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SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT
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Submission Cover Sheet

End of Life Choices in the ACT

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SUBMISSION TO THE SELECT COMMITTEE, INQUIRY ON END OF LIFE CHOICES IN THE ACT

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1. Introduction

Thank you for the opportunity to provide a submission to this inquiry. I have had a longstanding research involvement in this area – my PhD examined the 'Legal Aspects of Active Voluntary Euthanasia in Australia', and was subsequently published as a book by Oxford University Press (UK) entitled *Voluntary Euthanasia and the Common Law* (1997) (reprinted as a paperback edition in 2000.) I have also had numerous papers published in Australia and overseas on the subject.[1] On the basis of this extensive research in the area, over a considerable period of time, I believe I am well qualified to put forward informed comment in relation to the committee's inquiry and provide an independent viewpoint in the sense that I do not represent any religious, political or other organisation.

The broad issue I wish to address in this submission is the question of the desirability of the enactment of voluntary euthanasia legislation (rather than the details of a legislative regime). I am strongly of the view that the present law in most Australian jurisdictions in relation to medical assistance in dying is unsatisfactory and that it would be far preferable to have legislation directly dealing with the issue, legalising active voluntary euthanasia and doctor-assisted suicide in carefully specified circumstances.

2. Is There a Need for Reform?

In assessing the desirability of such legislation, the starting point is to ask is there a need for reform? I would submit that an analysis of the current position having regard to the law on the books and the law in practice, indicates that there are a number of major deficiencies in the current law and its operation that can only be addressed through legislative reform.

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[1] M. Otlowski, 'Active Voluntary Euthanasia - Options for Reform' (1994) 2 *Medical Law Review* 161-205; M. Otlowski, 'Legal and Ethical Issues in Palliative Care' (1995) 15 *Monash Bioethics Review* 33-47; M. Otlowski, 'Euthanasia' (1995) 20 *Alternative Law Journal* 90-91, 93; M. Otlowski, 'The Effectiveness of Legal Control of Euthanasia: Lessons from Comparative Law' (2002) *Recht der Werkelijkheid*, (Journal of the Dutch/Flemish Association for Socio-Legal Studies) Special Issue, 'Regulating Physician-Negotiated Death (20 pages); M. Otlowski, 'Legal Issues in Relation to Physician-Assisted Suicide', Forum Piece on Physician-Assisted Suicide (2003) 2 *The Lancet Neurology* 640-642; L. Bartles and M. Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 20 *Journal of Law and Medicine* 532-555; M. Otlowski, 'Getting the Law Right on Physician-Assisted Death' (2011) 3 *Amsterdam Law Forum* (Special Issue on Health Care, Bioethics and the Law) On-line journal: http://ojs.ubvu.vu.nl/alf/article/view/188/379

Notably, in recent years there have been a number of reviews undertaken in other common law jurisdictions, including that conducted by the Royal Society of Canada,[2] the Commission on Assisted Dying in the United Kingdom[3], and the Select Committee Report undertaken by the National Assembly of Quebec.[4] Significantly, these various reports have uniformly recommended reform of the law through specific legislation providing for voluntary assisted dying in clearly defined circumstances and subject to various safeguards. Note should also be made of the decision of the Canadian Supreme Court, in *Carter* v *Canada AG* (2015)[5] which upheld a challenge to assisted suicide legislation holding it to be contrary to the *Canadian Charter of Rights and Freedoms (1982).*

3. Problems with the Law in Practice

One of the principal arguments concerns the problems in the operation of the present law which absolutely prohibits active voluntary euthanasia and doctor-assisted suicide. The position is that active voluntary euthanasia is treated as murder by the criminal law and no account is taken of what are arguably extenuating circumstances usually existing in such cases. Where active voluntary euthanasia has been performed, it is irrelevant that the doctor acted out of compassionate and *bona fide* motives. Similarly, no significance is attached to the condition of the patient or the fact that the doctor may have merely hastened what was an inevitable and possibly even imminent death. Provided the doctor's intention was to cause death, liability for murder will be established. Nor is it a defence that the doctor acted upon the clearly expressed wish of a competent patient that they be assisted to die, since a person cannot validly consent to his or her own death. Similarly, in the case of doctor-assisted suicide, the law takes no account of the surrounding circumstances such as the patient's condition or the doctor's motive in providing such assistance.

Despite the strict legal prohibition of the practice, with the threat of the most serious criminal liability (i.e. for murder), the reality of the matter is that not infrequently, requests for active voluntary euthanasia are made by patients, and a significant proportion of doctors are responding to such requests.

3.1 Evidence of patient requests for and of doctors' practices of active voluntary euthanasia

As a result of a number of surveys of the medical profession that have been undertaken in Australia over the years, there is incontrovertible evidence to substantiate that some patients do make such requests for assistance to end their lives and that more than a quarter of the doctors who have received such requests have performed active voluntary euthanasia.[6] The results from the Australian surveys are,

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[2] The Royal Society of Canada Expert Panel, 'End-of-Life Decision Making', (Ottawa: The Royal Society of Canada – The Academies of Arts, Humanities and Sciences of Canada, November 2011),

[3] The Commission on Assisted Dying, 'The Current Legal Status of Assisted Dying is Inadequate and Incoherent …', (London: Demos, 2011).

[4] Select Committee, Dying with Dignity Report, National Assembly of Quebec (2012).

[5] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331.

[6] See H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *Medical Journal of Australia* 623; P. Baume and E. O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (1994) 161 *Medical Journal of Australia* 137 reporting on data from Victoria and New South Wales respectively.

to a large extent, paralleled by the survey findings from other jurisdictions, including the United Kingdom.[7]

These studies leave little room for doubt that active voluntary euthanasia is being performed in Australian jurisdictions in response to patient requests. There is also evidence to show that some doctors are providing suicide assistance to their patients. In addition to survey evidence, there have been some very public admissions by Australian doctors, in effect, seeking to challenge the existing laws - for example, the open letter to the then Victorian Premier, Jeff Kennett by seven Victorian doctors.[8] More recently, there has been a similar occurrence, with Dr Rodney Syme, a well-respected doctor and long time advocate for voluntary euthanasia, taking a public stand through *The Age* newspaper and laying down a legal challenge to charge him or change the law.[9] The group, 'Doctors for Voluntary Choice' have indicated their support for Dr Syme and have called for the legalisation of voluntary euthanasia for terminally ill patients with intolerable symptoms.[10] Other doctors have since come out publicly indicating their involvement with voluntary euthanasia and doctor-assisted suicide.[11]

The conclusion is inescapable that some doctors are responding to requests from their patients to provide active assistance in dying, notwithstanding the risk of criminal liability; what must be stressed is that the criminal law prohibition of active voluntary euthanasia and doctor-assisted suicide does not prevent the occurrence of these practices.

3.2 Problems with an illegal and covert practice

Because of their present illegality, these practices are largely covert and rarely come to the attention of others or are exposed to scrutiny. It is submitted that there are serious problems with a hidden and unregulated practice.[12] For one thing, it is most unsatisfactory to have a situation where it is commonly known that the law is being breached by the medical profession yet breaches are usually ignored or pass unpunished. Such discrepancies between the law on the books and the law as applied are likely to undermine public confidence in the law and bring it into disrepute.

Further, as a result of the serious discrepancies which exist between the legal principles and the law in practice, there is no established legal precedent by reference to which medical decisions in respect of terminal patients can be made and evaluated. In theory, the medical profession and the legal system both reject active voluntary euthanasia and doctor-assisted suicide as acceptable medical practices, yet there is evidence that not infrequently, these practices occur. Furthermore, because active voluntary euthanasia and assisting patient suicide are criminal, doctors will inevitably feel inhibited in discussing these practices with their colleagues in an open and honest

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[7] See, for example, B. Ward and P. Tate, 'Attitudes Among NHS Doctors to Requests for Euthanasia' (1994) 308 *British Medical Journal* 1332.

[8] 'Open Letter to the Premier', *The Age* (Melbourne), 25 March 1995.

[9] http://www.theage.com.au/comment/the-age-editorial/euthanasia-the-debate-must-start-now-20140429-37fsk.html

[10] *The Age*, Thursday 8 May 2014.

[11] See the coverage of the story of Dr Roger Percy, in *The Age*, Thursday 8 May 2014.

[12] See also R. Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (2002) Melbourne University Press.

way, and consequently will not be able to benefit from criticism or support from their professional peers with regard to their involvement in these practices. This, in turn, jeopardises the quality of medical decision-making in this area.

There is a very real risk of abuse if the law condones what is an unregulated practice.[13] Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism and in the belief that they are acting in the patient's best interests. There is survey evidence to suggest that active euthanasia is not always administered at the patient's request. One Australian study found that 20% of doctor respondents who had reported that they had administered drugs for the purpose of hastening a patient's death, had not received an unambiguous request for a lethal dose of medication.[14] A study undertaken by Kuhse, Singer and Baume,[15] found that, extrapolating from their sample of 3,000 doctors, that approximately 3.5% of all Australian deaths involved active termination of the patient's life without the patient's explicit request. This study sought to make comparisons with data from the Netherlands in the same time frame (1995)[16] and concluded that whilst the incidence of voluntary euthanasia in this period was roughly comparable in Australia and the Netherlands, (estimated to be 1.8% of all deaths in Australia in 1996 compared with 2.4% of all deaths in the Netherlands in 1995) the incidence of ending the life of patients by active means *without* the patient's explicit and concurrent request was, in fact, substantially higher in Australia than in the Netherlands (3.5% of all deaths in Australia in 1996 compared with 0.7% of all deaths in the Netherlands in 1995) where the issue of euthanasia has been more openly addressed. The authors suggest (and I would agree) that this discrepancy may be attributable to the current illegality of these practices in Australia and doctors are therefore reluctant to discuss the issue of euthanasia openly with their patients.

For doctors to take these decisions upon themselves clearly undermines patient self-determination and the patient's right not to be killed without his or her consent. There is, therefore, the possibility that the present state of the law may in effect be sanctioning such killings without providing adequate protection to unwilling victims. If active euthanasia is in fact being practised, it is imperative that these decisions are based upon the patient's choice rather than the idiosyncratic views of individual doctors. Having regard to the Netherlands' experience, where euthanasia has for many years been legally permissible in some circumstances, it is quite likely that the proportion of cases without an explicit request for assistance would be reduced if active voluntary were legalised. Thus, there is an argument that legislative action is necessary to address this incidence in Australia of unrequested killings.[17]

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[13] See also Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (above).

[14] C. Douglas *et al*, 'The Intention to Hasten Death: A Survey of Attitudes and Practice of Surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511.

[15] (1997) 'End of Life Decisions in Australian Medical Practice' (above).

[16] This drew on the data from the Remmelink Commission Inquiry: See reported by P. van der Maas, J. van Delden, L. Pijnenborg,. Euthanasia and Other Medical Decisions Concerning the End of Life. *Lancet* 1991; 338: 669-674

[17] For fuller elaboration, see M. Otlowski, 'The Effectiveness of Legal Control of Euthanasia: Lessons from Comparative Law' (2002) *Recht der Werkelijkheid* (Journal of the Dutch/Flemish Association for Socio-Legal Studies) Special Issue, 'Regulating Physician-Negotiated Death' 137.

There is also another aspect to the hypocrisy of the present legal position. Although there have, to date, been no prosecutions in Australia of doctors for assisting their patients to die, the experience from other jurisdictions such as the United Kingdom and the United States, indicates that in the event that a doctor comes before the courts charged with murder (or attempted murder) or assisting the suicide of a patient, there is every likelihood that the doctor would escape criminal liability, albeit on spurious technical grounds.[18] However, the prosecution and conviction of Dr Cox in the UK, a well regarded rheumatologist, for the attempted murder of one of his patients[19] illustrates that the leniency of the criminal justice system cannot be reckoned on as a certainty, even in cases where doctors are acting *bona fide*. In that case, a 12 month suspended prison sentence was imposed. The General Medical Council refrained from taking any disciplinary action against Dr Cox and he was able to continue to work as a consultant. The outcome of the *Cox* case thereby highlights the precarious legal position of doctors who take active steps to assist their patients to die at the patient's request.

3.3 Problems stemming from a gap between the law in theory and the law in practice

The gap between the law in theory and the law in practice creates enormous problems. Although questions of motive are strictly speaking irrelevant for the purposes of establishing criminal liability, in practice, they will often be decisive in determining the outcome of cases of active euthanasia and doctor-assisted suicide. Without disputing that such cases ought to be dealt with leniently, it is submitted that there are certain fundamental problems with the present legal position which tolerates serious inconsistencies between legal principles and the law in practice. First, there is the concern that because the administration of the law depends to such a large extent on intangible considerations of sympathy, there is no guaranteed consistency of application, thus raising serious questions regarding justice and equality before the law. The second problem is that the discrepancies between the law in theory and the law in practice threaten to undermine public confidence in the law and bring it into disrepute. Because the present criminal law principles which treat motive as irrelevant, are widely perceived as being inappropriate, devious means are frequently used to circumvent the full rigour of the criminal law. The motive of the offender is in fact being incorporated into decision-making, but only surreptitiously through the use of certain fictions or tactics. This can result in serious distortion of legal principles and widespread connivance to defeat the application of the criminal law.

In most of the cases which have come before the courts, doctors have tended to plead not guilty and rely on arguments based on lack of causation or lack of the necessary intention to kill and these arguments have usually been accepted by the jury, often contrary to the weight of the evidence. The criticism is that the use of such fictions represents a blatant abuse of the law, and when occurring on a regular basis, suggests that the current criminal prohibitions do not reflect common views of reprehensibility. This, in turn, indicates the need to close the gap and bring the overt culture as expressed by the law in accord with the covert culture, as expressed in what people

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[18] See, for example, *R* v *Carr* (unreported) *Yorkshire Post* 12 Nov. 1986; *People* v *Sander* (unreported) *N.Y. Times* 10 March, 1950.

[19] *The Times* 22 Sept. 1992. The patient had died and it is understood that he was charged with attempted murder rather than murder because her body had been cremated before the police investigation could establish the cause of death.

do. Essentially, there is a need for greater honesty in recognising what already occurs in medical practice; that active euthanasia is being performed but in a hidden and unregulated manner. In some instances, the practice of euthanasia is disguised under the guise of legitimate pain relief; indeed, the practice of palliative sedation in extreme cases of suffering, whereby the patient is rendered permanently unconscious, (or 'pharmacological oblivion' as it is also known) is in effect, a form of slow active euthanasia. There can also be no doubt that some doctors provide suicide assistance to their patients. The essence of the argument made here is that existing practices need to be acknowledged so that they can be regulated. Only in this way will we be able to better protect the interests of both doctors and patients.

4. Countering Arguments *Against* Legalisation

4.1 Concerns about the effects of legalisation: Fear of the 'slippery slope'

The most commonly cited objection to the legalisation of active voluntary euthanasia is the 'slippery slope' argument: that the legalisation of active voluntary euthanasia would lead to widespread involuntary euthanasia and the termination of lives no longer considered socially useful. This is, however, a completely unsubstantiated argument. The 'slippery slope' argument is typically made without regard to the risks of abuse or other problems involved in *retaining* the present law. As outlined above, an objective assessment of the available evidence suggests that the practice of euthanasia already occurs in Australia, and that it is, in some cases, performed other than at the request of the patient - indeed, from the mid 1990s figures referred to earlier - 3.5% of all deaths in Australia involved active assistance without an explicit request from the patient (almost twice as often as voluntary euthanasia) and which is much higher than the equivalent figure for the Netherlands (0.7% of all deaths). There are strong arguments to suggest that if the practice is legalised in carefully defined circumstances, and opened up to scrutiny, there would be *less r*isk of covert and improper conduct than is presently the case. It stands to reason that if doctors are given the option of gaining the protection of the law by performing active voluntary euthanasia in accordance with strict safeguards, they would take this course rather than running the risk of serious criminal liability.

The experience in the Netherlands, where active voluntary euthanasia has been given de facto legal recognition and performed relatively openly by the medical profession and more recently has been legalised,[20] provides evidence to suggest that openness on this issue is likely to protect the interests of patients and minimise the risk of abuse.

Data is now also available from Belgium and there are a number of authoritative peer reviewed papers which collectively debunk fears of a 'slippery slope' and in fact have demonstrated that legalisation of the practice of active voluntary euthanasia with appropriate safeguards has *reduced* the number of unrequested killings.[21]

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[20] See below for more detailed discussion of the position in The Netherlands.

[21] B. Onwuteaka *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 *Lancet* 908-915; K. Chambaere et al, 'Characteristic of Belgian 'Life Ending Acts Without Explicit Patient Request': A Large Scale Death Certificate Survey Revisited' (2014) 2(4) *Canadian medical Association Journal* Open; K. Chambaere *et al* 'Physician-Assisted Deaths Under the Euthanasia Law in Belgium: A Population-Based Survey' (2010) *Canadian Medical Association Journal* 182; 895-901; J. Bilsen *et al* 'Medical End-of Life Practices Under the

Rebuttal of Alex Schadenberg's Claims

Alex Schadenberg's book, *Exposing Vulnerable People to Euthanasia and Assisted Suicide* (2013) warrants particular attention in this context as he makes claims about slippery slopes based on the experience in the Netherlands and Belgium which appear to have gained some traction. On closer examination, however, it would appear that most of his arguments are unsubstantiated. Unlike the journal articles that Schadenberg reviews, his book *Exposing Vulnerable People to Euthanasia and Assisted Suicide* (2013) is not a refereed/peer reviewed publication so caution is needed in interpreting Schadenberg's analysis and presentation of data. Careful reading of the journal articles themselves is required as they are the best source for 'evidence' (noting that these are published in quality refereed journals that have been through a rigorous peer review process).

Schadenberg purports to draw on findings of a number of journal articles but draws on these very selectively, often omitting pertinent information and the conclusions that the study authors draw. Schadenberg's selective reporting from these articles contributes to flawed statements made in the various chapters of his book and conclusions reached that are without a valid foundation and indeed, are often contrary to the actual evidence. I would be happy to elaborate on this further if that would be helpful.

4.2 Other objections to the legalisation of active voluntary euthanasia

Role of palliative care?

Another argument which is frequently raised is that euthanasia is an unnecessary and inappropriate response having regard to the availability of palliative care to ease the pain and suffering of dying patients. However, the reality falls far short of the ideal and optimal palliative care is not universally available. But even assuming, for a moment, that optimum palliative care was available to all who sought it, there would still be a minority of patients for whom these methods would not provide adequate relief from suffering. Indeed, palliative care specialists acknowledge that they cannot relieve the suffering of all patients. Whilst developments in palliative care are to be welcomed, it is a fallacy to suggest that this has obviated the need for active voluntary euthanasia. Moreover, it is a mistake to regard palliative care and active voluntary euthanasia as mutually exclusive options: a patient may willingly accept palliative care for some time yet may ultimately opt for active voluntary euthanasia.

An alternative argument is that legalisation of active voluntary euthanasia would in some way detract from palliative care services. In response to arguments that legalising voluntary euthanasia may in some way undermine palliative care, it is pertinent to note the decision of Justice Smith in the case *Carter* v *Canada* (Supreme Court of British Columbia):

> 'My review of the evidence regarding Oregon, the Netherlands and Belgium suggests that in those jurisdictions, legalization of assisted death has not undermined palliative care; on the contrary, palliative

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Euthanasia law in Belgium' (2009) 361 *New England Journal of Medicine* 1119-1121, T. Smets *et al* 'Legal Euthanasia in Belgium: Characteristics of all Reported Euthanasia Cases' (2009) 47 *Medical Care* 1-6.

> care provision has been improved since legalization by some measures.'[22]

Support for this position, and demonstrating the emergence of more sophisticated palliative are in these jurisdictions can also be drawn from the contemporary literature.[23]

5. Relevance of Community Support for Reform

Arguments for reform of the law are bolstered by the high level of community support for legalisation. Opinion polls have been periodically conducted in Australia and other jurisdictions to gauge public attitudes to whether active voluntary euthanasia ought to be legalised and results have indicated growing public support for its legalisation.[24] Significantly, poll results indicate that the religion of respondents is a significant factor in shaping attitudes to euthanasia. Whilst there has, over time, been a noticeable increase in support for active voluntary euthanasia from Catholics evidenced in the poll results, there still appears to be some correlation between religious affiliation (particularly Catholic) and anti-euthanasia attitudes; generally speaking, persons who are religious are less likely to support active voluntary euthanasia than persons who are not; and more particularly, Catholics are less likely to support active voluntary euthanasia than members of other religious denominations or persons who are not religiously affiliated.

Obviously, public support for reform, demonstrated through opinion poll results, can never, of itself, be sufficient justification for reform of the law. Public opinion may quite possibly be misguided or misinformed, or may have failed to take into account the full implications of legalisation. Before the case for reform is made out, it must be shown that the consequences of legalisation of active voluntary euthanasia have been addressed, and that no harm is likely to result to society or its members if the practice is legalised (issues which have been addressed above). Within these confines, public opinion should have a role in shaping the law, indicating, as it does, prevailing morality and the needs of the community. After all, ultimately, the law must serve the community and it must, therefore, be responsive to real social needs. It is widely recognized that if a law is markedly out of tune with public opinion, it will quickly fall into disrepute. Thus, while evidence of community support for legalisation of active voluntary euthanasia is not of itself decisive, it is undoubtedly a relevant factor in determining the appropriateness of legalisation.

What is remarkable given the strong evidence of public support for reform, is the apparent lack of representativeness when voluntary euthanasia bill are debated in the parliament. Although ostensibly, a conscience vote is usually allowed, in practice, voting often splits along party lines.[25]

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[22] 2012 BCSC 886 para 731.

[23] See for example, J. Bernheim 'Development of Palliative Care and Legalisation of Euthanasia: Antagonism or Synergy?' (2008) 19 *British Medical Journal* 864-867; Onwuteaka 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 *Lancet* 908-915.

[24] In 2011, a Newspoll conducted in New South Wales showed an 83% affirmative response. In 2012 Newspoll surveyed 2521 Australian adults which showed 82.5% support for law reform.

[25] M. Otlowski, https://theconversation.com/another-voluntary-euthanasia-bill-bites-the-dust-19442

6. Position of the Medical Profession

Also of relevance in assessing the appropriateness of law reform is the position of the medical profession on the issue of active voluntary euthanasia. Substantial survey evidence is now available in Australia and other jurisdictions regarding doctors' attitudes to legalisation of active voluntary euthanasia and doctor-assisted suicide.[26]

Of particular significance is the growing body of evidence which suggests that a large proportion of doctors want the law changed so that they can, in appropriate circumstances, lawfully provide assistance in dying to patients who request it. For example, in the survey of Victorian doctors undertaken by Kuhse and Singer in 1988, 60% of the respondents supported reform of the law. A more recent survey by Neil *et al* of Victorian doctors found that 53% of those surveyed (total of 854 doctors) supported the legalisation of voluntary euthanasia.[27] The majority support for change amongst doctors is noteworthy in the light of the opposition to active voluntary euthanasia and doctor-assisted suicide by most professional medical associations, including the Australian Medical Association (AMA).[28] The position of the AMA has softened with its most recent 2016 statement which recognises that there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide (3.2). Further, the AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government (3.3). It is also on the record to state that: 'If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect: all doctors acting within the law; vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society; patients and doctors who do not want to participate; and the functioning of the health system as a whole' (3.4). Finally, the statement provides that 'Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services' (3.5.)

Having regard to this survey evidence, it is apparent that these professional medical organisations, in their ongoing opposition to these practices, cannot be taken as representing the views of the majority of their members. Not only do many doctors believe that the law should be changed to permit them to assist patients to die in certain circumstances, but many have indicated that they would personally be willing to provide such assistance if it were lawful for them to do so.[29]

In evaluating the current situation within the medical profession, it would be a mistake not to acknowledge the strength of opposition to any change. Indeed, in some

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[26] See Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (above) and Baume and O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (above) and Neil *et al*, 'End-of Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)' (above). For the position in the United Kingdom, see Ward and Tate, Among NHS Doctors to Requests for Euthanasia' (above).

[27] D. Neil *et al*, 'End-of-Life Decision in Medical Practice: A Survey of doctors in Victoria (Australia) (2007) 33 *Journal of Medical Ethics* 721-725.

[28] AMA, *Position Statement on Euthanasia and Physician Assisted Suicide* (2016).

[29] For example, in the survey of doctors in New South Wales undertaken by Baume and O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (above), 50% indicated that they would practice active voluntary euthanasia if it were legal.

of the survey results, views of the respondent doctors have been sharply divided, for and against legalisation of active voluntary euthanasia. It is worth noting that in a number of the surveys of doctors' attitudes, religious affiliation and activity has been identified as one of the most significant factors to shape attitudes to active voluntary euthanasia. These differences are merely reflective of the trend shown in opinion poll results of the general population noted above, namely that there is a correlation between religious affiliation and the levels of support for active voluntary euthanasia. As was argued earlier, religion is a matter personal to individuals which must be respected, but given our pluralistic society, it should not be permitted to dominate legal or social policy.

Account should also be taken of the view of other relevant health care professionals, in particular, nurses who have direct experience with people who are dying and are conversant with the ethical dilemmas involved. Evidence from surveys of nurses suggests that a significant majority believe that the law should be changed to allow voluntary euthanasia and doctor-assisted suicide.[30]

The survey evidence of both public opinion and attitudes of doctors indicating support for reform of the law to permit active voluntary euthanasia in carefully defined circumstances also goes some considerable way in countering arguments raised by opponents of legalisation that empowering doctors to perform active euthanasia at a patient's request would undermine the doctor/patient relationship. If one has regard to the position in the Netherlands, where active voluntary euthanasia is now openly practised, there does not appear to have been any erosion of trust between doctors and their patients. In fact, for many people, the knowledge that their doctor could assist in administering active euthanasia at their request would have a positive effect, fostering greater confidence, and relieving anxiety about an agonising and undignified death. Thus, contrary to the claims of opponents, the legalisation of doctor administered active voluntary euthanasia could have the effect of strengthening the doctor/patient relationship.

7. Reform Developments in Other Jurisdictions

7.1 Key reports and inquiries from common law jurisdictions recommending reform

As noted above, over the last few years, a number of reviews have been undertaken in other common law jurisdictions which have consistently recommended reform of the law through specific legislation providing for voluntary assisted dying in clearly defined circumstances and subject to various safeguards. This includes reviews undertaken by The Royal Society of Canada Expert Panel, 'End-of-Life Decision Making' reporting in 2011,[31] the Commission on Assisted Dying in the United Kingdom[32] with its 2011 Report, 'The Current Legal Status of Assisted Dying is Inadequate and Incoherent …', and the 2012 Select Committee Report of the National Assembly of Quebec.[33] This indicates a strong trend towards recognition that reform

[30] See for example, B. Kitchener, 'Nurses' Attitudes to Active Voluntary Euthanasia: A Survey in the ACT' (1998) 22 *Australian and New Zealand Journal of Public Health* 269.

[31] Ottawa: The Royal Society of Canada – The Academies of Arts, Humanities and Sciences of Canada, November 2011.

[32] (London: Demos, 2011).

[33] Select Committee, Dying with Dignity Report, National Assembly of Quebec (2012).

of the current law is required; indeed, the Supreme Court of Canada decision in *Carter v Canada (Attorney General*[34]*)* noted earlier is further evidence of this trend.

7.2 Mounting reform momentum for voluntary euthanasia/medically assisted suicide

Significantly, the momentum for reform of the law is mounting, both in Australia and internationally, with the Victorian Parliament passing legislation last year to allow voluntary assisted dying.[35] In 2016, Canada passed legislation to allow medically assisted suicide in response to direction from the Canadian Supreme Court noted above.[36] In the United States, a number of states have enacted physician-assisted suicide[37] and early evidence had disproved many of the initial fears that it would be disproportionately chosen by or forced on terminally ill patients who were poor, uneducated, uninsured, or fearful of the financial consequences of their illness; this proved to not be the case.[38] Moreover, the decision to request and use a prescription for lethal medication was associated with concern about loss of autonomy or control of bodily functions, not with fear of intractable pain or concern about financial loss. Further, it was found that the choice of physician-assisted suicide was not associated with level of education or health insurance coverage.

7.3 In Europe, The Netherlands has been a leader with its *Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001)* to formalise the de facto recognition of euthanasia that had existed for many years. Pursuant to this legislation, active euthanasia is legal if it is carried out by a doctor at the request of a patient who is unbearably suffering from a serious medical condition with no prospect for improvement; the doctor must consult a second independent doctor and comply with a variety of other procedural requirements including reporting what has been done. The doctor's report is reviewed by an interdisciplinary review committee. If the committee finds that the doctor has complied with all the legal requirements, the case ends there. If not, the case is forwarded to the prosecutorial authorities. Data suggests that the great majority of euthanasia cases are now being openly reported and that whilst the overall rate of euthanasia has increased, this is due to a rise in the number of patients requesting euthanasia.[39] As noted above, there has been a decline in the number of cases of assistance without an explicit request. Belgium and Luxemburg have also introduced legislation legalising active euthanasia and assisted suicide in certain circumstances.[40]

8. Conclusion

Concerns about abuse are real but I would submit that it is preferable to recognise the difficulties inherent in the present law and to take steps to permit medical assistance

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[34] 2015 SCC 5, [2015] 1 S.C.R. 331.

[35] *Voluntary Assisted Dying Act* 2017 (Vic).

[36] *An Act to Amend the Criminal Code and to make Related Amendments to other Acts (Medical Assistance in Dying)* 2016

[37] For example, in Oregon, *Death with Dignity Act* 1994; Washington, *Death with Dignity Act* (2008) 70-245 RCW; Vermont, *The Patient Choice and Control at End of Life* (2013) *Act* 18.

[38] A. Chin, M. Hedberg, G. Higginson and D. Fleming, 'Legalised Physician-Assisted Suicide in Oregon – The First Year's Experience' (1999) 340 *New England Journal of Medicine* 577.

[39] J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (2008) Hart Publishing; B. Onwuteaka 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 *Lancet* 908-915.

[40] Belgium, *Act on Euthanasia* (2002); Luxemburg, 2009 Law on euthanasia and assisted suicide.

in dying. By confronting the issue and reforming the law to permit medical assistance in dying in carefully controlled circumstances, there is, in the long run, far greater opportunity to regulate the practice and safeguard the interests of both patients and doctors than if these practices remain hidden. Whilst active voluntary euthanasia and doctor-assisted suicide remain serious criminal offences, those doctors wishing to assist their patients will be inclined to act in secret without the benefit of consultation and advice from colleagues. In these circumstances, there is more potential for error and abuse than if the practice is permitted but carefully controlled and I would argue that this is borne out by a comparison of the figures regarding unrequested killings in Australia and the Netherlands outlined above.

What is important is that we create an environment in which decision-making can be open and subject to scrutiny and in which doctors who wish to take the benefit of an immunity from liability are accountable for their decisions. Only in this way are we going to be able to make active voluntary euthanasia safely available and avoid many of the anomalies and inconsistencies which the present situation entails.

In addressing the need for such legislation, it is of fundamental importance to recognise that the practice of euthanasia and doctor-assisted suicide *already occurs* but in a covert and unregulated fashion which fails to protect the interests of either patients or *bona fide* doctors. It is therefore not a choice of whether we *begin* to permit euthanasia but rather, under what circumstances it should be performed. In the interests of protecting both patients and their doctors, I would submit that it is necessary and appropriate for legislation to be introduced allowing active voluntary euthanasia and doctor-assisted suicide; in view of developments in other jurisdictions there are now good models which can be adopted for the development of appropriate legislation with strong safeguards[41] and which have been demonstrated as not creating a slippery slope. The numbers of people who would be provided with assistance in dying pursuant to this legislation is not expected to be great (and not necessarily more than what already occurs surreptitiously in practice). Nevertheless, the lawful and transparent availability of this option is likely to bring significant peace of mind to many people through a process of empowerment in decision-making, even if these individuals ultimately never need to avail themselves of such assistance.

I would be happy to provide any further information or assistance to the committee.

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[41] Drawing on my PhD research I have published on options for reform - see M. Otlowski, 'Active Voluntary Euthanasia - Options for Reform' (1994) 2 *Medical Law Review* 161-205 but account should now also be taken of the legislative models that have been in operation including in the Northern Territory (albeit briefly) and models from overseas.