suggesting this should lead to a lower level of scrutiny than that which generally occurs in these cases.

C Conflict of Interest

One factor that tends to undermine confidence that the deceased's death occurred as a result of an autonomous choice by him or her is that there is an interest on the part of the suspect that conflicts with the interest of the deceased in making that autonomous choice. Sometimes the nature of the conflict is such that it creates a challenge to the deceased making an autonomous choice in that the suspect is tempted to coerce the deceased or otherwise undermine his or her free choice. Other times the conflict might not be in direct opposition to a deceased's autonomy, but rather lead to or encourage the suspect to be careless or disinterested in ensuring that death was genuinely the deceased's choice. In both instances, however, the existence of a conflict creates the risk that the deceased is not making an autonomous choice and this is what warrants inclusion of conflict of interest as a confidence factor in the guidelines.

There are a range of interests that can give rise to conflict. One is where a suspect has a financial interest in the deceased's death. The obvious example is where the suspect or a person close to him or her will benefit financially through an inheritance. A financial conflict of interest can also arise not because of the deceased's death but because a suspect is financially remunerated for providing assistance of some kind. This could arise in relation to an organisation that facilitates voluntary euthanasia or assisted suicide for a fee. Another example is where a medical or other health professional participates
in the deceased’s death and is remunerated for that. Other conflicts of interest may be non-financial. A suspect may have reputational interests he or she is interested in advancing that may be in conflict with the deceased making an autonomous choice. A suspect may also wish to be relieved of the burden of caring for the deceased.

The presence of a conflict of interest will trigger a DPP to scrutinise closely the circumstances of the deceased’s death and to weigh the evidence in relation to the nature of any choice made by the deceased in light of that conflict. The level of this additional scrutiny and deliberation will depend, however, on the nature of the conflict and the extent to which the suspect’s own interests were significant in the decision to end the deceased’s life or provide assistance to do so.\(^{128}\) This approach is consistent with how the law in relation to fiduciary relationships, from which the conflict rule comes, has developed in Australia. Not all conflicts of interest by fiduciaries will be regarded as breaching the conflict rule:

> if the doctrine be inexorably applied and without regard to the particular circumstances of the situation, every transaction will be condemned once it be shown that the fiduciary had such a hope or expectation, however unlikely to be realized it may be, and however trifling an inducement it will be if it is realized … We have found no decisions that have applied this rule inflexibly to every occasion in which the fiduciary has been shown to have had a personal interest that might in fact have conflicted with his loyalty. On the contrary in a number of situations courts have held that the rule does not apply, not only when the putative interest, though in itself strong enough to be an inducement, was too remote, but also when, though not too remote, it was too feeble an inducement to be a determining motive.\(^{129}\)

Applying this approach, while a possible conflict of interest will be a trigger for DPPs to take care, the nature of that conflict will determine the extent of that additional scrutiny and deliberation. The issue is whether the potential for the suspect to benefit is either, first, so remote so that it is of no consequence, or secondly, if it is not too remote, it is insufficient to be a relevant

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\(^{128}\) This approach has similarities to the ‘common sense’ one outlined in the England and Wales policy, where a suspect may obtain a benefit from the deceased’s death but that this need not be a factor in favour of prosecution if ‘compassion was the only driving force’ for his or her actions: Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, [44].

factor in the decision to end the deceased’s life or to assist with that decision. It is this second issue that will be most significant in this context and will ultimately be a matter for the DPP to determine, on the facts of the case, how troubled he or she is by the conflict of interest. To illustrate, an inheritance for a suspect will automatically trigger additional scrutiny and deliberation but a DPP will need to determine the extent to which it could be regarded as a relevant factor in the suspect’s decision-making process. We consider that very close scrutiny would be called for where the suspect’s financial circumstances had recently changed for the worse and this seemed to prompt a renewed interest in assisting the deceased. By contrast, a medical or other health professional who received payment for providing a medical or other health service as part of their usual care for a patient is unlikely to consider that remuneration a relevant factor in their decision to be involved in the death. But more scrutiny will be required, however, if that professional had established a practice devoted exclusively or primarily to assisting people to die and so depended for his or her livelihood on voluntary euthanasia or assisted suicide.\footnote{We note that earlier in this paper we have argued against treating ‘acting in a professional capacity in and of itself’ as a factor tending in favour of prosecution: see Crown Prosecution Service (England and Wales), \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, above n 13, 6 [43(14)], which states that acting in a professional capacity is a public interest factor tending in favour of prosecution. Therefore the fact that a medical or other health professional is involved in voluntary euthanasia or assisted suicide in a professional capacity does not of itself point towards prosecution. However, if that involvement gives rise to a conflict of interest then that must be considered by a DPP as a confidence factor.} Finally, people volunteering in a not-for-profit organisation might obtain some reputational or other benefit from being involved in a death. Although perhaps less likely than where financial incentives are involved, such interests are capable of giving rise to a conflict of interest and additional scrutiny and deliberation is needed commensurate with the nature and extent of the conflict.

D Reporting the Death

The guidelines include as a confidence factor that either the suspect reported the death to the police and cooperated fully with its investigation, or did not take such action. How a suspect behaves in this regard can inform a prosecutor’s confidence as to whether a deceased’s death occurred in conformity with the non-prosecution factors in the guidelines which, as noted above, goes indirectly to the confidence a DPP can have in relation to whether there was
an autonomous choice by the deceased. While there can be other motivations, one reason why a suspect may feel able to report the death to police is that they will not be prosecuted based on the criteria in the guidelines. By contrast, it could be argued that a suspect whose involvement in a death points towards the factors in favour of prosecution would be more likely to conceal the death or his or her involvement in it, or refuse to participate in a police investigation, for fear of the adverse consequences.\textsuperscript{131}

If these arguments are correct, then reporting and cooperation is an appropriate confidence factor for the guidelines. As with other confidence factors, a troubling response warrants additional scrutiny and deliberation, whereas a comforting response would not reduce the rigour of a prosecutor’s approach but is relevant to deliberations as to how any evidence in relation to an autonomous choice is weighed.

We also note that including this particular factor has additional systemic benefits for how the guidelines operate above and beyond deliberations in particular cases. Incentivising disclosure of cases involving voluntary euthanasia and assisted suicide so they may be investigated adds to the public confidence that potential suspects are acting, and will in future act, in accordance with the guidelines. It also bolsters the public reporting of cases involving the guidelines (proposed below) which again promotes public confidence that the guidelines are functioning appropriately.

E Guidelines

The guidelines should include the following confidence factors, namely those factors which either give confidence or raise doubts as to whether a deceased’s death occurred as a result of an autonomous choice.

\textsuperscript{131} Of course, there could also be other motivations for not reporting the death to police and cooperating with its investigation. For example, a person whose conduct is otherwise unlikely to attract prosecution may not be aware of the guidelines and so conceal his or her involvement in the death for fear of prosecution.
4  Confidence whether Death Occurred as the Result of Autonomous Choice

The presence of factors that give confidence that the deceased’s death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.1 the deceased’s decision for his or her life to end appeared to be a settled one;
4.2 the suspect reported the death to the police within a reasonable time and cooperated fully with the investigation.

The presence of factors that raise doubts that the deceased’s death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.3 a history of violence or abuse by the suspect towards the deceased;
4.4 an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect’s decision-making;
4.5 the suspect did not report the death to the police within a reasonable time or did not cooperate fully with the investigation.

IX  Decision to Be Made by the Director of Public Prosecutions

It was noted above that two of the principles that inform how the guidelines are constructed are:

1  the decision-making pursuant to the prosecutorial discretion in this area needs to be of high quality; and
2  the decision-making pursuant to that discretion needs to attract public confidence.

One way in which these goals can be promoted is by requiring that decisions whether or not to prosecute under the guidelines be made by the DPP himself or herself. We note that this is consistent with some Australian jurisdictions
that already have provisions in their general prosecutorial guidelines dealing with when the DPP’s consent is specifically required either to bring or discontinue a prosecution for certain types of offences.\textsuperscript{132} Such an approach is also consistent with the position in England and Wales although the DPP’s role in that jurisdiction is given legislative force. Section 2(4) of the \textit{Suicide Act 1961}\textsuperscript{133} provides that proceedings under that Act may be instituted only with the consent of the DPP. There are also other key differences between the position in England and Wales and what is being proposed in these guidelines. One is that our proposed guidelines are broader than the position in England and Wales in that the DPP’s consent in that jurisdiction is only required if a prosecution is instituted. The DPP is not required by the Act to make decisions where it is proposed that a person not be prosecuted; his or her role is only mandated where there is a decision to prosecute. We understand, however, that the practice to date is for the DPP to be involved in all decisions (including those not to prosecute),\textsuperscript{134} which is consistent with our proposed approach.

Another key difference relates to the wider function of the consent provision in England and Wales. The House of Lords in \textit{Purdy} identified the ‘basic reason’ for the relevant sub-section as being to prevent the risk of prosecutions in ‘inappropriate circumstances’.\textsuperscript{135} A significant motivation for imposing a legislative requirement for DPP consent to prosecutions is to avoid vexatious or inappropriate private prosecutions.\textsuperscript{136} Our proposed guidelines do not directly address this concern as they only purport to guide the exercise of prosecutorial discretion by the state and cannot of themselves (unlike a legislative requirement for consent) prevent inappropriate private prosecutions.

Nevertheless, despite these differences, some of the rationales for s 2(4) of the \textit{Suicide Act 1961}\textsuperscript{137} are relevant to the proposed fifth component of our

\textsuperscript{132} See, eg, Office of the Director of Public Prosecutions (Qld), \textit{Director’s Guidelines}, above n 18, 21; Office of the Director of Public Prosecutions (NT), \textit{Guidelines}, above n 18, 9–10, 12.

\textsuperscript{133} 9 & 10 Eliz 2, c 60.

\textsuperscript{134} Commission on Assisted Dying, \textit{Transcript of Evidence from Keir Starmer QC}, above n 53, 6.

\textsuperscript{135} [2010] 1 AC 345, 392 [45].

\textsuperscript{136} For a wider discussion of the importance of the right to bring a private prosecution, and the corresponding justifications advanced for requiring DPP or other consents to prosecution, see Law Commission, England and Wales, \textit{Consents to Prosecution} (Report No 255, 1998) 12–14 [2.12]–[2.21] (private prosecutions), 22–6 [3.27]–[3.35] (justifications for a requirement of consent). See also ibid.

\textsuperscript{137} 9 & 10 Eliz 2, c 60.
guidelines. In particular, we note that Lord Hope in *Purdy* pointed to reasons underpinning the consent requirement as including

> to secure consistency of practice … [and] to enable account to be taken of mitigating factors and to provide some central control of the use of the criminal law where it has to intrude into areas which are particularly sensitive or controversial.  

We agree and consider that requiring the DPP to make all decisions whether to prosecute or not under these guidelines will lead to greater consistency and predictability in decision-making. This is partly because all such decisions will be made by a single person in each jurisdiction (at least for the duration that they hold office). We also point to the likely calibre of the individual in the role of the DPP as the person making this decision; as the highest-ranked prosecutor in the jurisdiction, they would possess a high level of competence and a breadth of experience to ensure high quality decision-making. These factors would also promote public confidence in decisions made pursuant to the guidelines.

5  **Decision to Be Made by the Director of Public Prosecutions**

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be made by the Director of Public Prosecutions.

**X  Public Reporting of Decision-Making**

Another way in which high quality decision-making that attracts public confidence can be promoted is through giving reasons for decisions and making them publicly available. We propose this be done where possible in relation to individual decisions not to prosecute but also that information about how the guidelines are operating at a systemic level be collected and published.


139  We note that the relevant legislation establishing the DPPs generally permits for the delegation of his or her functions but we consider that it should not occur for these decisions. In relation to specific delegation powers in these Acts, see *Director of Public Prosecutions Act 1990* (ACT) s 17; *Director of Public Prosecutions Act 1986* (NSW) s 33; *Director of Public Prosecutions Act 1990* (NT) s 32; *Director of Public Prosecutions Act 1991* (SA) s 6A; *Public Prosecutions Act 1994* (Vic) s 30 (although note the limitations in this provision as to when delegation may occur); *Director of Public Prosecutions Act 1991* (WA) s 31.
Subject to any contrary legal obligations prohibiting such a course, DPPs are able to give reasons for their prosecutorial decisions and make them publicly available. Five of the Australian state and territory prosecution guidelines contain discrete policies specifically addressing the giving of reasons. Six of them also contain specific policies dealing with media interaction, generally in the context of using the media as a vehicle to engage with the public, and sometimes with reference to publishing reasons for decisions. To advance the guiding principles of high quality decision-making and public confidence, we consider that the guidelines should require that, where possible, reasons for decisions be given in these cases and made publicly available. We do note, however, that this aspect of the guidelines applies only to decisions not to prosecute and not to decisions for a prosecution to go ahead. Aside from concerns about prejudicing either the Crown's ability to prosecute or the accused's right to a fair trial, a decision to prosecute means the Crown's case is subjected to the public rigour of the criminal justice system, and this is sufficient to address the guiding principles of high quality decision-making and public confidence identified above.

There are a number of benefits of publishing reasons for decisions. One is that the discipline of producing written reasons assists a decision-maker in his

140 Although note that administrative decision-makers are under no general duty at common law to provide reasons for their decisions: Public Service Board of New South Wales v Osmond (1986) 159 CLR 656.

141 Office of the Director of Public Prosecutions (ACT), Prosecution Policy, above n 18, [6]; Office of the Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 19 [12]; Office of the Director of Public Prosecutions (Qld), Director’s Guidelines, above n 18, 28 [22]; Director of Public Prosecutions Victoria, Director’s Policy: The Giving of Reasons for Discretionary Decisions (3 March 2010) <http://www.opp.vic.gov.au/getattachment/25f36122-017f-4896-8dac-85fe996eb6524-The-Giving-of-Reasons-for-Discretionary-Decisio.aspx>; Director of Public Prosecutions for Western Australia, Statement of Prosecution Policy and Guidelines, above n 18, 16 [72]; see also specific consideration of the issue as part of the media policy: at 28 [164], app 6. There is no separate policy in the Northern Territory but the guidelines do mention this issue in various places: see, eg, Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, 9 [7.2], 11 [7.11], 12 [7.18].

or her deliberations and ensures the reasoning is subjected to the rigour of justification, thereby promoting high quality decision-making.143 Another benefit is that it ensures accountability and transparency in decision-making by requiring justification of a conclusion to the public, and this also supports public confidence.144 A third benefit is that awareness of the basis of how these decisions are made promotes predictability and consistency in decision-making.145 This is of advantage for successive DPPs seeking to exercise their discretion consistently and there would also be scope to consider and benefit from decisions made in other Australian jurisdictions. It also assists members of the public who will know not only the general criteria for prosecution decisions, but also how those criteria are being applied in practice. This means they will be in a position to regulate their own conduct so as to ensure, if possible, that it is not in the public interest for them to be prosecuted.

While these benefits are applicable generally to the exercise of prosecutorial discretion, we consider the case for published reasons for decisions is particularly compelling in relation to voluntary euthanasia and assisted suicide. As the experience in England and Wales has demonstrated, prosecutorial discretion in this area can give rise to a high level of public interest and concern about how it may be exercised.146 It is therefore appropriate that the public can scrutinise these decisions, and be reassured if they are being made in accordance with the guidelines. These concerns have prompted the DPP in England and Wales to make publicly available reasons for his decisions in relation to the assisted suicide policy where the information about the case is already in the public domain.147 Accordingly, although the majority of guidelines already address in a generic way the issue of reasons for decisions,


144 Pittard, above n 143, 174; Flick, above n 97, 118–19. See also above n 102 as to these arguments specifically applied in the context of prosecutorial decision-making.

145 Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Palme (2003) 216 CLR 212, 242 [105] (Kirby J); Pittard, above n 143, 174.

146 See, eg, Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide: Summary of Responses, above n 46, 6 [1.14].

we consider it should be specifically dealt with in these guidelines and that reasons for decisions should be provided and made public wherever possible.

We do recognise, however, that the context of prosecutorial decision-making means there are constraints that may limit or preclude the giving of full reasons or making them publicly available. For example, DPPs are subject to various legislative privacy obligations which, absent a relevant exception, prohibit publication of certain information.148 Some or all of these obligations may not apply, however, in relation to information that is already in the public domain, for example, if it is discussed in open court at a committal hearing and the prosecution is later discontinued. Another relevant consideration is whether the production and publication of reasons would prejudice the prosecution of a co-offender, or an ongoing investigation.149 Other public interest considerations which may weigh against giving reasons are if doing so would significantly prejudice the administration of justice or cause serious harm to witnesses or the suspect.150 Accordingly, while it is desirable as outlined above, it will not always be possible to produce and publish reasons for decisions. Nevertheless, we consider the publication of reasons should be the presumption, and where that is not possible, consideration should also be given to whether it is possible to publish reasons of some kind that do not prejudice meeting those other obligations. For example, it might be possible to make reasons for a decision available in a de-identified form or for the reasons not to refer to particular information that should not be disclosed.


149 Director of Public Prosecutions Victoria, Director's Policy: The Giving of Reasons for Discretionary Decisions, above n 141, 3 [24.3(e)].

150 Office of the Director of Public Prosecutions (ACT), Prosecution Policy, above n 18, [6]; Office of the Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 19 [12]; Office of the Director of Public Prosecutions (Qld), Director's Guidelines, above n 18, 28 [22(v)]; Director of Public Prosecutions for Western Australia, Statement of Prosecution Policy and Guidelines, above n 18, 16 [72].
B Systemic Data Reporting in Annual Report

Another way in which high quality decision-making that attracts public confidence can be promoted is to monitor how the guidelines are working at a systemic level. This permits a level of scrutiny of global trends to ensure that the guidelines are leading to appropriate outcomes. Such an approach is generally a feature of voluntary euthanasia and assisted suicide legislation that establishes or empowers a commission or other body to oversee the administration of the legislation.151 Again, this information should be made available for public scrutiny.

The reporting of systemic data (which can be done in a de-identified form) will be valuable for determining whether the terms of the guidelines themselves are appropriate or not. It will also permit scrutiny of how the guidelines are being applied in practice over a period of time. This sort of scrutiny ensures that decision-making is of a high quality and enables problems to be identified and addressed.152 It can also provide a measure of public confidence in that the community knows how the guidelines are being used and what the outcomes are. These data can include decisions to prosecute as concerns about prejudicing the prosecution identified in relation to reasons for decisions need not arise at this systemic de-identified level of reporting, or if they do, the data can be included at a later stage once all proceedings have concluded.

The nature of the systemic data we consider should be captured includes:

- demographic data for the deceased such as gender, age, ethnic background, health status, disabilities (if any), income level and educational level;
- the deceased's underlying illness (if any);
- whether the deceased had access to palliative care;
- whether the deceased had private health insurance;
- the relationship between the suspect and the deceased;
- whether the case involved voluntary euthanasia or assisted suicide;

151 See, eg, the summary description of the various oversight mechanisms in the Netherlands, Belgium, Luxembourg, Oregon and Washington State in Schüklenk et al, above n 14, 55–9. The collection and publication of data to improve the administration of criminal law processes has also been suggested in relation to death penalty cases in the United States: James S Liebman, ‘The Overproduction of Death’ (2000) 100 Columbia Law Review 2030, 2150 n 288.

152 See, eg, experiences with respect to ‘life ending acts without explicit request of the patient’ and reporting rates in the Netherlands as discussed in Rietjens et al, above n 99. See also Chambaere et al, above n 103, for a discussion of trends in end-of-life decision-making in Belgium.
• the number of decisions reached to prosecute or not prosecute; and
• the number of convictions that occurred in those cases where the decision was to prosecute.

To achieve an understanding of the trends that might be emerging from the use of the guidelines, the data collected in the first six bullet points needs to be correlated with those collected in the last two bullet points.

6 Public Reporting of Decision-Making

6.1 Subject to any contrary legal obligation, the Director of Public Prosecutions will produce and publish reasons for a decision not to prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

6.2 The Director of Public Prosecutions will publish in his or her Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

XI Conclusion

The purpose of this article was to construct offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. In undertaking this task, we were guided by the principles of respect for autonomy, the need for high quality prosecutorial decision-making and the importance of public confidence in that decision-making. We also drew on the existing England and Wales policy.

We propose that in light of the Purdy decision, and given the recent Canadian developments noted above, it is timely for the various state and territory DPPs around Australia to consider guidelines of this type. As Murphy notes:

The Purdy case should send a signal to the various prosecution authorities that the need to incorporate offence-specific policy is on the horizon, especially where the jurisdiction contains or anticipates the introduction of express

153 See above n 14.
human rights enactments. The Purdy case is highly significant for any jurisdiction that has, or is planning to introduce, human rights Acts or Charters.154

Others have reached a similar view.155 Australia presently does not have a human rights statute at federal level. There is, however, human rights legislation in Victoria and the Australian Capital Territory, and both jurisdictions have provisions dealing with privacy in broadly similar terms to art 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which was considered in Purdy.156 One commentator has noted the view that if the Purdy decision is applied in Victoria, aspects of current criminal law may be inconsistent with its Charter of Human Rights and Responsibilities Act 2006 (Vic).157

We do observe, however, that the case for such guidelines may be less urgent in Australia as the situation here is different from that in England and Wales. One difference which may be of significance is the lack of history in Australia of a publicly compassionate approach to non-prosecution of these offences. This can be contrasted with the DPP in England and Wales, who had declined to prosecute in a number of cases of assisted suicide involving travel to permissive jurisdictions, including the very public Daniel James case in which reasons for the decision were published.158 The DPP’s approach to these cases was considered significant by the House of Lords in Purdy in concluding that greater clarity and certainty was needed as to when a prosecution will occur and when it will not. Other points of possible contrast that were relevant to the House of Lords’ deliberations were the obligation on the DPP to produce prosecution guidelines (whereas in Australia, DPPs are empowered but not required to do so) and that in England and Wales assisted suicide can only be prosecuted with consent of the DPP.159

154 Murphy, above n 12, 356.
155 See, eg, Rapke, above n 12, 11–17; Faunce and Townsend, above n 12, 714–15.
157 Rapke, above n 12, 11.
159 See Suicide Act 1961, 9 & 10 Eliz 2, c 60, s 2(4).
Nevertheless, despite these differences, we consider that the *Purdy* decision squarely raises questions about the need for specific prosecutorial guidelines dealing with voluntary euthanasia and assisted suicide. This is particularly so in jurisdictions with a human rights statute but we also consider there is merit in considering this approach in the absence of such legislation. For those jurisdictions contemplating such a step, we offer these guidelines as a principled approach to decisions whether or not to prosecute cases of voluntary euthanasia and assisted suicide.
XII Appendix: Proposed Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide

1 Autonomous Choice: An Additional Public Interest Factor
Specific to these Offences

1.1 An additional public interest factor that tends in favour of prosecution is that the deceased’s death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

1.2 An additional public interest factor that tends against prosecution is that the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

2 Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

2.1 the deceased was competent to make the decision to end his or her life;
2.2 the decision was made voluntarily by the deceased; and
2.3 the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

3 Direct Evidence in relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased’s death occurred as a result of an autonomous choice by him or her include whether:

3.1 the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (competence);
3.2 the deceased needed assistance to make decisions about other aspects of his or her life (competence);
3.3 there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntariness);
3.4 the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntariness);
3.5 the suspect or others took steps to ensure that the deceased’s decision was not brought about by pressure or coercion (voluntariness);
3.6 the suspect or others took steps to ensure that the deceased had received, or was offered, sufficient and accurate information about the decision including, where appropriate, information from qualified medical or other health professionals (sufficient information).

4 Confidence whether Death Occurred as the Result of Autonomous Choice

The presence of factors that give confidence that the deceased’s death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.1 the deceased’s decision for his or her life to end appeared to be a settled one;
4.2 the suspect reported the death to the police within a reasonable time and cooperated fully with the investigation.

The presence of factors that raise doubts that the deceased’s death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.3 a history of violence or abuse by the suspect towards the deceased;
4.4 an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect’s decision-making;
4.5 the suspect did not report the death to the police within a reasonable time or did not cooperate fully with the investigation.

5 Decision to Be Made by the Director of Public Prosecutions

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be made by the Director of Public Prosecutions.
6 Public Reporting of Decision-Making

6.1 Subject to any contrary legal obligation, the Director of Public Prosecutions will produce and publish reasons for a decision not to prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

6.2 The Director of Public Prosecutions will publish in his or her Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.
Voluntary palliated starvation: A lawful and ethical way to die?

Ben White, Lindy Willmott and Julian Savulescu

Increasingly, individuals want control over their own destiny. This includes the way in which they die and the timing of their death. The desire for self-determination at the end of life is one of the drivers for the ever-increasing number of jurisdictions overseas that are legalising voluntary euthanasia and/or assisted suicide, and for the continuous attempts to reform State and Territory law in Australia. Despite public support for law reform in this field, legislative change in Australia is unlikely in the near future given the current political landscape. This article argues that there may be another solution which provides competent adults with control over their death and to have any pain and symptoms managed by doctors, but which is currently lawful and consistent with prevailing ethical principles. “Voluntary palliated starvation” refers to the process which occurs when a competent individual chooses to stop eating and drinking, and receives palliative care to address pain, suffering and symptoms that may be experienced by the individual as he or she approaches death. The article argues that, at least in some circumstances, such a death would be lawful for the individual and doctors involved, and consistent with principles of medical ethics.

INTRODUCTION

Voluntary euthanasia and assisted suicide are a source of ongoing discussion at both federal and State level in Australia. Despite this agitation for change, apart from a brief period in the Northern Territory, efforts to legalise assisted dying have failed. But is there a means to achieve this same outcome, a comfortable death desired by a competent adult at a time of their choosing, which is justifiable according to current medical ethics and within the law? The concept of “voluntary palliated

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1 For example, before the 2013 federal election, the Voluntary Euthanasia Party was formed and had seven candidates, with two Senate candidates standing in each of the Australian Capital Territory, New South Wales and South Australia seats, and one candidate standing for a lower house seat in the Northern Territory: “Euthanasia Party Launches Candidates”, news.com.au (online) (19 August 2013). http://www.news.com.au/national/breaking-news/euthanasia-party-launches-candidates/story-er6fikz8 -1226699930838?from=public_rss. More recently, on 10 November 2014, the Senate Standing Committee on Legal and Constitutional Affairs tabled its final report on the Medical Services (Dying with Dignity) Exposure Draft Bill 2014 which was released in June 2014 by Greens Senator, Richard Di Natale. Since the Northern Territory euthanasia legislation, Rights of the Terminally Ill Act 1995 (NT), was overturned by the Euthanasia Laws Act 1997 (Cth), there have also been ongoing attempts to repeal the relevant Commonwealth legislation, particularly by the Australian Greens party.

2 Over the past five years, for example, New South Wales has introduced the Rights of the Terminally Ill Bill in 2010 (lapsed on prorogation) and 2013 (defeated 23:13); South Australia has introduced nine separate euthanasia Bills, the last two of which lapsed on prorogation; Tasmania has introduced the Dying with Dignity Bill 2009 (defeated 15:7) and the more recent Voluntary Assisted Dying Bill 2013 that was narrowly defeated 13:11; Victoria has introduced the Medical Treatment (Physician Assisted Dying) Bill 2008 (defeated 25:13); and finally Western Australia has introduced the Voluntary Euthanasia Bill 2010 (defeated 24:11). The various legislative attempts in Australia are also discussed in White B and Willmott L, “How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?” (2012) 20 JLM 410. See also the Australia21 report following a euthanasia and assisted dying roundtable in Brisbane in January 2013: Douglas B, Willmott L and White B, The Right to Choose an Assisted Death: Time for Legislation? (Australia21, 2013), http://eprints.qut.edu.au/59240.
starvation” (VPS), advanced elsewhere, refers to when a competent adult refuses to eat or drink and then receives palliative care to relieve any suffering he or she experiences from dying due to a lack of food and water. Of note is that this provides a means for people, whether or not they are terminally ill or dependent on medical treatment to survive, to die comfortably.

Death resulting from a competent patient’s decision to cease eating and drinking is not a new concept, and has been discussed as an option for hastening death for more than two decades. As early as 1993, Bernat and his colleagues urged consideration of patient refusal of hydration and nutrition as an alternative to physician-assisted suicide and voluntary active euthanasia. At the same time, Bernat called for more scientific research into the physiological effects of starvation and dehydration so that patients would be confident that death in this way would not be accompanied by suffering. There is now a body of research which provides evidence that death as a result of starvation and dehydration for patients who are dying may not be uncomfortable if appropriately managed. So while there has been some consideration of the situation for individuals who are dying, there has been less focus on this kind of death for those who are not terminally ill.

At this point, it is useful to recount the situation of Tony Nicklinson, a man who was not terminally ill, but wished to die. Tony was the applicant in Nicklinson v Ministry of Justice and his wife, as testatrix of his estate, was a party to the appeal to the English Court of Appeal in Nicklinson v A Primary Care Trust. Tony died before the appeal was heard. This litigation was commenced because Tony sought assistance to die as he was not in a position to kill himself and he wished to challenge the current law that prohibited him receiving the desired assistance. Tony found himself in this situation after suffering a stroke and becoming “locked-in” so that he was almost completely paralysed. He relied on others for all his care needs and, while able to eat, needed to be “fed like a baby”. However, he was not dying nor was he terminally ill. Tony was competent and his decision to want to die was described as “rational” by the court. After being unsuccessful in the English High

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4 Ivanovic N, Buche D and Fringer A, “Voluntary Stopping of Eating and Drinking at the End of Life – A ’Systematic Search and Review’ Giving Insight into an Option of Hastening Death in Capacitated Adults at the End of Life” (2014) 13(1) BMC Palliat Care 1. For an overview and history of the very limited legal engagement on this issue, see Pope T and West A, “Legal Briefing: Voluntarily Stopping Eating and Drinking” (2014) 25 J Clin Ethics 68. While there is only limited empirical evidence about the frequency with which deaths occur as a result of voluntarily ceasing to eat and drink, research in the Neth-

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10 Nicklinson was not “terminally ill” in the sense that he was not dying and was capable of living for some time. In another sense, however, he may be regarded as terminally ill in that he was dependent on ongoing care and artificial nutrition and hydration to continue living.
Court, Tony refused nutrition, fluids and medical treatment with the intention of dying, and he subsequently died of pneumonia.11 Although the media reported his widow as describing his death as “thankfully” quick, she also said that his final 48 hours were “pretty unpleasant”.12

Tony’s plight illustrates some of the issues that arise in this article but to elucidate them more clearly, let us consider a revised scenario (or at least add facts to remove possible uncertainty). Let us assume that Tony is not suffering from pneumonia or any other illness: his cause of death will be starvation and/or dehydration. And as he starves and dehydrates, he slowly starts to feel discomfort, then some pain and suffering. Let us also assume that Tony is then provided with palliative care to manage that pain and those symptoms as they arise.

The key issue is the implications of making palliative care available in this situation. As discussed, a competent refusal to eat and drink, even when that results in death, is not particularly controversial from an ethical or legal perspective. But does the provision of palliative care to manage the pain and/or symptoms associated with this decision alter the legal or ethical implications of this conduct? It is argued that it need not do so and that there are cases (such as the revised Tony scenario) where VPS would be both lawful and ethical.

**VOLUNTARY STARVATION BY A COMPETENT ADULT**

Every competent adult has the right to refuse to eat and drink, and not to be force-fed contrary to their wishes. This is a recognised ethical right and also has entrenched support in law.

**Legal perspective**

The most frequently cited authority for this principle is the landmark case of *Schloendorf v New York Hospital* in which Cardozo J observed that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body”.13 This is also a part of the common law of Australia14 and is reflected in the civil and criminal law of trespass (battery) in each State and Territory.15 This protection of the person remains even if the course of action adopted, such as refusing life-sustaining treatment, will lead to death.16

It is now well accepted in Australia (and elsewhere) that artificial nutrition and hydration are capable of being lawfully refused. This has been approached often on the basis of it being a refusal of medical treatment, and the cases are generally in the context of incompetent adults. At times, the decisions arise due to the relevant legislative framework that operated,17 but the principles at play are consistent with the common law. The same principles also apply to a decision by a competent adult to refuse to eat and drink. The right to bodily integrity embedded in law protects all bodily integrity, not just in relation to medical treatment and so protects a refusal to eat and drink and prevents force-feeding. This principle was recently applied by the English Court of Protection, commenting that “[p]eople with capacity are entitled to make decisions for themselves, including about what they will...

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11 *Nicklinson v A Primary Care Trust* [2013] EWCA Civ 961 at [12].
13 *Schloendorf v New York Hospital* 211 NY 125 at 129 (1914).
14 *Secretary, Department of Health and Community Services (NT) v JWB (Marion’s Case)* (1991) 175 CLR 218.
17 *Re BWV; Ex parte Gardner* (2003) 7 VR 487.
and will not eat, even if their decision brings about their death”, 18 and by the Supreme Court of South Australia in a case where the competent refusal of food and water was held to be lawful. 19

In recognising the common law right to refuse to eat and drink, courts have also been called upon to consider the corresponding liability of those who respect this refusal such as residential aged care facilities 20 and residential disability care facilities. 21 Generally this has involved considering statutory provisions in the relevant State and whether they alter this common law right. Although the legislative framework will differ between jurisdictions, the general principles from these cases show, as one might expect, that respecting a competent refusal will not give rise to liability.

One area of possible legal risk that has been suggested is whether respecting this competent refusal might be treated as assisting a suicide (the concept of suicide, although no longer a crime in Australia, has been judicially described as “the intentional taking of one’s own life”). 22 The case of H Ltd v J has rejected this concern concluding, by analogy, that as refusing life-sustaining medical treatment is not suicide, 23 nor should refusing to eat and drink be considered suicide:

I acknowledge that there is a difference between food and medicine. There is also a difference between the taking of food by natural means and the medical administration of nutrition. However, those differences do not appear to me to be sufficient to sustain a distinction between suicide and the exercise of a right to self-determination … I find that refusal of sustenance and medication is not suicide within the common law meaning of that term. 24

So because a refusal to eat and drink is not suicide, one cannot be guilty of assisting a suicide by respecting that refusal. 25 In H Ltd v J, Kourakis J (now Chief Justice) also concluded that, even if he was wrong and refusing to eat and drink was capable of being suicide, merely respecting a competent refusal would not constitute the necessary aiding, abetting or counselling of the suicide required under the law of that State. Courts are likely to require at least some assistance or encouragement before imposing liability in this setting. 26

Indeed, a person who is respecting a competent refusal of food and fluids may, at the same time, be attempting to discourage, challenge or otherwise dissuade a person wishing to die. However, when ultimately a person is not persuaded to take food and fluid, the law requires that the person’s own wish over what is introduced into his or her own body be respected.

Another possible area of legal concern is the duty on those who have charge of another to provide the necessaries of life, where a failure to do so would give rise to criminal responsibility for the

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18 Re E (Medical Treatment: Anorexia) [2012] EWHC 1639 at [7].
19 H Ltd v J (2010) 107 SASR 352 at [64].
21 Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84.
23 See also, for example, two recent Australian cases that have concluded that refusing life-sustaining treatment is not suicide: X v Sydney Children’s Hospitals Network [2013] NSWCA 320; Re JS [2014] NSWSC 302.
24 H Ltd v J (2010) 107 SASR 352 at [64]-[65].
25 This view, and the reasoning in H Ltd v J (2010) 107 SASR 352, can be critiqued as inconsistent both as a matter of logic and legal principle. One example of such critique (although it preceded H Ltd v J) is Ołkowski, n 22, Ch 2. However, these critiques of themselves do not have force of law and so do not alter the legal position described in this article. The task here is to state the law as it is likely to be, drawing upon the most applicable and relevant primary legal sources.
26 In Attorney-General v Able [1984] QB 795, Woolf J outlined the elements of the offence of aiding and abetting suicide under the relevant legislation at the time, and determined that a conviction required both intent to assist and that the deceased was assisted or encouraged to suicide. See also, for example, the Australian cases (sentencing remarks) of R v Maxwell [2003] VSC 278; R v Hood [2002] VSC 123; R v Nielsen [2012] QSC 29.
person’s death.\textsuperscript{27} Here, again, the courts have concluded that where there is a lawful refusal in place, this duty will not arise.\textsuperscript{28} While there is some variation in the framing of this duty nationally (for example, some jurisdictions rely on the common law while others have it in statute), this is likely to be the position under Australian law. There was also an alternative argument advanced in \textit{Brightwater Care Group (Inc) v Rossiter} that a competent adult should not be regarded as being in the “charge of another” and so a care facility would not be subject to this duty,\textsuperscript{29} although this argument has been criticised elsewhere.\textsuperscript{30}

\textbf{Ethical considerations}

From an ethical perspective, the right of a competent adult to refuse to eat and drink could be seen as a basic right or derivative from the right not to have one’s body invaded or violated without consent. One of our most basic interests is control over our own bodies. Thus, our body should not be subjected to the will of another without our consent. This is so on either Kantian or consequentialist grounds (though Kant himself and some modern Kantians think suicide in many cases is morally wrong). There is a basic moral principle of inviolability of the person:

- It is impermissible for one person, A, or several people, B-D, to insert any part of their body, object or substance into the body of another competent person, X, without X’s consent. (A more formal version is:
  - It is impermissible for one person, A, or several people, B-D, to perform an act which involves foreseeably and avoidably inserting any part of their body, object or substance into the body of another competent person, X, without X’s valid consent.)\textsuperscript{31}
- While it follows from this that every person has the ethical right to refuse to eat and drink, does it remain ethical if that refusal results in death through starvation?

Historically, there was no property in the body. Indeed, at times, our bodies belonged to the sovereign. Thus there used to exist the ancient crime of \textit{maim}, which is rendering the body unfit for fighting (whether or not that injury is consented to).\textsuperscript{32} Others believed that our body belonged to God and so it was to usurp His will to prematurely take one’s own life. However, if anyone owns the body, it is the person who resides in it. So we have a right to end our life as we choose. The central ethical concept relevant to assisted dying in general is that of autonomy. Autonomy comes from the Greek words “autos” and “nomos” which together mean “self-governing”. Respect for autonomy is the principle that we should respect each individual’s own conception of what is a good life for him or her, unless he or she presents a direct threat of harm to other people. Each of us has a right to determine how our lives should go, even when those decisions appear irrational or extraordinary.

It is respect for autonomy which grounds the justification for allowing Jehovah’s Witnesses to die by refusal of life-saving blood transfusion. Witnesses believe, contrary to all other Christian denominations, that the Bible forbids literally the taking of blood. If they do not refuse, they believe they will not enjoy eternal paradise. This interpretation is unlikely to be correct given the weight of scholarship, even within the Christian tradition, against it. Yet nonetheless the wishes of autonomous Witnesses are respected. So to be allowed to die does not require that our values be maximally rational or universally shared.

\textsuperscript{27} In terms of the legal duty of doctors to provide “necessaries of life” and how that operates in the contexts of decisions to withhold or withdraw medical treatment, see Willmott L, White B and Then S, “Withholding and Withdrawing Life-Sustaining Medical Treatment” in White B, McDonald F and Willmott L (eds), \textit{Health Law in Australia} (Thomson Reuters, Sydney, 2010) at [13.20].

\textsuperscript{28} \textit{Brightwater Care Group (Inc) v Rossiter} (2009) 40 WAR 84 at [43]-[49]; \textit{H Ltd v J} (2010) 107 SASR 352 at [73]-[74].

\textsuperscript{29} \textit{Brightwater Care Group (Inc) v Rossiter} (2009) 40 WAR 84 at [33]-[42].


\textsuperscript{31} Savulescu, n 3 at 111.

\textsuperscript{32} See \textit{R v Brown} [1993] 2 WLR 556 at 589 (Lord Mustill). See also \textit{Arthur v Arthur} [1964] ALR 1021; \textit{R v Woodward} [1970] QWN 30. The obsolete common law crime of “maim” has been subsumed into what is now known as grievous bodily harm and other similar non-fatal offences to the person.
However, some choices do not reflect our deeply held values. Some are frivolous, influenced by social or peer pressure, or solely the result of addictions or depression. From an ethical perspective, it may not be acceptable to respect a person’s choice to die in such circumstances. Yet unusual choices are not necessarily non-autonomous. Perhaps the most unusual is the desire by the philosopher Michael Bayles to commit suicide, as evidenced in his obituary:

Michael Bayles committed suicide August 6, 1990. He was born in Charleston, Illinois January 21, 1941, and so died in his fiftieth year. His suicide was carefully planned and is as much an expression of Myke as his varied writings in ethical theory and applied ethics, philosophy of law, and political theory. Myke’s argument for the moral acceptability of suicide is that, as he put it, “only humans can choose when they will die” and that “to fail to exercise that choice is to deprive oneself of a distinctive freedom”. A person’s life is a story, he suggests, and a person ought to consider how the story ought to end, with suicide an option under appropriate circumstances. “If”, he says, “what makes life a good story is happiness or the pursuit of projects, then a long, drawn out ending without either is a bad end of what may have been a good story”.

Bayles had been very productive in the years leading up to his death though he progressively took on fewer and fewer projects. He wanted to die without unmet obligations. He had, in the three years before his death, been seen to publication his Principles of Law and what Joel Feinberg has called “a groundbreaking theory of procedural justice with applications not only to legal practices but to social institutions generally”. And the day he committed suicide he received word that his book on HLA Hart had been accepted for publication.

Some wrote Bayles was depressed. This may have been the case. But if that depression were unchangeable and his valuing suicide had persisted for some time and was the result of rational reflection, then it may still have been an expression of his autonomy. What matters according to the principle of respect for autonomy is not that a person makes the right decision, but that they make their own decision, according to their values.

Lisette Nigot, aged 79 and apparently healthy, also made an unusual choice. This retired academic, who was living in Perth, took an overdose and died shortly before her 80th birthday. The note that she left behind her bed when she died explained: “After 80 years of a good life, I have [had] enough of it. I want to stop it before it gets bad.” It was important to Nigot to end her life while she was well and before her health deteriorated and this represented her autonomous choice.

While autonomy is key in ethical terms, what is critical in clinical terms is whether the person is competent. For clinical practice, independent, competent determinations of competence are central. A patient refusing nutrition and hydration in order to end her life runs the risk of being deemed incompetent just because she wants to end her life. A patient who is terminally ill, or suffering from a condition like motor neurone disease, or even just tired of life is unlikely to be deemed incompetent and so forcibly prevented from acting on that strategy.

Importantly, doctors can respect autonomy by providing information and argument to patients in an attempt to engage and perhaps even change a person’s values. Yet when argument and facts have been presented, respect for persons requires that their decisions for their own lives be respected, including the decision of when to end their life.

Now if doctors, courts and family members can make a decision that a person’s life is no longer worth living and feeding should be stopped (as can occur legally when the patient is incompetent and cessation of feeding is assessed as being in the patient’s best interests), why cannot the person, like

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34 Robinson, n 33 at 2.
Tony Nicklinson, make that decision, and it be acted upon? Surely the person who has the most right to decide whether life is tolerable is the person who must live that life.

**Palliation in the course of voluntary starvation by a competent adult**

The discussion so far has made the reasonably uncontroversial claim that a person has both a legal and ethical right to refuse to eat and drink, even if this will lead to his or her death. And if there is a lawful refusal, respecting it will not attract legal liability. In the revised scenario above, Tony may refuse to eat and drink and his carers would need to abide by his decision. But dying in this way – through dehydration and/or starvation – can lead to suffering, particularly if the person is not already dying.

In the recent English Court of Appeal decision of *Nicklinson v A Primary Care Trust*, an attempt to die by refusal to eat and drink was described as constituting the “most distressing circumstances”.

The dilemma that is grappled with now is whether a person refusing to eat and drink (self-induced starvation) should be able to receive palliative care to manage the pain and symptoms associated with this choice to make their dying comfortable. Does the addition of palliative care, so called “voluntary palliated starvation” or VPS, alter the legal and ethical analysis above? It is argued that the provision of palliative care, at least in the situations contemplated as illustrated by the revised Tony scenario above, can be legally and ethically justifiable.

**Legal perspective**

The argument is that first, there is no legally relevant distinction between providing palliative care to manage the symptoms of a refusal to eat and drink and other situations where palliative care can be lawfully provided. Secondly, the addition of palliative care need not alter the position relating to criminal responsibility discussed above that respecting a competent refusal to eat and drink is lawful.

**Palliative care is lawful for refusals to eat and drink**

Palliative care may be lawfully provided to a patient as they approach death to manage their pain and symptoms. *Brightwater Care Group (Inc) v Rossiter* makes clear that this position does not change just because the death is occurring due to a refusal of treatment:

> There are a number of general principles which can be confidently stated in relation to this issue. The first is that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter’s withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. Put another way, Dr Benstead’s rights and obligations with respect to the provision of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration are no different to the obligations which attend the treatment of any other patient who may be approaching death.

Similarly, it would be lawful (as well as good and acceptable medical practice) to relieve the suffering of a person dying from a valid refusal of blood transfusion, such as a Jehovah’s Witness. It is the fact of the suffering that is relevant, not its origin.

Mr Rossiter, therefore, was entitled to the same palliative care to ease his dying process even though the symptoms and the need for that care arose due to his refusal of artificial nutrition and hydration. Indeed, it was clear from the judgment and the declaration made by the judge that he expected (and hoped) Mr Rossiter would be provided with palliative care. As a matter of logic, this position must also hold for the refusal of food and water (not just nutrition and hydration provided artificially) as the decision to refuse to eat and drink is protected in the same way and for the same reasons by the law. And the failure to receive either could be expected to cause equal suffering.

Further support for this proposition can be gleaned from three other cases where the issue of palliative care to deal with the symptoms of treatment refusal was raised during the course of

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37 It is noted that there is evidence to suggest that when not eating or drinking is part of the normal dying process, the absence of food and drink may not result in suffering to the patient. See further n 6.

38 *Nicklinson v A Primary Care Trust* [2013] EWCA Civ 961 at [9].

39 *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84 at [52].
proceedings but not seen as unlawful. In *H Ltd v J*, a case which involved a refusal of food and water (and insulin) and not artificial nutrition and hydration, the judge contemplated that palliative care would be given to manage pain and symptoms and this was not flagged as being problematic.\(^{40}\) If such conduct were to be unlawful, one would expect a judge to have grappled with such a concern before granting declarations that respecting refusals of food and water (and insulin) would be lawful. Likewise in the case of *Australian Capital Territory v JT*, the declaration sought was that it would be lawful to act on an adult’s refusal of food and water and provide only palliative care. Although the declaration was not granted on the facts of the case, the Supreme Court made no adverse comment about the general lawfulness of such an approach.\(^{41}\) Finally, in *Re JS*, where a competent adult was refusing mechanical ventilation that was keeping him alive, the New South Wales Supreme Court also made no adverse comment about the lawfulness of palliative care to manage symptoms associated with the cessation of treatment. The court did decline to grant a declaration that the provision of such care would be lawful but this was because it would not be appropriate to prescribe the limits of JS’s future care rather than concerns about lawfulness.\(^{42}\)

This consistent approach to palliative care for patients refusing to eat and drink would mean that it would be lawful for that palliative care to hasten death provided the intention was to relieve pain. While there is some variation around Australia (some States being governed by the common law and others by statute), the provision of appropriate palliative care that intends to relieve pain and not cause death is lawful\(^{43}\) and this would also be the case for VPS.

**Addition of palliative care does not give rise to other criminal responsibility**

Even if the administration of palliative care to manage the symptoms of a refusal to eat and drink is lawful as if it had been provided to deal with symptoms of refusing medical treatment, it might still be argued that the addition of palliative care alters the general principles of criminal responsibility that were discussed above. In other words, while refusing to eat and drink is lawful and that refusal must be respected, does the provision of palliative care in this situation change the nature of that interaction between patient and care providers such that criminal responsibility might arise?

The revised scenario of Tony Nicklinson helps to crystallise this type of case. Tony is dying from starvation and/or dehydration and starts to feel discomfort, then pain and suffering. He is then provided with palliative care to manage that pain and those symptoms as they arise until he dies.

In terms of the law related to assisted suicide, the same main hurdle for prosecutors mentioned above would arise. If refusing food and water is not suicide, those providing palliative care, with the intention of providing symptom relief rather than hastening death, in “assistance” of that aim, cannot be assisting a suicide. This is made clear in the quote from *H Ltd v J* above. As noted earlier though, that there was an alternative or “back-up” ground advanced in that case. The judge stated that even if he was wrong and it was suicide, merely respecting a competent refusal falls short of the required encouragement to constitute aiding and abetting and so no criminal offence is committed. This reasoning might not apply where palliative care is being provided. There is an argument that offering palliation could constitute some kind of encouragement in the sense that the patient might not be prepared to refuse to eat and drink without the availability of palliative care. That said, the judge in *H Ltd v J* made clear that this second line of reasoning was advanced as a back-up to the main proposition that refusing to eat and drink is not suicide in legal terms. If that first argument is accepted, and this article submits it should be, then the addition of palliative care does not alter the criminal responsibility discussed above.

The other area of potential liability identified earlier was in relation to causing death through the failure to provide the necessaries of life. The addition of palliative care does not change the above analysis. It is the competent refusal to eat and drink that relieves carers of this duty and the addition of

\(^{40}\) *H Ltd v J* (2010) 107 SASR 352 at [98].

\(^{41}\) *Australian Capital Territory v JT* (2009) 4 ACTLR 68.

\(^{42}\) *Re JS* [2014] NSWSC 302 at [30], [35].

further care does not alter any responsibilities in this regard. And questions of causing the death in the
scenario proposed would also not arise. As noted above, appropriate palliative care intended to relieve
pain – as it clearly is in the revised Tony scenario – does not give rise to criminal responsibility even
if an unintended consequence is to hasten death.

This is not to say, however, that a refusal to eat and drink coupled with palliative care could never
give rise to liability. The criminal law is inevitably interacting with a particular situation and set of
facts and it is possible to consider other scenarios where the combination of palliative care with a
decision to refuse to eat and drink could change the nature of the parties’ conduct and corresponding
responsibility. One such instance might be where the clear intention of the palliative care is to cause
death immediately and not merely to relieve pain and suffering. That said, the types of cases discussed
in this article, as illustrated by the revised Tony scenario, remain within the law and palliative care can
be provided to ameliorate the suffering that refusing to eat and drink can give rise to. VPS can be
lawful and therefore is a legal option available to those wishing to die comfortably who are not
terminally ill or dependent on life-sustaining medical treatment.

Ethical considerations
There are two connected but separate issues associated with the ethics of providing palliative care to a
competent patient who has chosen to die through cessation of eating and drinking. The first is whether
it is ethical for doctors to provide clinical support to a patient who is seeking to die in this way. The
second issue arises only if it is concluded that it is ethical to provide that support, and it is whether an
individual doctor should be required to provide such support. Each issue is considered in turn.

As to the first, it is argued that it is ethical for doctors to provide palliative care. To recap on the
earlier argument, it is claimed that it is ethical for a competent person to refuse to eat and drink even
if that decision results in death, because a person has a fundamental right not to have their body
violated or invaded without their consent. It follows, as explained, that doctors are morally required to
respect competent refusals of medical treatment and refusals to eat and drink.

What then are the ethical implications of providing palliative care to such a patient? Many
commentators over the past two decades have argued that for patients who have expressed a wish to
die by not eating or drinking, the provision of palliative care should be seen as part of the health
professional’s role as a caregiver. Support for dying through stopping food and fluid, while not
universal, has been expressed from both medical and nursing perspectives.

The article argues that the provision of palliative care to a patient dying as a result of a decision
not to eat or drink is ethically sound. Respect for autonomy entails respecting a person’s desire to live
and die in their own way. When the choice to die causes suffering, doctors have a professional
obligation to relieve that suffering, for example by the provision of palliative care. Reasons not to
provide medical care include that it is unlawful, a competent patient validly refuses it, it is itself
harmful, or otherwise not cost-effective and so precluded by principles of distributive justice. But
palliative care to relieve the suffering of self-chosen dying is none of these. Doctors ought to provide
it.

Some might object that medical care should not be provided to those who inflict their suffering
upon themselves. However, this would preclude much of current medical care: provision of care to

44 See, for example, Bernat et al, n 5; Quill TE and Byock JR, “Responding to Intractable Terminal Suffering: The Role of
Refuse Nutrition and Hydration” (2005) 11(2) Alternat Complement Ther 100; Berry ZS, “Responding to Suffering: Providing
Options and Respecting Choice” (2009) 38 J Pain Symptom Manage 797; Schwarz JK, “Death by Voluntary Dehydration:
Suicide or the Right to Refuse a Life-prolonging Measure?” (2011) 17 Widener L Review 351.

45 See, for example, Jansen L, “No Safe Harbor: The Principle of Complicity and the Practice of Voluntary Stopping of Eating

46 Bernat et al, n 5; Berry, n 44.

47 Yale, n 44. See also Harvath TA et al, “Voluntary Refusal of Food and Fluids: Attitudes of Oregon Hospice Nurses and Social
Workers” (2004) 10 Int J Palliat Nurs 236 where the authors reported support by nurses in hospice programs for patients who
choose to die through the voluntary refusal of food and fluids.
smokers, alcoholics, obese people, those who engage in risky activities (including sexual activities),
those who harm themselves through physical violence, and so on. Clearly doctors have an obligation
to relieve suffering, whether or not it was self-inflicted.

The second ethical issue relates to the nature of the doctor’s obligation. If it is accepted that it is
ethical for doctors to provide palliative care to a patient who is dying in these circumstances, are they
morally required to provide palliation? It is important here to distinguish between moral obligations
and moral requirements. A moral obligation stipulates something there is a moral reason to do: what a
person ought to or should do. A moral requirement stipulates something a person must do, on pain of
legal or social sanction. For example, we ought to be more concerned about global inequality, poverty
and climate change but we are not required to make significant sacrifices, such as giving up larger
proportions of income, for these causes.

It has been argued above that doctors have an obligation to relieve suffering. However, to say that
something ought to be done is not to say that it must be done (that it is morally required). Some
doctors will, understandably, refuse to be complicit in what they regard as killing. They will
conscientiously object to assisting the patient to die. Thus doctors might legitimately decide not to
support a dying patient who has chosen to die by providing palliative care or other medical treatment
if they believe that person is acting for bad reasons. However, it is argued in this article that VPS is
not unlawful and that it should be permissible within medical practice. And where there are a range of
permissible practices (such as VPS), doctors do have a minimal obligation to respect autonomy by
directing a patient to other practitioners who might take a different view of the request. Conscientious
objection has limits and requires referral on, where a practice has been deemed lawful and generally
permissible in medicine.48

Whether a doctor should morally accede to such a request in a jurisdiction where providing
assistance is lawful turns on whether the person has a good reason to die. Existential suffering, ageing,
loss of one’s ideals could all be good reasons to die, in certain circumstances.49

CONCLUSION
This article has argued that it is both lawful and ethical to respect lethal refusals to eat and drink. This
proposition is neither legally nor ethically controversial. It has been further argued that it can be both
lawful and ethical to provide palliative care to reduce the suffering associated with such self-induced
dying. This second argument is more controversial, yet an important one to have in light of the
ongoing debate about whether competent adults should be entitled to assistance to die, and the
ongoing resistance of Australian Parliaments to enact laws that allow assistance to be given. There is
widespread but not unanimous community support to reform the law to allow assistance in dying. But
there would be unanimous support for the proposition that a person should not die suffering and in
pain. A lawful and ethical model (VPS) to achieve this end is therefore worth considering.

The VPS model presents an opportunity for that cohort for whom end-of-life decision-making
frameworks have struggled to assist – individuals who are sick (whether or not they are terminally ill)
and in pain, but not dependent on life-sustaining treatment. The model would also be an option for
elderly people who are “tired of living” and autonomously choose to die while they still have a quality
of life that is acceptable to them (as in the case of Lisette Nigot). These groups cannot lawfully receive
assistance to die in any jurisdiction which has enacted laws to facilitate voluntary euthanasia and
assisted suicide.

The argument in this article is not that palliative care physicians or other doctors be required to
provide the palliative care – only that they should be allowed to. And there can exist good moral
reasons to ground a moral obligation to provide palliative support to those who choose to die for good
reasons. There are also good reasons not to require doctors to engage in medical practices if they

49 Savulescu J, “Rational Desires and the Limitation of Life-Sustaining Treatment” (1994) 8 Bioethics 191; Savulescu J,
“Autonomy, the Good Life, and Controversial Choices” in Rhodes R, Francis LP and Silvers A (eds), The Blackwell Guide to
cause distress to doctors: these doctors may not perform the service adequately, and there are sufficient other doctors to provide the necessary palliative support. If there are insufficient doctors and other health professionals to provide palliative support to those who choose to die, there may be a need to readdress the extent of professional obligations to relieve the suffering of self-induced dying.

Taking as the starting point the case of Tony Nicklinson, it has been argued that VPS is both ethically justifiable according to current medical ethics and within what is already permitted by law. If the currently accepted position that a competent adult should be able to refuse to eat and drink is adopted, why then should deaths that occur in this way be painful? Some may argue that VPS is a step too far but if existing rights are taken seriously, it is hard to argue why a lawful death through refusing to eat and drink should occur in pain.

VPS is not ideal as a mode of dying. It requires courage and determination – it is not for everyone. There is the possibility of being declared incompetent and forcibly treated. There is the possibility of not receiving, or receiving inadequate, palliative care and subsequently suffering. People entertaining the option of VPS need to be aware of these possibilities and take steps to minimise their happening, for example, receiving in advance the assurances that their wishes will be respected. While VPS is likely to be an option accepted by the medical profession in cases of terminal illness, it is likely to be more unpopular when requested for non-terminal conditions. Since patients cannot demand medical treatment, it is likely to be more difficult to secure and people should ensure they have a willing physician to provide palliative care.

VPS has other shortcomings. It involves slow dying and many people wishing to die and many families will yearn for a quick death. And lastly, practising VPS may lead some to think that it renders legal reform around dying unnecessary, sapping political and social will to introduce voluntary euthanasia and/or physician-assisted suicide legislation.

This latter concern need not arise, however. The difficulties identified with VPS mean that it should only be a part of a comprehensive approach to assisted dying. In fact, that VPS is currently lawful and ethical should add weight to calls for reform and it can be seen as a bridge to the legalisation of voluntary euthanasia and/or physician-assisted suicide. We had no choice over how or when we entered this world but we can and should exercise choice over how and when we leave it.
Doctors’ knowledge of the law on withholding and withdrawing life-sustaining medical treatment

Decisions to withhold or withdraw life-sustaining treatment are part of mainstream medical practice. Almost 40 000 adult deaths occur each year across Australia following a medical decision to withhold or withdraw life-sustaining treatment. Doctors play a critical clinical role in the provision of medical treatment at the end of life. What is less recognised is that doctors also play a significant legal role in that process. For example, a doctor must assess whether a patient has the capacity to make a treatment decision, determine who the authorised decisionmaker is if the patient does not have that capacity, and know whether a person’s previously expressed wishes comprise a valid advance directive that must be followed. Further, the law in this field is complex and differs between states and territories. For example, in some situations a doctor may be obliged to follow an advance directive in one state but will be in breach of the law if he or she does so in the same situation in another.

Doctors currently receive some training about the law in this and other areas in medical school, during specialist training, and/or as part of continuing medical education. However, it is unclear whether this training equips doctors sufficiently with adequate practical knowledge. One aim of this research was to establish the level of doctors’ legal knowledge about withholding or withdrawing life-sustaining treatment from adults who lack decision-making capacity.

Methods

This study explored doctors’ knowledge of the law relevant to end-of-life care in New South Wales, Victoria and Queensland. These states have both similarities and differences between legal regimes, which allowed us to explore whether the different regimes affected levels of knowledge.

Data were collected through a survey instrument, developed over 18 months, informed by a detailed review of the law in each state, focus groups, pretesting, and piloting of the instrument with specialists. The accuracy of the legal questions and responses were confirmed by independent legal experts in each state. The sample cohort comprised all specialists in emergency medicine, geriatric medicine, intensive care, medical oncology, palliative medicine, renal medicine and respiratory medicine who were on the AMPCo Direct (a subsidiary of the Australian Medical Association) database in the three states at the time the instrument was distributed (n = 2858). These specialties were chosen as these specialists are likely to be involved in making decisions about whether to withhold or withdraw life-sustaining treatment.

This was determined by a review of relevant literature, interviews and an analysis of pilot results. Although general practitioners are commonly involved in end-of-life decision making, they were excluded from our study, which focused on the acute care setting.

AMPCo Direct administered the survey mailout, which began on 18 July 2012. Recruitment strategies included having the survey instrument professionally designed, providing incentives (continuing professional development [CPD] points, educational material and a chance to win one of six prestige bottles of wine), engaging with all the colleges and specialist societies of the target specialties (except the emergency medicine society given the overlap with the college) and publishing editorials in relevant professional journals to request participation in the study. Two follow-up requests were sent to non-responders and the survey was closed on 31 January 2013.

The project was approved by the human research ethics committees at the
Preliminary analyses examined descriptive statistics and bivariate associations by \( \chi^2 \) tests. Mean scores were calculated to assess differences in knowledge among subgroups and linear trends associated with ordinal variables. Formal comparison of mean scores was performed using a general linear model, assuming a normal distribution for scores. Variables examined as predictors of knowledge were state, age, sex, main specialty, religion, years of practice, country of birth, country of degree, self-perceived knowledge of the law, number of decisions made in relation to withholding and withdrawing life-sustaining treatment, and CPD training. Mean scores for subgroups were compared with the sample average using the Nelson–Hsu method within the SAS Statistics GLM procedure, which also adjusts for multiplicity of comparisons. Linear trends associated with ordinal variables, such as self-perceived knowledge, were assessed by modelling these as continuous. Likelihood ratio tests (LRTs) were used to assess each variable overall. Adjusted means were obtained from a linear model that included selected covariates, and similarly compared.

### Results

The final overall response rate was 32% (867/2702): 29% (335/1147) from NSW, 33% (314/957) from Victoria and 36% (218/598) from Queensland. Response rates by specialty by state ranged from 75% for palliative medicine specialists in Victoria to 22% for oncologists in NSW.

The mean correct response for the knowledge of law questions overall was 3.26 (out of a possible score of 7), with a standard deviation of 1.32.

State and specialty were the strongest predictors of knowledge (Box 1), with LRTs giving \( P_{LRT} < 0.001 \) for both variables. NSW showed the highest scores and Queensland the lowest. All pairwise differences were statistically significant at \( P < 0.001 \). After adjustment for state, specialists in geriatric medicine \( (P = 0.001) \) and in palliative medicine \( (P = 0.033) \) had significantly higher scores than average, and specialists in emergency medicine \( (P = 0.035) \) and respiratory medicine \( (P < 0.001) \) had significantly lower scores than average. Medical

### Measures

The survey instrument had six sections: perspectives about the law; education and training; knowledge of the law; practice of and compliance with the law; experience in making end-of-life decisions; and demographics. The knowledge section contained two questions. The first comprised six items: three concerning the validity of an advance directive, two concerning consent from and the authority of substitute decisionmakers, and one dealing with both issues. All questions were to be answered True, False or Don’t Know in relation to the relevant state law. The second question asked which of four plausible decisionmakers had legal authority to make medical decisions for a patient without capacity. Participants could score correct responses on a scale of 0 to 7 (Don’t Know was scored as an incorrect response).

Doctors were asked how much knowledge of the relevant law they felt that they currently had: very little; some; moderate; or considerable.

To determine any correlation between decision making and knowledge, doctors were asked how many decisions to withhold or withdraw life-sustaining treatment they were directly involved in as a member of the treating team in the previous 12-month period, including situations where such decisions were considered but treatment was ultimately provided or continued.

To determine any correlation between the extent of CPD training received in this area and knowledge, doctors were asked whether they had received such training and, if so, when.

### Statistical analysis

Questionnaires were coded and double-entered into an Access database and transferred to SPSS Statistics 20 (IBM) and SAS 9.3 (SAS Institute Inc) for analyses.

### 1 Mean correct responses to seven statements relating to knowledge of the law regarding end-of-life care, and number of respondents scoring ≥ 4, by doctor characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of respondents</th>
<th>Mean correct score (SD)</th>
<th>Adjusted mean score*</th>
<th>No. of respondents scoring ≥ 4 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>867</td>
<td>3.26 (1.32)</td>
<td>365 (42.1%)</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>335</td>
<td>3.65 (1.24)</td>
<td>325 (55.2%)</td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>314</td>
<td>3.17 (1.38)</td>
<td>294 (39.5%)</td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>218</td>
<td>2.79 (1.18)</td>
<td>156 (25.7%)</td>
<td></td>
</tr>
<tr>
<td>Specialty†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>107</td>
<td>3.89 (1.28)</td>
<td>74 (57.0%)</td>
<td></td>
</tr>
<tr>
<td>Palliative medicine</td>
<td>52</td>
<td>3.71 (1.49)</td>
<td>30 (57.7%)</td>
<td></td>
</tr>
<tr>
<td>Intensive care</td>
<td>125</td>
<td>3.48 (1.35)</td>
<td>87 (50.4%)</td>
<td></td>
</tr>
<tr>
<td>Renal medicine</td>
<td>80</td>
<td>3.37 (1.13)</td>
<td>37 (46.3%)</td>
<td></td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>270</td>
<td>3.09 (1.27)</td>
<td>185 (38.1%)</td>
<td></td>
</tr>
<tr>
<td>Medical oncology</td>
<td>80</td>
<td>3.07 (1.23)</td>
<td>29 (36.3%)</td>
<td></td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>98</td>
<td>2.72 (1.34)</td>
<td>25 (25.5%)</td>
<td></td>
</tr>
<tr>
<td>Sex‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>567</td>
<td>3.18 (1.30)</td>
<td>232 (40.9%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>298</td>
<td>3.43 (1.35)</td>
<td>132 (44.3%)</td>
<td></td>
</tr>
<tr>
<td>Country of birth‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>517</td>
<td>3.35 (1.32)</td>
<td>231 (44.7%)</td>
<td></td>
</tr>
<tr>
<td>Other English-speaking</td>
<td>151</td>
<td>3.23 (1.42)</td>
<td>65 (43.0%)</td>
<td></td>
</tr>
<tr>
<td>Asia</td>
<td>120</td>
<td>3.12 (1.18)</td>
<td>45 (37.5%)</td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>31</td>
<td>2.87 (1.31)</td>
<td>7 (22.6%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>3.12 (1.35)</td>
<td>15 (34.9%)</td>
<td></td>
</tr>
</tbody>
</table>

* Adjusted mean scores for specialty were adjusted for state; for each of sex and country of birth, they were adjusted for state and specialty and each other. †55, 2 and 5 respondents did not state main specialty, sex and country of birth, respectively.
oncologists had a lower mean score than average but this was not significant \( (P = 0.53) \), because of the small number of medical oncologists.

Sex and country of birth were weaker predictors of knowledge. Women and Australian-born doctors scored somewhat higher than other groups. The sex effect is reduced when adjusted as described in Box 1, but remains significant \( (P_{LR} = 0.05) \). Country of birth was also a significant predictor after adjustment \( (P_{LR} = 0.042) \). The difference between Australian-born doctors and others was significant after adjustment for state, specialty and sex \( (P = 0.017) \).

Years of practice, age, country of degree and religion did not predict knowledge (data not shown).

The results demonstrated a highly significant and linear association between doctors’ perception of and actual knowledge of the law in this area (Box 2; \( P < 0.001 \)). This effect remained after adjusting for state, specialty, sex and country of birth \( (P < 0.001) \).

The results also demonstrated a highly significant and linear association between the number of decisions doctors made and their knowledge of the law \( (Box 2; P < 0.001) \), an effect which remained after adjustment for state, specialty, sex and country of birth \( (P = 0.007) \).

Doctors who had received CPD training had greater knowledge than those who had not, and the association between knowledge and recency of training was significant and linear \( (Box 2; P = 0.007) \) for linear trend in mean scores, after adjusting for state, specialty, sex and country of birth.

### Discussion

Our results demonstrate critical gaps in the legal knowledge of many doctors who practise end-of-life medicine. Before considering the consequences of these gaps, and the implications of these results, we make two general observations.

First, doctors in NSW had the highest level of knowledge, followed by those in Victoria and then Queensland. Research into reasons for the disparity between states is needed and may provide guidance for successful education and training strategies. Is the law easier to understand in some jurisdictions? Does the law reflect good medical practice to a greater extent in some jurisdictions? Are doctors in some jurisdictions better trained in the law? Further, respondents in some specialties were more knowledgeable than those in other specialties.

Second, the results indicate that doctors have an accurate perception of their level of knowledge. This may be useful if doctors are persuaded that it is important to be familiar with the law in the course of their clinical practice. As they have insight into their level of knowledge, they will know whether further efforts are needed to augment that knowledge.

There are limitations to research of this kind. Doctors with an interest in law may be more likely to respond, so our sample may be more legally knowledgeable than the wider medical population. Also, not all aspects of legal knowledge about withholding or withdrawing treatment can be tested. However, two important aspects of the law were explored: validity and effect of advance directives and the authority of substitute decisionmakers. The results show that many doctors do not possess sufficient legal knowledge to determine whether an advance directive presented to them is valid. Further, even if they are confident that it is valid, many doctors do not know whether they are legally obliged to follow a directive that refuses treatment in a situation when providing treatment is clinically indicated. The results also indicate doctors’ lack of knowledge in determining the legally authorised decisionmaker for medical treatment where there are various people who have an interest in the wellbeing of a patient.

Significant consequences for patients can flow from a failure to know and comply with the law. Life-sustaining treatment may be unlawfully withheld or withdrawn; for example, where the purported decisionmaker lacks legal authority. For patients, the outcome of such decisions is that, at least as a matter of law, their lives are being ended wrongly. Conversely, life-sustaining treatment may be unlawfully provided; for example, despite a lawful refusal of treatment through an advance directive or by a substitute decisionmaker. This may infringe a patient’s legal rights, including their right to bodily integrity, and cause patients to survive...
with poor quality of life, which they had sought to avoid.  

For medical professionals, criminal responsibility could arise for murder or manslaughter (where treatment is withheld or withdrawn unlawfully) or for assault (where treatment is provided without appropriate consent or authorisation). A lack of legal knowledge will not excuse a medical professional from liability. Claims of civil liability may also flow from such actions, along with disciplinary or coronial proceedings.

In addition, conflict may arise where medical professionals and patients’ family or friends have little or no legal knowledge, or different understandings of what the law requires, leading to adverse consequences for everyone involved.

Our findings strongly suggest that doctors in a specialty involving end-of-life decision making should improve their knowledge of the law, in the interests of their patients and for their own protection. To achieve this goal, three things must occur: legal reform; improved training and resources; and a shift in doctors’ attitudes to knowing the law.

We have argued elsewhere that there are problems with the law in NSW, Victoria and Queensland, and have identified aspects that could be simplified. Some level of legal complexity in this area is unavoidable, but where it is unnecessary, the law should be reformed. There is also an urgent need for a national approach to the law in this area. For medical professionals, a single Australian legislative framework, or a harmonised national approach, is likely to be easier to know and understand.

Training in medical law remains uneven and unsystematic at all stages of medical education. This is reflected in the general knowledge deficits and variations by specialty demonstrated by our research, only partly offset by knowledge gained by practical involvement (the number of decisions).

Nevertheless, the correlation between knowledge level and recent CPD training is promising. Even if a harmonised approach to the law in this area were to be achieved, the need for a substantial increase in educational effort would remain to ensure that all doctors involved in end-of-life care know and understand the applicable law. We advocate a broad approach to improving doctors’ knowledge of the law across the three main stages of medical education and note those with responsibility for change:

- undergraduate training in basic ethical principles and the related law at the end of life, within a wider framework of dedicated coursework in ethics, law and professional practice (universities and medical schools, Australian Medical Council);
- continuing training for interns and junior doctors in the hospital setting, in relevant rotations, as components of educational packages under accreditation requirements (hospital executives, directors of clinical training, medical education officers, specialist consultant leaders, intern training accreditation bodies, Medical Board of Australia); and
- specialist college-sponsored, non-elective training programs in all specialties concerned with end-of-life decision making (specialist colleges, Australian Medical Council).

However, providing training opportunities and resources — even in the format and at the times most desired by doctors — is not enough. Attitudes must also shift; doctors who are under ever-increasing time pressures must be satisfied that knowing the law is valuable. Learning about and understanding the law that applies at the end of life will require significant intellectual engagement and commitment of time. The challenge is convincing doctors that it is worth the effort. A good start is to ensure that doctors recognise that lack of legal knowledge places their patients’ interests and rights at risk — and them at legal risk.

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Competing interests: No relevant disclosures.

10 Hunter and New England Area Health Service v A (2009) 74 NSWLR 88: [60].
12 Inquest into the Death of June Woo (Unreported, Queensland Coroner’s Court, State Coroner Barnes SM, 1 Jun 2009).