Euthanasia - the Australian Law in an International Context

Part 2: Active Voluntary Euthanasia

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Euthanasia - the Australian Law in an International Context

Part 2: Active Voluntary Euthanasia
'when medical intervention takes place, at the patient's request, in order to end the patient's life'

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9 September 1996

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Major Issues

The Northern Territory likes to think of itself as frontier country - it is certainly at the forefront of the international debate over euthanasia. On 25 May 1995 it became the first jurisdiction in the world to pass laws allowing a doctor to end the life of a terminally ill patient at the patient's request. In doing so, the law permits both physician-assisted suicide and active voluntary euthanasia in some circumstances. However, under the Rights of the Terminally Ill Act 1995 (NT) strict conditions apply: it is neither an unqualified 'licence to kill' nor an unqualified affirmation of a competent adult patient's right to assistance in dying.

The Act has caused a furore nationally and internationally, with both extensive criticism and extensive support for the Rights of the Terminally Act 1995 from politicians, healthcare professionals, religious groups, 'pro-life' and 'pro-choice' pressure groups, academics, the media and members of the general public.

The Australian Medical Association condemned the Act - its then President, Dr Brendan Nelson, saying the legislation devalued human life.\(^1\) The President of the Australian Federation of AIDS Organisations, Mr Tony Keenan, welcomed it as 'a great achievement' and 'a very good example of humane, compassionate legislation that responds to community demand and community need'.\(^2\) In the United States, an Oregon Right To Life lobbyist, Ms Gail Atteberry, said she was 'horrified' by the new law, and believed it would lead to a new kind of tourism: 'I believe the Northern Territory will become not only the suicide capital of Australia but of the world.'\(^3\) In the other corner, Mr Robin Fletcher, a spokesman for the Hemlock Society - the largest pro-euthanasia group in the United States - said the law was 'wonderful'. 'It sounds like it was well thought out and a compassionate answer to a problem'.\(^4\)

The law has already survived attempts to repeal it in the Northern Territory Legislative Assembly, and a challenge to its validity in the Northern Territory Supreme Court. Leave is being sought to challenge the Act in the High Court. In Federal Parliament in September, a Liberal backbencher, Mr Kevin Andrews MP, is introducing a Private Member's Bill aimed at overturning it. The Commonwealth has the power to enact its own legislation overriding Territory law under section 122 of the Constitution.

The Federal Bill has the personal support of the Prime Minister, Mr John Howard, although he will be allowing Liberal Members of Parliament a conscience vote. The
Leader of the National Party, Mr Tim Fischer is adopting the same approach. It has been reported that the Leader of the Opposition, Mr Kim Beazley personally opposes euthanasia but that members of the ALP will also have a conscience vote. No-one has yet used the Territory legislation, perhaps in part, because medical practitioners are afraid they could be charged with murder if it is subsequently overturned.

This paper, the second in a four-part series on euthanasia, examines the Northern Territory legislation in the wider national and international context, including the approach taken to active voluntary euthanasia in the Netherlands, England, the United States and Canada.

Under English common law, a doctor is prohibited from taking active steps to end a patient’s life - but there is an exception. A doctor who administers a pain killer to a terminally ill patient in great suffering, knowing an incidental effect will be to shorten the patient’s life, will be safe from criminal liability, providing the primary reason for giving the pain killer was to relieve suffering, not to cause death.

However, it is unclear whether Australian doctors have the same protection. No doctor has faced criminal prosecution here under those circumstances. Under Australian homicide laws, a doctor may be guilty of murder if he or she administered drugs knowing they might cause death, and they did in fact cause death - even if the doctor did not intend the patient to die. South Australia is the only state to have clarified the law on this issue. It appears to have followed the English common law lead.

The Netherlands has a unique approach to regulating active voluntary euthanasia and physician-assisted suicide. It is often held up as a jurisdiction in which euthanasia has been decriminalised. This is not an accurate description of the Dutch legal situation. Active voluntary euthanasia and physician-assisted suicide are both prohibited under the Dutch Penal Code. However, doctors have been guaranteed immunity from prosecution providing they have complied with a number of ‘rules of careful practice’. The acceptance of active voluntary euthanasia and physician-assisted suicide in the Netherlands is largely due to a unique combination of social and cultural attitudes including:

• a willingness to discuss difficult moral issues openly;

• the increased secularisation of Dutch society since the 1960s;

• a Calvinist sense of individual responsibility combined with a respect for the autonomy of others;

• the Royal Dutch Medical Association’s approval of doctors participating in voluntary euthanasia;

• great trust in, and respect for, the medical profession; and
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- universal and comprehensive medical coverage.

In 1990, the Dutch Government set up the Remmelink Commission to investigate 'the practice of action and inaction by a doctor that may lead to the end of a patient's life at the patient's explicit and serious request or otherwise.' The commission ordered the first empirical study of all medical decisions at the end life. That study found that in the Netherlands in 1990 there were:

- 2,300 cases of active voluntary euthanasia, representing 1.8 per cent of all deaths;
- 400 cases of physician-assisted suicide, representing 0.3 per cent of all deaths;
- 22,500 cases where death followed the administration of drugs to alleviate pain and symptoms in such dosages that the risk of shortening the patient's life was considerable. This represented 17.5 per cent of all deaths;
- 22,500 cases where death had resulted from non-treatment decisions (ie withdrawal or withholding of medical treatment) representing 17.5 per cent of all deaths;
- 1,000 cases where a doctor had deliberately ended the life of a patient without a clear and explicit request from the patient, representing 0.8 per cent of all deaths.

No similar studies have been done in Australia. A number of studies however, about the attitudes, experiences and practices of health professionals have been conducted. One in South Australia found that 45 per cent of doctors sampled supported the legalisation of active voluntary euthanasia in certain circumstances. Another, of doctors in New South Wales and the ACT found majority support for changes to the law to allow active voluntary euthanasia. In one survey of Victorian nurses, it was found that about 75 per cent of those taking part in the survey favoured law reform to enable doctors to perform active voluntary euthanasia in some circumstances. Sixty-five per cent of the nurses said they would participate in active voluntary euthanasia if it were legal. Another study of Victorian nurses involved in palliative care and oncology, found that only 40 per cent were prepared to assist with active euthanasia if it were legal. However, 50 per cent favoured law reform to enable doctors to take active steps to bring about a patient's death in some circumstances.
Preface

This paper is the second in a series discussing the Australian law relating to euthanasia in an international context.

For the purposes of these papers, 'euthanasia' is divided into the following four categories:

• passive voluntary euthanasia
  - when medical treatment is withdrawn or withheld from a patient, at the patient's request, in order to end the patient's life

• active voluntary euthanasia
  - when medical intervention takes place, at the patient's request, in order to end the patient's life

• passive involuntary euthanasia
  - when medical treatment is withdrawn or withheld from a patient, not at the request of the patient, in order to end the patient's life

• active involuntary euthanasia
  - when medical intervention takes place, not at the patient's request, in order to end the patient's life

This paper discusses the Australian law relating to the second of these categories: active voluntary euthanasia. Comparison is made with the approaches to active voluntary euthanasia developed in a number of other legal systems: in the Netherlands, the United States of America, England and Canada.

The law in relation to the first category, passive voluntary euthanasia, is discussed in an earlier paper. The law in relation to the final two categories, passive involuntary euthanasia and active involuntary euthanasia, will be discussed in forthcoming papers.
Introduction

A patient has no legal right to insist on medical intervention that would end his or her life.

A competent patient's common law 'right to bodily self-determination' only extends to refusal of treatment; a patient cannot require any doctor to administer any treatment or medical procedure that the patient requests. This restriction extends to medical procedures that would cause or hasten a patient's death. Thus a patient cannot compel an unwilling doctor to perform such procedures or otherwise to help the patient die.

Even if a doctor wishes to accede to a patient's request to perform acts that would hasten the patient's death, the criminal law generally prevents the doctor from doing so. In every Australian jurisdiction, except the Northern Territory, the crimes of murder and assisting suicide prohibit a doctor from complying with a patient's request to take active steps with the aim of bringing about the patient's death. For the purposes of establishing liability for these crimes under Australian law, none of the following factors are relevant:

• the doctor was motivated by compassion for the patient;
• the patient was terminally ill;
• the doctor's behaviour merely hastened a death that was inevitable and/or imminent;
• the patient was competent at the time s/he asked the doctor for assistance, and the request was both informed and voluntary.

Three categories of life-ending medical intervention

It is useful to examine three different situations in which a competent patient requests and a doctor provides assistance to end the patient's life, to discover whether the doctor would be criminally liable in each situation:

• Situation One: The patient is in excruciating pain and asks the doctor for release from that pain; the doctor administers increased doses of pain-killing drugs; this hastens the patient's death.
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- Situation Two: The patient wants to die and asks the doctor for assistance; the doctor assists by (for example) prescribing drugs, setting up a mechanism, providing advice about effective means; but the lethal act is performed by the patient rather than by the doctor.

- Situation Three: The patient wants to die and asks the doctor for assistance; the doctor assists by performing the lethal act (for example, by administering a lethal injection).

Situation One - The patient is in excruciating pain and asks the doctor for release from that pain; the doctor administers increased doses of pain-killing drugs; this hastens the patient's death.

The principle in R v. Cox - death as an incidental effect of pain relief

English courts have stated that the criminal law will not intrude here if the doctor's intention can be described as an intention to relieve pain rather than as an intention to end the patient's life. In such a case the law characterises the patient's death as a mere 'side effect' of the use of drugs to relieve pain and suffering:

... the established rule [is] that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful.

The rule has also been articulated as follows:

If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.

This legal principle will not protect a doctor from criminal liability in every circumstance where a patient's death results from the administration of drugs in response to a patient's request for pain relief. The principle appears to be confined to situations where the patient has a terminal illness and has reached a stage where there is no hope of recovery. In addition it does not allow a doctor to act with the intention of ending life as the only way of relieving a patient's pain. A doctor will be exposed to criminal liability if the doctor's primary purpose in administering drugs is to hasten the patient's death. A court is more likely to conclude that this was the doctor's primary purpose if: the doctor does not use a standard pain killing drug; the doctor uses a standard pain killing drug but could instead have
employed safer pain relieving alternatives; the doctor administered a larger dose of pain killing drug than was necessary to reduce the patient's pain to acceptable levels; or the doctor otherwise departed from accepted professional standards of palliative care.\cite{17}

An important case illustrating the application of this legal rule is the 1992 English case of R v. Cox.\cite{18} The case involved the criminal prosecution of Nigel Cox, a consultant rheumatologist, in connection with the death of his terminally ill patient, Lilian Boyes. Ms Boyes was 70 years old and had been Dr Cox's patient for thirteen years. She was suffering from rheumatoid arthritis complicated by internal bleeding, gangrene, anaemia, gastric ulcers and pressure sores. As a result she was in acute and constant pain from which standard pain-killing drugs did not offer relief. During the last few days before her death, she repeatedly asked Dr Cox to end her life. He reassured her that her last hours would be as free of pain and as dignified as possible. He injected her with a potentially lethal dose of potassium chloride, a drug without recognised pain killing properties. She died within minutes of the injection.

Dr Cox was prosecuted for attempted murder.\cite{19} The jury at Winchester Crown Court found him guilty as charged, and the trial judge gave him a suspended sentence of 12 months' imprisonment.

Professional disciplinary proceedings were also taken against Dr Cox. The Professional Conduct Committee of the General Medical Council admonished Dr Cox for his conduct in this case, describing it as "both unlawful and wholly outwith a doctor's professional duty to a patient".\cite{20} The Professional Conduct Committee nonetheless expressed its "profound sympathy" for his situation and declined to suspend his registration or take further action against Dr Cox. The health authority who employed Dr Cox, however, refused to allow him to return to work unless he complied with certain conditions. These included the requirement that he receive further training in palliative care.

How is this exception justified?

Any or all of the following rationales may underpin this 'exception' under English law to the legal prohibition against performing acts that will kill a patient:

- The philosophical doctrine of 'double effect'. This doctrine originates in Roman Catholic moral theology. Applying this doctrine, the doctor who acts intending to achieve a primary effect which is good (relieving pain) does not intend and is not culpable for a secondary effect which is bad (killing the patient).\cite{20}

- Acting with the intention to relieve pain is in accordance with the doctor's duty to act in the patient's best interests, whereas acting with the primary intention to kill is not.\cite{21}
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These rationales have been criticised as relying on 'illogical legal fictions' and 'fine and arguably unworkable distinctions'. It has been argued that all these rationales employ sophistry to avoid acknowledging that many doctors who administer life-shortening pain relief do in fact intend their patient's death. It has been further claimed that this leads to hypocrisy on the part of doctors (who cannot admit that their intention when administering pain relief is in many cases to hasten death, as well as to relieve pain) and on the part of society (which does not wish criminal sanctions to apply to doctors who hasten their patient's death in this way). One commentator states this claim as follows:

Everything ultimately turns on what the doctor claims he was trying to achieve. As long as he uses the right verbal formula and records it in the patient's notes and to be on the safe side does not use too unusual a drug, he will stay within the law. Knowing how to play the game becomes the crucial determinant of criminal liability, rather than what objectively is done or what results. When the crime is murder, this can hardly be satisfactory.

... The current state of the law endorses, indeed entrenches, hypocrisy. 'We all know what you are doing, but use the magic words, 'I'm doing this to relieve your pain' and all will be well'. Alternatively, the law encourages casuistry, as those who are anxious to do right by their patients, as they see it, feel compelled to resort to subterfuge out of fear of prosecution. Fear of prosecution is of course eminently desirable when designed to deter what is accepted as wrong. But when it is neither the means nor the end which is regarded as wrong but rather the absence of the attendant rhetoric or ritual, such fear becomes itself a wrong.

The claim that the legal authorisation of 'unintentional' deaths as the result of pain relief is being used to disguise situations involving criminal behaviour (i.e. situations where death results from the actions of a doctor whose primary intention is to bring about that death) is not uncontroversial. The claim nonetheless deserves serious attention, particularly as it is often associated with a further claim: that some doctors hasten their patients' deaths on request in situations where the doctors' behaviour is clearly not associated with any attempt at pain relief. These arguments are often then used in support of removing or relaxing the legal prohibitions on 'physician-assisted suicide' (i.e., behaviour falling within situation 2, discussed below) and/or 'active voluntary euthanasia' (i.e., behaviour falling within situation 3, discussed below).

These charges of hypocrisy and reliance on damaging legal fictions might be deflected, however, if the law acknowledged an alternative rationale for the 'exception' outlined in the English case law. That rationale is the legal doctrine of 'necessity'. Applying this doctrine, the administration of a potentially fatal dose of pain relieving drugs would be excused as necessary if that was the only way for the doctor to relieve the patient's pain, and thus the doctor's only other option would be to leave the patient without adequate pain relief. Importantly, the doctor would not need to believe or pretend that the death of the patient was unintended to utilise this defence.
The sophistication of modern methods of pain relief would mean, however, that explicit legal recognition of a 'necessity' defence in these terms would only justify intentional administration of life-shortening pain relief by a doctor in the most exceptional circumstances.\(^{31}\) If the law wished to use the doctrine of necessity to legitimise such behaviour by doctors in a broader range of circumstances, it would need to specify clearly and explicitly in which circumstances the doctrine would apply. In developing such criteria the crucial question would be exactly where the law should draw the line between life-shortening behaviour that is criminal and behaviour that is not. This would lead inevitably beyond consideration of when it should be lawful to administer pain-relieving drugs in potentially fatal doses, to the broader question of whether the law should ever permit a doctor to perform any act that amounts to 'physician-assisted suicide' (i.e., behaviour falling within situation 2) and/or 'active voluntary euthanasia' (i.e., behaviour falling within situation 3).\(^{32}\) This would require serious assessment of the argument that it is not exceptional for doctors to comply with their patients' requests to hasten their deaths, and that there is a corresponding and undesirable disparity between what the law says and what doctors do in practice.

Is the Australian legal position as stated in the English case law?

**No judicial clarification of the law**

There have been no criminal prosecutions of doctors in Australia in relation to their administration of pain relieving drugs that have hastened death.\(^{33}\) There has been no judicial clarification, therefore, of the legal position in Australia. In the absence of such clarification it may not be safe to assume that the legal 'exception' articulated in the English case law is part of the criminal law of Australia. It has been suggested that, under a strict interpretation of the relevant Australian homicide laws, a doctor actually may not be immune from liability for murder, in respect of the death of a patient resulting from the administration of pain killing drugs, simply because the situation can be characterised as one where the doctor did not intend to cause the death. Rather, the doctor may be potentially liable for murder if the doctor administered the drugs in the knowledge that the patient might die as a result and if the drugs did in fact hasten the patient's death.\(^{54}\) Thus:

> Although it appears to be widely accepted amongst the medical profession that the administration of life-shortening palliative care is ethical and constitutes legitimate medical practice, it is open to question whether this practice is in fact lawful.\(^{55}\)

It should also be noted that, even if an Australian court did reach the same result as the courts in England, it might not necessarily adopt the same legal rationale(s) for doing so. It therefore is possible that an Australian court would express this legal exception in terms of
the doctrine of necessity, in preference to any rationale that depends upon an absence of intention to hasten the patient's death.

**Limited statutory clarification of the law**

In 1991 the Law Reform Commission of Western Australia expressed concern at the uncertainty of the legal position when death is hastened by the administration of pain relieving drugs. Accordingly it recommended that legislation be introduced to protect doctors from liability 'for administering drugs or other treatment for the purpose of controlling pain, even though the drugs or other treatment may incidentally shorten the patient's life, provided that the consent of the patient is obtained and that the administration is reasonable in all the circumstances'. No such legislation has been enacted in Western Australia.

Only South Australia has statutory provisions that clarify the law on this issue. The relevant provisions seem to confirm the applicability in South Australia both of the English legal rules and of their dependence on the doctor's primary intention being to relieve pain. Section 17(1) of the new Consent to Medical Treatment and Palliative Care Act 1995 (SA) applies to the situation where a doctor, or other health care professional acting under a doctor's supervision, administers medical treatment 'with the intention of relieving pain or distress', even though 'an incidental effect of the treatment is to hasten the death of the patient'. This section provides that the doctor or other health care professional will incur no civil or criminal liability in this situation provided she or he acts:

- with the consent of the patient or the patient's representative; and
- in good faith and without negligence; and
- in accordance with proper professional standards of palliative care.

This legislation also provides that the administration of medical treatment for the relief of pain or distress in accordance with these conditions 'does not constitute an intervening cause of death' for the purposes of South Australian law.

The Medical Treatment Act 1988 (Vic) provides that its operation 'does not affect any right, power or duty which a medical practitioner or any other person has in relation to palliative care'. The definition of palliative care includes 'the provision of reasonable medical procedures for the relief of pain, suffering and discomfort'. Thus the Victorian legislation does not disturb the common law rules as to when administration of pain relieving measures that hasten death can result in criminal liability; but it neither clarifies those rules nor explains their underlying rationale.
The Natural Death Act 1988 (NT) is similarly unhelpful. It provides that its operation 'does not affect the legal consequences (if any) of taking ... therapeutic measures (not being extraordinary measures) in the case of a patient who is suffering from a terminal illness, whether or not the patient has made a direction under this Act.' Therapeutic measures are not defined in this context, but presumably would include the administration of pain relieving measures. The legislation does not specify what the unaffected legal rules governing the administration of such measures might be. Nor does it refer to any possible rationale for those rules.

Like the Victorian legislation, the Medical Treatment Act 1994 (ACT) provides that its operation 'does not affect any right, power or duty which a medical practitioner or any other person has in relation to palliative care.' It similarly includes 'the provision of reasonable medical and nursing procedures for the relief of pain, suffering and discomfort' in its definition of palliative care. These provisions also do not indicate when (or why) the administration of pain relieving measures that result in a patient's death will not result in criminal liability. Nor does the section of the ACT legislation that, 'notwithstanding the provisions of any other law of the Territory' confers on a patient 'a right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances.' The legislation does not indicate whether or under which circumstances pain relief that kills a patient will be considered to be 'reasonable' for these purposes. It merely states that a health professional must 'pay due regard to the patient's account of his or her level of pain and suffering' when administering pain relief to a patient.

In June 1995 the Queensland Parliament passed the Criminal Code Act 1995 (Qld) to repeal the Criminal Code Act 1899 (Qld) and thereby introduce a new Criminal Code. The amending legislation replaces section 282 of the old Criminal Code with a new section 82. This new section absolves 'a person' of criminal responsibility for providing 'medical treatment' (defined as including 'pain relief') where such provision is provided 'in good faith and with reasonable care and skill', is 'for the patient's benefit' and is 'reasonable, having regard to the patient's state at the time and all the circumstances'. The rather loose wording of this section suggests that it may authorise the administration of pain killing drugs that shorten a patient's life in circumstances that would not fall within the 'exception' delineated in the English case law. The new section 82 would seem to authorise the administration of life-shortening pain relief by a doctor or any other person even where the intention clearly is to end the patient's life. It also seems to authorise the administration of other 'medical treatment' (that is not associated with 'pain relief') with the intention of ending the patient's life, although it is not clear exactly what would amount to medical treatment for the purposes of new section 82. The new section therefore may be interpreted as possibly authorising 'active voluntary euthanasia' (ie behaviour falling within situation 3), provided only that the acts performed to end the patient's life are:

- performed in good faith:
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• performed with reasonable care or skill;
• for the patient's benefit; and
• reasonable, having regard to the patient's state at the time and all the circumstances.

The new section offers no explanation of when these conditions might be satisfied.

During the parliamentary debate on the Criminal Code Bill 1995 (Qld), the Queensland Minister for Justice and Attorney-General stated the following in relation to the proposed new section 82:

... it is not the intention of this Parliament by this provision to legalise euthanasia and there is no intention in this Parliament to diminish the force of existing prohibitions against euthanasia ... if there is any member of this Parliament who, by this section, wishes to legalise euthanasia and wishes this Bill here and now to legalise euthanasia, let them now speak. Let the Hansard record show that no member of this House spoke. Let the Hansard record show that the intention of this Parliament is translucently clear.47

The relevant sections of the Criminal Code Act 1995 (Qld) have not yet commenced and will not do so until at least 14 June 1997.

Situation Two - The patient wants to die and asks the doctor for assistance; the doctor assists by e.g. prescribing drugs, setting up a mechanism, providing advice about effective means; but the lethal act is performed by the patient rather than the doctor.

Situation Two is often described as 'physician-assisted suicide' and shall be referred to as such in this paper.

The criminal law prohibits physician-assisted suicide

A doctor who complies with a patient's request in this way is exposed to criminal liability. The relevant offence is assisting suicide.

Although the criminal law in Australia no longer proscribes suicide or attempted suicide, assisting suicide is a crime in all Australian jurisdictions. In New South Wales, the Australian Capital Territory, Victoria and South Australia, it is an offence for a person to 'incite, counsel, aid or abet' another person to commit suicide or attempt to commit suicide.48 In Queensland, Western Australia and the Northern Territory, it is an offence to 'procure' or 'counsel' another person to kill himself or 'aid' another in killing himself.49 In Tasmania, it is
an offence to 'instigate or aid another to kill himself'. The penalties for assisted suicide vary between jurisdictions.

The law is not enforced against doctors

Prosecutions for assisting suicide are rare in Australia. The few cases that have come before the courts have tended to involve provision of assistance by family members or friends of the victim, where the accused has been motivated by compassionate motives. These cases are sometimes referred to as involving 'mercy-assisted suicide'. The law clearly states that a person who has assisted another's suicide cannot escape liability by virtue of compassionate motive or other extenuating circumstances. The Australian criminal justice system nonetheless treats an accused person who was motivated by compassion with relative leniency, even where that person has clearly violated the criminal law. In particular, Australian judges have imposed very lenient sentences on people convicted of assisting suicide in this context.

There have been no prosecutions of doctors in Australia for assisting the suicide of their patients. Should such a case arise, however, it is likely that a court would display the same leniency it has shown in other 'mercy-assisted suicide' cases if the doctor's motive was compassionate.

Physician-assisted suicide is now permitted in the Northern Territory

Physician-assisted suicide, however, is legal in some circumstances in the Northern Territory due to the enactment of the Rights of the Terminally Ill Act 1995 (NT). The Northern Territory legislation is discussed further below.

Situation Three - The patient wants to die and asks the doctor for assistance; the doctor assists by performing the lethal act (e.g., by administering a lethal injection).

Situation Three is sometimes described as 'physician-aid-in-dying'. It is more frequently described as 'active voluntary euthanasia', however, and shall be referred to as such in this paper.
The criminal law prohibits active voluntary euthanasia

A doctor who complies with a patient's request in this way is exposed to criminal liability. The relevant offence is murder. In all Australian jurisdictions, murder is committed if a person dies as the result of an act deliberately undertaken to bring about that death.  

Life imprisonment remains the mandatory sentence for a murder conviction in the Northern Territory, Queensland, South Australia, Tasmania and Western Australia. The sentence for murder is now discretionary, with a maximum sentence of life imprisonment, in New South Wales, the Australian Capital Territory and Victoria.  

The law is not enforced against doctors

No doctor has ever been prosecuted for murder in Australia for performing active voluntary euthanasia.  

There has been one case in Western Australia in which a doctor was charged with the murder of a patient who died following the administration of morphine after she had suffered a heart attack. It is unclear, however, whether the case involved active voluntary euthanasia: first, because it was not clear whether the patient had asked the doctor to end her life; and secondly, because the dose of morphine may not have been sufficiently large to infer that the doctor clearly intended the patient's death. Further, the evidence did not conclusively indicate whether the patient had died from the morphine or from her heart attack. The case was dismissed at the end of committal proceedings on the basis that there was insufficient evidence that could support a conviction.  

There has also been a case in New South Wales in which criminal charges were laid against a nurse's assistant who had administered an unauthorised dose of pethidine to an elderly patient. The charge was attempted murder rather than murder, because the patient subsequently died from natural causes rather than from the overdose of pethidine. The accused (initially) admitted that he had administered the drug with the intention of killing the patient, but claimed he had acted out of merciful motives because the patient had been in severe pain. Again, however, this case seems not to have involved active voluntary euthanasia because the evidence did not indicate whether the patient had asked to receive a lethal overdose. At his trial the accused pleaded not guilty and the court was presented with evidence that he had been receiving psychiatric treatment. The jury acquitted the accused of the charge.

There have also been a significant number of Australian cases involving murder prosecutions of family members or friends of the victim, where the accused has been motivated by compassionate motives. These cases are sometimes referred to as 'mercy killing' cases.
with assisted suicide, the law clearly states that the accused's compassionate motive or other extenuating circumstances are not relevant in establishing liability for murder. As with those accused of assisted suicide, however, the Australian criminal justice system treats with leniency a person who has clearly murdered a friend or family member but was motivated by compassion:

- ... a number of mechanisms within the criminal justice system have been invoked to temper the rigours of the criminal law in true instances of mercy killing ... These include the exercise of prosecutorial discretion, acquittals (either by the judge or the jury) or findings of guilt on a lesser charge, lenient sentencing by the courts, favourable parole determinations, and the exercise of executive clemency.\(^5\)

It may be inferred that any doctor charged with murder for compassionately performing active voluntary euthanasia would be treated with similar leniency.

**Active voluntary euthanasia is now permitted in the Northern Territory**

The only Australian jurisdiction in which active voluntary euthanasia is clearly legal in some circumstances is the Northern Territory.

This situation is due to changes in the law introduced by the *Rights of the Terminally Ill Act 1995 (NT)*. The long title of the legislation is as follows:

- An Act to confirm the right of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life in a humane manner; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance; to provide procedural protection against the possibility of abuse of the rights recognised by this Act; and for related purposes.

The legislation sets out a statutory regime under which physician-assisted suicide and active voluntary euthanasia may be performed without violating the criminal (or any other) law. The legislation allows a doctor to comply with a request by a terminally ill, competent adult patient for assistance in ending the patient's life if specified conditions are satisfied. Thus it is neither an unqualified 'licence to kill' nor an unqualified affirmation of a competent adult patient's right to assistance in dying. The provisions of the legislation are discussed in detail below.
Exactly what does the Northern Territory legislation permit?

The Rights of the Terminally Ill Act 1995 (NT) allows a doctor to respond to a patient’s request for assistance in terminating the patient’s life if, and only if, all the following conditions are satisfied:

- the patient is terminally ill.\(^{69}\)

  'Terminal illness' is defined as 'an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient'.\(^{61}\)

- the patient has attained the age of 18 years.\(^{62}\)

- the terminal illness is causing the patient 'severe pain or suffering',\(^{63}\) such that the patient is 'experiencing pain, suffering and/or distress to an extent unacceptable to the patient'.\(^{64}\)

- there are no palliative care options 'reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient'.\(^{65}\)

- the doctor has informed the patient about:
  - the nature of the illness and its likely course; and
  - the medical treatment that is available to the patient (including palliative care, counselling and psychiatric support).\(^{66}\) If the doctor does not hold specialist qualifications in the field of palliative care, this information must be provided by another doctor who does hold such qualifications.\(^{57}\)
  - after receiving the information described above, the patient has indicated to the doctor the desire to end his or her life.\(^{68}\)

- the doctor is satisfied, on reasonable grounds, that:
  - the patient is suffering from a terminal illness, i.e., an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient;\(^{69}\) and
  - there is no medical treatment acceptable to the patient that can cure the patient's condition;\(^{70}\) and
  - the only medical treatment available to the patient is palliative care, i.e., treatment to relieve 'pain, suffering and/or distress with the object of allowing the patient to die a comfortable death';\(^{71}\) and
Active Voluntary Euthanasia

- the patient is 'of sound mind' and the patient's decision to end his or her life 'has been made freely, voluntarily and after due consideration'; 72 and

- the patient has considered the possible implications of this decision for his or her family. 73

• The doctor has been entitled to practise medicine in Australia for a continuous period of not less than five years, and is currently a resident of the Northern Territory and entitled to practise medicine in the Northern Territory. 74 Note that the legislation does not require that the patient be a Northern Territory resident.

• A second independent doctor, who is a specialist in the treatment of the terminal illness from which the patient is suffering, 75 has confirmed the first doctor's opinions about the patient's illness. 76 This doctor must also have been entitled to practise medicine in Australia for a continuous period of not less than five years, and be currently a resident of the Northern Territory and registered to practise medicine in the Northern Territory.

• A third independent doctor, who is a qualified psychiatrist, 77 confirms that the patient is not suffering from a treatable clinical depression in respect of the illness. 78 This doctor need not be a resident of the Northern Territory nor registered to practise medicine in the Northern Territory.

• The patient (or, if the patient is physically unable to do so, someone appointed by the patient) has signed a 'certificate of request' in or to the effect of the form in Schedule 7. The signature must be witnessed by the (first) doctor. The certificate of request must also be signed, in the presence of the patient and the first doctor, by another doctor who has discussed the case with the patient and the first doctor. Neither the first doctor nor the countersigning doctor, or their close relatives or associates, must knowingly stand to gain any financial or other advantage (other than a reasonable payment for medical services) as a result of the patient's death. 79

• The certificate of request must not have been signed before a 7 day 'cooling off period' has elapsed since the patient indicated to the (first) doctor that the patient wished to end his or her life. 80

• A second 'cooling off' period of 48 hours has elapsed since the certificate of request was signed. 81

• The patient has at no time indicated to the (first) medical practitioner that the patient no longer wished to end his or her life. 82

• The patient has been appropriately assisted by a qualified interpreter, if the patient's first language is not the same as that of any of the doctors who are required to communicate with the patient in this process. 83
Even if all these conditions have been satisfied, the patient may 'at any time and in any manner' rescind his or her request for assistance in dying. Further, a doctor is at no time under any legal obligation to accede to the patient's request for assistance. The legislation specifically states that a doctor may 'for any reason and at any time' refuse to assist the patient to end his or her life. Further, no health care provider is under any legal duty to participate in the provision by a doctor of assistance to end a patient's life.

If a doctor does choose to comply with the patient's request, the doctor may do so by prescribing a lethal substance, preparing a lethal substance, giving the lethal substance to the patient for self-administration, and/or administering the lethal substance to the patient. This authorises both physician-assisted suicide and active voluntary euthanasia. When assisting a patient to die in any of these ways, the doctor must be guided by 'appropriate medical standards', must 'consider the appropriate pharmaceutical information about any substance reasonably available for use' and should choose the 'drug or combination of drugs which the medical practitioner determines is the most appropriate to assist the patient'. The doctor need not be present at the time of the patient's death in order to comply with the legislation. Where the doctor is to assist the patient by administering lethal drugs, the doctor should provide information about the effects of those drugs to the patient's friends and family members so that they may decide whether to be present at the death. The doctor should also 'remain for a reasonable time after the death of the patient with the family and friends of the patient who are in attendance' to answer any questions they may have about the death.

The doctor must keep detailed written records in relation to assisting a patient to die under this legislation. These records must include notes of any oral request made by the patient for assistance in signing, the certificate of request, a written opinion as to the patient's state of mind when the patient signed the certificate of request, the reports of the second and third doctors, and a record of the steps taken to carry out the patient's request and of the substance prescribed to cause death. The doctor must also report any such death and forward the relevant medical records to the Coroner, who is in turn required to report the annual number of deaths under this legislation to the Attorney-General. The Coroner may also report to the Attorney-General on any other matter relating to the operation of the legislation. The Attorney-General must report the Coroner's findings to the Legislative Assembly.

A doctor who assists a patient to end his or her life in compliance with this legislation is immune from civil or criminal action and professional disciplinary action, provided the doctor has acted 'in good faith and without negligence'. This immunity extends to all other people, including other health care professionals, who are involved with the death of the patient.

The legislation imposes strict penalties for certain behaviour:
• Anyone who makes inducements or threats to a doctor or to another person in relation to a patient's request for assistance in terminating his or her life commits an offence. The penalty is $10 000.95

• Anyone who uses deception or improper influence to procure the signing or witnessing of a certificate of request commits an offence. The penalty is $20 000 or imprisonment for four years.96

• A doctor who fails to comply with the record-keeping or reporting requirements imposed by the legislation commits an offence. The penalty is $10 000 or imprisonment for two years.97

The background to the Northern Territory legislation

The Rights of the Terminally Ill Bill 1995 (NT) was introduced into the Northern Territory Legislative Assembly as a Private Member's Bill on 22 February 1995 by Marshall Perron, the (then) Chief Minister of the Northern Territory. On the same day, a Select Committee on Euthanasia was established to inquire into the Bill and report back to the Northern Territory Legislative Assembly by 16 May 1995.98 On 25 May 1995, the Legislative Assembly passed the legislation by 15 votes to 10 after over 50 amendments had been made to the original Bill.99

The Northern Territory thereby became the first jurisdiction in the world to pass legislation permitting active voluntary euthanasia.100 Unsurprisingly, therefore, the passing of this legislation attracted a great deal of attention. Worldwide access to information about the new legislation was facilitated by an Internet website established by the Northern Territory Legislative Assembly.101 Nationally and internationally, there was both extensive criticism and extensive approval of the Northern Territory legislation from politicians, health care professionals, religious groups, 'pro-life' and 'pro-choice' pressure groups, academic, the media and members of the general public.

Opponents of the new legislation immediately called for its repeal by the Northern Territory Legislative Assembly. There were also suggestions that the Governor-General of Australia should disallow, and thereby repeal, the legislation using his powers under the Northern Territory (Self-Government) Act 1978 (Cth).102

The Administrator of the Northern Territory assented to the Rights of the Terminally Ill Act 1995 (NT) on 16 June 1995. On 20 February 1996, the NT Legislative Assembly passed further amendments to the legislation.103 These amendments were contained in the Rights of the Terminally Ill Amendment Act 1996 (NT). The amendments increased by one the number of doctors who must be involved in the process of assessing a patient who has asked to be helped to die under the legislation, and made it clear that one of those doctors must be a
qualified psychiatrist and another a specialist in the patient's illness clarified the qualifications that those doctors must possess. Attempts to include an amendment to introduce a sunset clause into the Rights of the Terminally Ill Act 1995 (NT) to terminate its operation on 1 July 1999 failed. Attempts to introduce an amendment to repeal the Rights of the Terminally Ill Act 1995 (NT) also failed, as did separate attempts to pass a new Private Member's Bill to the same effect.

On 29 June 1996 the Administrator of the Northern Territory made regulations under the Rights of the Terminally Ill Act 1995 (NT). These regulations - the Rights of the Terminally Ill Regulations 1996 (NT) - came into effect on 1 July 1996. The Rights of the Terminally Ill Act 1995 (NT) also commenced on 1 July 1996.

In August 1996, attempts in the Northern Territory Legislative Assembly to amend and repeal the Rights of the Terminally Ill Act 1995, failed.

**Wake and Gondarra v. Northern Territory and Asche**

In an unsuccessful attempt to prevent the Rights of the Terminally Ill Act 1995 (NT) from coming into effect, in June 1996 a private legal challenge was initiated against the Northern Territory of Australia, the Administrator of the Northern Territory and the Commonwealth of Australia. The President of the Northern Territory Branch of the Australian Medical Association, Dr Chris Wake, and Aboriginal leader Reverend Dr Djiniyini Gondarra lodged a writ in the Northern Territory Supreme Court challenging the validity of the legislation. The Northern Territory Supreme Court heard the case on 1-2 July 1996 and reserved its decision. Judgement was delivered on 24 July 1996. By a majority of 2:1 the Supreme Court rejected the challenge to the legislation.

The plaintiffs in *Wake and Gondarra v. Northern Territory and Asche* claimed that the Rights of the Terminally Ill Act 1995 (NT) was invalid on two broad bases:

- that no valid assent had been given to the legislation; and
- that the legislative competence of the Northern Territory did not extend to the making of this.

In respect of the first claim, all three judges agreed that this question turned on the proper construction of sections 7, 32 and 35 of the Northern Territory (Self Government) Act 1978 (NT) and of Regulation 4 of the Northern Territory (Self-Government) Regulations 1978 (NT).
The two majority judges, Martin CJ and Mildren J, in a joint judgement concluded that the Administrator had given valid assent to the legislation under section 7(2)(a), because the *Rights of the Terminally Ill Act 1995 (NT)* satisfied the requirement that it was a law 'for or in relation to a matter specified under section 35'. These matters are listed in Regulation 4. They are the matters over which the Administrator is given executive authority by section 32. The majority judges denied that the fact that the Northern Territory is not yet a State means that the scope of these matters, which are expressed in broad terms, should be interpreted narrowly. These judges accordingly held that the challenged legislation related to three of these matters: 'maintenance of law and order and the administration of justice'; 'private law'; and 'the regulation of businesses and professions'.

The dissenting judge, Angel J, disagreed on this point. He concluded that the challenged legislation had no substantial connection with any of the matters listed in Regulation 4, even on the most generous interpretation of the scope of those matters. He stated that these heads of executive power could not encompass 'the legislative establishment of intentional termination of human life other than as punishment,' and that the challenged legislation purported to do this. Angel J therefore concluded that the legislation had not been lawfully assented to and had not passed into law.

In respect of the second claim, Martin CJ and Mildren J concluded that the *Rights of the Terminally Ill Act 1995 (NT)* was not *ultra vires* the legislative power of the Northern Territory Legislative Assembly. That power is conferred by section 6 of the *Northern Territory (Self Government) Act 1978 (Cth)* and enables the Legislative Assembly 'to make laws for the peace, order and good government of the Territory'. The majority judges referred to case law indicating that this power is a plenary power of the same quality as that enjoyed by State legislatures. They rejected the plaintiffs' claim that the exercise of legislative power by the Legislative Assembly is constrained by an obligation to protect an inalienable 'right to life', which is 'deeply rooted in our democratic system of government and the common law'. These judges stated that they did not need to decide whether the challenged legislation infringed any fundamental right because, in the absence of 'a constitutionally enshrined Bill of Rights', that question was 'ethical, moral or political' and not legal. These judges further stated that, like a State Parliament, the Northern Territory Legislative Assembly had legislative power to abrogate any 'fundamental rights, freedoms or immunities', provided its intention to do so was manifested clearly and unmistakably. Thus, even if the challenged legislation could be said to affect any 'fundamental rights, freedoms or immunities', the legislation was not *ultra vires* because its language was clear and unambiguous.

In view of his conclusion that the *Rights of the Terminally Ill Act 1995 (NT)* had not been assented to validly, Angel J considered that he need not express any final view on the question of whether the legislation was *ultra vires* the legislative power of the Legislative Assembly. Angel J did state, however, that in this context he did not think that 'the legal
question can ignore the philosophical questions, both moral and political involved, and the
values at stake. He considered that the plaintiffs' submission involved 'much deeper and
broader questions than whether parliament by clear words can abrogate a 'fundamental
right'. Although he doubted the existence of any legally enforceable 'right to life', he
considered that the plaintiffs' arguments rested on more than the claim that this right existed.
Rather, he considered that their arguments embraced 'the Natural lawyers' criticisms of the
sovereignty of parliament, and the view that parliament itself is subject to the Rule of Law'
and that the approach adopted by the majority judges did not dispose of these questions.

The High Court of Australia is expected to agree to hear an appeal against the findings of the
Northern Territory Supreme Court in this case.

The Commonwealth Parliament has the power to override the Rights of the Terminally Ill Act
1995 (NT)

Regardless of the final outcome of the challenge to the validity of the Northern Territory
legislation, it is possible that the Commonwealth Parliament will enact its own legislation to
override the Rights of the Terminally Ill Act 1995 (NT).

The Commonwealth Parliament has the power to do so under section 122 of the Australian
Constitution. That power is a plenary power which enables the Commonwealth Parliament to
pass legislation to override any Northern Territory law.

In Wake and Gondarra v. Northern Territory and Asche, Martin CJ and Mildren J referred to
this power and made the following comment:

To the extent that there is any force in the argument that the Territory Parliament or
Territory Ministers are somehow not to be trusted with the full extent of legislative or
executive power which the wording of section 6 or reg 4 would plainly permit, either
because of the novelty of the proposed new law or because they, as in this case, provide
a limited power to do that which no other legislature in the world has so far found fit to
permit, or because it abrogates some fundamental human right, the existence of the
powers retained by the Commonwealth suggest that these are matters which are to be
determined by political and not legal resolution. The same may be said in respect of
laws which adversely affect Australia's image as a nation or the interests of Australians
resident in the States which the Commonwealth feels an obligation to protect.

Mr Kevin Andrews MP (Liberal Party, Victoria) has indicated his intention to introduce a
Private Member's Bill into the Commonwealth Parliament to override the Northern Territory
legislation. He has also indicated that such a Bill might have retrospective effect.
Attempts to legalise active voluntary euthanasia in other Australian jurisdictions

There have been a number of recent attempts in other parts of Australia to enact legislation modelled on the Rights of the Terminally Ill Act 1995 (NT).

On 9 March 1995 Mr John Quirke MLA, the Shadow Treasurer of South Australia, introduced a Private Member's Bill entitled the Voluntary Euthanasia Bill 1995 (SA) into the South Australian Legislative Assembly. The Bill was rejected by the Legislative Assembly on 27 July 1995, by 30 votes to 12.

In August 1995 Mr Michael Moore MLA, who had introduced the ill-fated Voluntary and Natural Death Bill 1993 (ACT) into the ACT Legislative Assembly, introduced an exposure draft of a Private Member's Bill entitled the Medical Treatment (Amendment) Bill 1995 (ACT). This Bill was tabled in its final form in September 1995. The Bill was defeated in the ACT Legislative Assembly on 22 November 1995 by 10 votes to 7. Two ALP members and one Independent voted with the Liberal Party in opposing the Bill. Two Greens and five ALP members voted in support of the Bill.

On 30 May 1995 Mr Paul O'Grady MLC was given leave by the Australian Labor Party to introduce a Private Member's Bill into the New South Wales Legislative Council to provide for 'regulation to protect medical practitioners who assist the terminally ill to end their lives'. He had not done so, however, at the time of his resignation from Parliament in January 1996 due to ill health. No other member of the NSW Parliament has expressed a firm commitment to introducing legislation of this kind. In June 1995 the AIDS Council of NSW launched a draft Bill, entitled the Voluntary Euthanasia Bill 1995, the provisions of which are broadly similar to the Northern Territory legislation.

The Australian law in an international context - the lawfulness of physician-assisted suicide and active voluntary euthanasia in other countries

The Netherlands

The Dutch approach to regulating euthanasia

The Netherlands has a unique approach to the regulation of physician-assisted suicide and active voluntary euthanasia. Both are an openly practiced and widely accepted part of medical practice in the Netherlands. The Dutch approach to this issue therefore has attracted considerable international interest:
The Netherlands is the only country in which [active voluntary] euthanasia is openly practised in accordance with formal regulation. Evaluation of experience there is therefore useful to any assessment of the likely effects of the practice of euthanasia, allowing of course for social and cultural differences, and for differences in the healthcare environment.\(^{139}\)

Due to these social and cultural differences, however, aspects of the Dutch approach to the regulation of this kind of euthanasia are often misunderstood. It therefore is important to note that the Dutch approach to this issue has been characterised and/or influenced by the following:\(^{130}\)

- a willingness to discuss 'difficult moral issues' openly, and an associated belief that such openness is necessary in order to be able to regulate potentially problematic activities. This belief also underlies the Dutch approach to the regulation of matters such as prostitution, the age of consent, contraception, abortion, homosexuality and the use of soft drugs.

The issue of euthanasia has been debated 'vigorously and publicly' in the Netherlands since the early 1970s. Since the mid-1980s, public debate in the Netherlands on this issue has focussed on whether active voluntary euthanasia and physician-assisted suicide should be legalised altogether, or should instead remain criminal acts in principle but with clear rules about not to prosecute.\(^{131}\)

- the increased secularisation of Dutch society since the 1960s.

- a Calvinist sense of individual responsibility and accountability for one's own actions; combined with a respect for the autonomy of others, and tolerance of different philosophies of life and lifestyles ('live strictly and let live').

- The Royal Dutch Medical Association, which represents 60 per cent of Dutch doctors and currently has over 24,000 members, accepted in 1984 that physician-assisted suicide and active voluntary euthanasia can form a part of proper medical practice, provided certain guidelines are observed. It is the only leading national medical association in the world that officially approves of doctors practising active voluntary euthanasia and physician-assisted suicide.

- cooperation and dialogue between the government and the medical profession concerning the regulation of euthanasia.

- recognition (since 1990) of the need to obtain empirical evidence about the practice of euthanasia before making government policy and laws about euthanasia; and the willingness of government to fund research to obtain this empirical evidence.

- great trust in, and respect for, the medical profession among the general public.
• a medical system in which the family doctor (*huisart*) plays a central role. Many people in the Netherlands die at home, cared for by their general practitioner with whom they have had a personal and long-standing relationship.

• a strong commitment to the ethic of the welfare state.

• universal, comprehensive medical coverage and a high standard of medical care.

• a generally high standard of nursing home care.

• It is often claimed, however, that both palliative care and the hospice movement are underdeveloped in the Netherlands.\(^{132}\)

**The criminal law technically prohibits active voluntary euthanasia**

It is often reported that active voluntary euthanasia has been decriminalised in the Netherlands. This is not an accurate description of the Dutch legal situation.

The Penal Code of the Netherlands contains a variety of provisions prohibiting the intentional taking of human life. Two of these provisions specifically relate to physician-assisted suicide and active voluntary euthanasia:

• Article 293 of the Penal Code prohibits taking a person's life at that person's 'express and serious request'. This crime, sometimes described as 'the offence of voluntary euthanasia'\(^{133}\), is punishable by imprisonment for a maximum of 12 years or by a fine.

• Article 294 of the Penal Code prohibits assisting suicide. Where a death by suicide has occurred, anyone who helped bring about that death could be prosecuted under article 294 for intentionally inciting another to commit suicide, assisting in the suicide of another, or procuring the means for another to commit suicide. Where a death has occurred, this crime is punishable by imprisonment for a maximum of 3 years or a fine.

These statutory provisions remain in force and there is no indication that the Dutch legislature intends to repeal Article 293 or Article 294 in the foreseeable future. Despite this, physician-assisted suicide and active voluntary euthanasia are permitted in certain defined circumstances. A combination of prosecutorial policy and case law permits doctors in the Netherlands to intervene actively to shorten a patient's life, without fear of legal sanction, if specific conditions are satisfied. These conditions are described below.
Active Voluntary Euthanasia

The prosecutorial policy

By virtue of an agreement between the Dutch Ministry of Justice and the Royal Dutch Medical Association, since November 1990 a doctor has been guaranteed immunity from prosecution under Articles 293 and 294 if the doctor has complied with a number of 'rules of careful practice'. These rules comprise a number of substantive and procedural requirements.\(^\text{134}\)

The \textit{substantive} requirements are based on guidelines developed in 1984 by the Royal Dutch Medical Association. To comply with these requirements, the doctor must ensure that:

- the request for euthanasia\(^\text{135}\) or physician-assisted suicide is made by the patient and is voluntary.
- the request is well-considered - the patient has adequate information about his or her medical condition, about the prognosis and about alternative treatments; and the patient has considered alternative solutions but these alternatives are ineffective, unreasonable or not acceptable to the patient.
- the request is durable and persistent.
- the patient's situation entails unbearable suffering with no prospect of improvement. The patient need not be terminally ill to satisfy this requirement.

The \textit{procedural} requirements are as follows:

- euthanasia must be performed by a doctor.
- before the doctor assists the patient, the doctor must consult a second doctor.\(^\text{136}\)
- the doctor must keep a full written record of the case.
- the death must be reported to the prosecutorial authorities as a case of euthanasia or physician-assisted suicide, not as a case of death by natural cause.

Where a death is reported as a case of euthanasia or physician-assisted suicide, the doctor must complete a form containing a list of questions relating to the death. The questions assess whether the doctor has complied with the 'rules of careful practice'.

This notification procedure was given formal legal status by a recent amendment to the Law on the Disposal of Corpses. The Dutch Parliament passed this amendment in late 1993 and it came into effect on 1 June 1994.
The case law - the defence of necessity

Very few reported cases of physician-assisted suicide or active voluntary euthanasia in the Netherlands result in a criminal prosecution. Moreover, if a prosecution is initiated under Article 293 or 294 of the Penal Code, the accused doctor will not be convicted if the court concludes that the defence of 'necessity' should be invoked.

Article 40 of the Penal Code provides for a defence to criminal charges that incorporates the notion of *noodtoestand* or '(situation of) necessity':

*noodtoestand* refers to the situation of the patient's dire distress, wherein an ethical dilemma and conflict of interests arise, resulting in a decision by the physician to break the law in the interest of what is considered a higher good.

The Dutch courts have determined that the defence of necessity will apply, to protect a doctor from criminal liability in this context, if a number of criteria are satisfied. There are substantial similarities between these criteria and the 'rules of careful practice' that enable doctors who adhere to them to avoid prosecution in the first place.

The criteria that enable the defence of necessity to apply are:

- The request for euthanasia or physician-assisted suicide must come only from the patient and must be entirely free and voluntary.

- The patient's request must be well considered, durable and persistent.

- The patient must be experiencing intolerable suffering, with no prospect of improvement. The patient need not be suffering from a terminal illness. The suffering need not necessarily be physical suffering.

- Euthanasia or physician-assisted suicide must be a last resort. Other alternatives to alleviate the patient's situation must have been considered and found wanting.

- Euthanasia must be performed by a physician. The case law establishes that the defence of necessity cannot be invoked in this context by another health care professional (such as a nurse).

- The physician must consult with an independent physician colleague who has experience in this field.
Active Voluntary Euthanasia

The Remmelink Commission

In 1990 the Dutch Government set up the Remmelink Commission to investigate 'the practice of action and inaction by a doctor that may lead to the end of a patient's life at the patient's explicit and serious request or otherwise'. The Remmelink Commission therefore collected information about the practice both of euthanasia - strictly defined to refer to the deliberate termination of another's life at his or her request - and of other medical decisions at the end of life. As part of its inquiries, the Remmelink Commission ordered the first empirical study of all medical decisions at the end of life. The study was led by Dr P. Van der Maas of the Erasmus University in Rotterdam. The study found that in 1990 in the Netherlands:

- there were 2,300 cases of active voluntary euthanasia, representing 1.8 per cent of all deaths.\(^\text{143}\)

- there were 400 cases of physician-assisted suicide, representing 0.3 per cent of all deaths.\(^\text{144}\)

- there were 22,500 cases where the patient had died after the administration of drugs to alleviate pain and symptoms in such dosages that the risk of shortening the patient's life was considerable. This represented 17.5 per cent of all deaths.

  In 6 per cent of these cases life-termination was the primary goal and in the remainder it was the secondary goal.

  In about 40 per cent of these cases the decision to increase drug dosages and the possibility that this might hasten death had been discussed with the patient. In 73 per cent of the cases where these matters had not been discussed with the patient, the patient was incompetent.\(^\text{145}\)

- there were 22,500 cases where death had resulted from non-treatment decisions (ie withdrawal or withholding of medical treatment), representing 17.5 per cent of all deaths.

  In 30 per cent of these cases the non-treatment decision had been discussed with the patient. In 62 per cent of these cases it had not. In 88 per cent of all cases where the non-treatment decision had not been discussed with the patient, the patient was incompetent.\(^\text{146}\)

- there were 1,000 cases where a doctor had deliberately ended the life of a patient without a clear and explicit request from the patient. This represented 0.8 per cent of all deaths.

The data relating to these deaths indicated the following:

In more than half of these cases the decision had been discussed with the patient or the patient had in a previous phase of his or her illness expressed a wish for euthanasia should suffering become unbearable.
Active Voluntary Euthanasia

In other cases, possibly with a few exceptions, the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. The decision to hasten death was then nearly always taken after consultation with the family, nurses, or one or more colleagues. In most cases, the amount of time by which, according to the physician, life had been shortened was a few hours or days only. 147

The same study also found that:

• Each year there are about 9,000 explicit requests for physician-assisted suicide or active voluntary euthanasia in the Netherlands. Of these requests, less than one third are agreed to. The remainder do not result in physician-assisted suicide or active voluntary euthanasia, because either alternatives are found that make the patient change his or her mind or the patient dies before any action has been taken. 148

• 54 per cent of all doctors (and 62 per cent of general practitioners) involved in the research said they had practised active voluntary euthanasia or assisted suicide at the explicit and persistent request of a patient. 34 per cent said they had never practised active voluntary euthanasia or assisted suicide but could conceive of situations in which they would be prepared to do so. 149

• In cases where death had been caused by physician-assisted suicide or active voluntary euthanasia, the patient had mentioned the following reasons for making the request: loss of dignity (57 per cent of cases), pain (46 per cent), unworthy dying (46 per cent), being dependent on others (33 per cent), or tiredness of life (23 per cent). Pain was the only reason mentioned for making the request in less than 6 per cent of cases. 150

The Remmelink Commission also obtained data from an independent study conducted by Dr G. Van der Wal of the Medical Inspectorate of Health for North Holland. The results of this study confirmed many of the findings of Van der Maas and his colleagues. 151


The empirical data obtained by the Remmelink Commission has been cited in support of very different conclusions. Some commentators have argued that the data, particularly the finding that 1,000 deaths took place without the patient's explicit and persistent request, supports the 'slippery slope' argument and shows that tolerance for physician-assisted suicide and active voluntary euthanasia inevitably results in the practice of involuntary euthanasia. 153 Other commentators have argued that, to the contrary, the Dutch findings show that physician-assisted suicide and active voluntary euthanasia can be safely regulated. Some commentators have cautioned against misinterpreting the findings of the Remmelink research:

The Dutch data on medical practices which shortens life, in the cases of non-competent or of competent but not-consulted patients, are indeed a matter of concern... [but there]
really is not a shred of evidence that the frequency of this sort of behaviour is higher in
the Netherlands than, for example, in the United States; the only thing that is clear is
that more is known about it in the Netherlands. In short, there is no reason to assume ...
a causal relationship between limited legalisation of euthanasia and 'lack of control'
over other sorts of medical behaviour. 

New controversy - the Chabot case

In June 1994 the Supreme Court of the Netherlands delivered its judgment in the Chabot
case. The case involved the prosecution of a psychiatrist who had assisted the suicide of
one of his patients. The patient, Ms B, was not suffering from any physical illness. She was a
50 year old woman who had a 20 year history of depression. Her very unhappy personal life,
including a violent marriage and the death of one of her sons by suicide and of the other from
cancer, had resulted in her abandoning any wish to go on living. Psychiatric treatment had
not helped her and she had made at least one attempt at committing suicide. For several years
she had made it known to other people - including her sister, friends and her family doctor -
that she wished to die, 'but in a humane way which would not confront others involuntarily
with her suicide'. In 1991 Ms B approached the Dutch Federation for Voluntary
Euthanasia who referred her to the defendant, Dr Chabot. He concluded that she was not
suffering from a psychiatric illness or a major depressive episode, but rather that she had an
adjustment disorder 'consisting of a depressed mood, without psychotic signs' arising from
bereavement. Her condition was in principle treatable but the chance of success was small.
Dr Chabot tried to persuade Ms B to accept some form of therapy but she refused. She asked
him instead to assist her suicide.

Dr Chabot was of the opinion that Ms B was experiencing intense, long-term psychic
suffering with no prospect of improvement. He was also of the opinion that her explicit and
clearly expressed request for assistance with suicide was well-considered, and based on
understanding of her situation and the consequences of her decision. He further believed that
her rejection of therapy was well-considered. He consulted seven independent experts who
all agreed with his assessment of Ms B's situation. None of the doctors consulted by Dr
Chabot examined Ms B.

In September 1991, Dr Chabot helped Ms B commit suicide by prescribing a lethal dose of
drugs. She took these drugs in the presence of Dr Chabot, a general practitioner and a friend.
Dr Chabot reported her death to the local coroner as death by physician-assisted suicide. He
was prosecuted under Article 294 of the Penal Code. In April 1993 the District Court in
Assen applied the defence of necessity and found him not guilty of this offence. The Court of
Appeals in Leeuwarden upheld the trial court's decision in September 1993. The Dutch
Supreme Court, however, overturned the rulings of the lower courts. It concluded that the
defence of necessity should have been rejected in this case and accordingly found Dr Chabot
guilty as charged.
In the course of its judgment the Supreme Court stated the following:

- the necessity defence is not limited to cases where the patient is in the terminal phase of an illness of somatic (physical) origin.

- the necessity defence can also apply where a patient's suffering is entirely of a non-somatic origin (i.e., mental suffering only, rather than suffering due to physical pain). A psychiatric patient's wish to die therefore can be legally considered the result of a competent and voluntary judgement.\textsuperscript{158} Further, the suffering of a psychiatric patient can be legally considered 'lacking any prospect for improvement' if the patient has refused a realistic therapeutic alternative.

- the courts must approach cases where the necessity defence is said to be based on non-somatic suffering 'with exceptional care'. Accordingly, the defence cannot be invoked in these cases unless the patient has been examined by an independent colleague/medical expert.\textsuperscript{159}

Dr Chabot was convicted under Article 294, therefore, not because the defence of necessity could not apply in a situation where a patient's suffering was of the kind experienced by Ms B. Rather it was because he had not ensured that Ms B was actually examined by another doctor before he assisted her suicide.

Despite finding Dr Chabot guilty, in view of 'the person of the defendant and the circumstances in which the offence was committed', the Supreme Court declined to impose any punishment. In February 1995, however, Dr Chabot was reprimanded by a Medical Disciplinary Tribunal which concluded that his behaviour had 'undermined confidence in the medical profession'.\textsuperscript{160}

In September 1994 the Dutch government revised its prosecutorial guidelines to reflect the holdings of the Supreme Court. If a patient has a psychiatric disorder, the guidelines now require the doctor who receives the request for physician-assisted suicide or active voluntary euthanasia to have the patient examined by at least two other doctors, one of whom must be a psychiatrist. The government also responded to the Supreme Court's ruling by dropping 11 of 15 pending prosecutions in relation to cases where the patient was not in the 'terminal phase' of a somatic illness.\textsuperscript{161}

Like many other developments in the Netherlands relating to the regulation of the practice of euthanasia, the Chabot case has been used to found arguments that lead to opposing conclusions. Some commentators view the case as evidence that once the law begins to allow doctors to perform physician-assisted suicide and active voluntary euthanasia, even in strictly and narrowly defined circumstances, the categories of patients who may be legally euthanased will inevitably expand. Thus, it is claimed, the Chabot case is 'another step down the slippery slope' towards a situation where euthanasia is tolerated and practised in an (even
more) unacceptably wide range of circumstances, including situations where the patient has not requested death.

Other commentators acknowledge that the Chabot case raises the real possibility that Dutch courts may in the future 'hold assistance with suicide justifiable in several categories of cases in which the person concerned is not "sick" at all (eg the case of very elderly persons who are incapacitated in various ways and simply "tired of life") and that [f]rom there it is only a small additional step to the case in which the person concerned is not suffering at all at the time the request is made but, in anticipation of coming deterioration, wants to be in a position to choose the time of death in advance of becoming incapacitated and dependent'.

They reject the claim, however, that such developments necessarily will result in an increase in the incidence of involuntary euthanasia. Some commentators also describe the Chabot case as a development that tightens the restrictions on the practice of euthanasia in the Netherlands. They argue that the Supreme Court's ruling clarifies the circumstances in which it is not acceptable (as well as the circumstances in which it is acceptable) for a doctor to help a psychiatric patient commit suicide.

Other Recent Developments

The Prins case and the Kadijk case

Since the Supreme Court ruling in the Chabot case, the Dutch courts have inspired further controversy in two cases in which doctors ended the lives of severely disabled infants, who were in severe pain and were expected to die within months. In April 1995 the District Court in Alkmaar found Doctor Henk Prins formally guilty of the murder in 1993 of a baby girl who had been born with a partly formed brain and spina bifida, by giving her a lethal injection after consultation with her parents and other doctors. The court refused, however, to punish the doctor. In November 1995 the Amsterdam Appeals Court affirmed the lower court's decision. It did so on the basis that the doctor had adhered closely to the guidelines that regulate active voluntary euthanasia, had acted at the explicit request of the child's parents, and generally had behaved 'according to scientifically and medically responsible judgments, and in line with ethical norms'. A week later, the District Court in Groningen reached an almost identical conclusion in another case where a doctor had been charged with murder for administering a lethal injection to a severely disabled baby. Both cases were reported as 'the latest in a series of legal precedents that are slowly eroding the Netherlands' strict limitations on euthanasia'. Both cases are on appeal to the Supreme Court of the Netherlands as test cases.
New KNMG Guidelines

In August 1995, the Royal Dutch Medical Association (Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, KNMG) adopted new guidelines for doctors who choose to accede to a patient's request for the hastening of death. Under the new guidelines patients must self-administer drugs whenever possible. The new guidelines also clarify a doctor's obligation to consult a second doctor before proceeding with euthanasia, emphasising the need for this consultation to take place with an experienced doctor who has no professional family relationship with either the patient or the first doctor. The new guidelines also affirm that a doctor is under no obligation to perform euthanasia, but state that a doctor who is opposed on principle to euthanasia should make his or her views known as soon as possible to a patient who raises the subject, and should help the patient find another doctor who is willing to assist.165

These new guidelines have not yet been incorporated by the Dutch Parliament into the official reporting procedure, that confirms a doctor's compliance with the 'rules of careful practice' and underpins the prosecutorial policy discussed above. The Dutch Parliament may consider doing so later this year, however, when it considers the results of more Remmelink-type research that is currently being undertaken to assess the operation of this reporting procedure. The researchers - Van der Wal and Van der Maas - are expected to release their report in October or November 1996.

New NVVE proposal for law reform

In January 1996, the Dutch Federation for Voluntary Euthanasia (Nederlandse Verniging voor Vrijwillige Euthanasia, NVVE) released a proposal to change the law relating to euthanasia in the Netherlands. The proposal recommends that euthanasia should not be punishable by law unless it is proved that a doctor has not adhered to specified criteria; rather than the current situation, where euthanasia technically remains illegal unless it is shown that a doctor has adhered to specified criteria. Media statements made around the same time by the Dutch Minister for Justice indicated her support for this kind of change to the law. The Dutch Parliament expressed concern at her statements, on the basis that they inappropriately preempted the Parliament's forthcoming assessment of the findings of the empirical research that is currently being done on the euthanasia reporting procedure.

United States of America

In the United States of America, the laws in forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide, including physician-assisted suicide.166
In recent years there have been a number of unsuccessful attempts to introduce state legislative reform to allow a doctor to comply with a patient's request for intervention to hasten the patient's death. These attempts have included Initiative 119 in the state of Washington, which proposed the legalisation of both physician-assisted suicide and active voluntary euthanasia, for competent patients who were expected to die within six months. Initiative 119 was rejected 54%:46% by voters at a state referendum that took place in November 1991. In 1992, Californian voters rejected a similar proposal known as Proposition 161, also by a majority of 54%: 46%.

Concern at these developments prompted the establishment of State task forces to examine whether the law in this area should be reformed. The May 1994 report of the New York State Task Force on Life and Law recommended retaining the criminal prohibition on assisted suicide in that State. By contrast, the June 1994 report of the Michigan Commission on Death and Dying recommended decriminalising physician-assisted suicide under some circumstances.

To date, the only jurisdiction in the United States of America that has passed legislation expressly permitting a doctor to intervene to hasten a patient's death is the state of Oregon. The Oregon legislation was passed in November 1994 and permits physician-assisted suicide. This legislation is discussed in more detail below.

Attempts continue in other States to enact legislative reform similar to the new Oregon law. Attempts also continue, however, to introduce legislation specifically prohibiting assisted suicide in states where such a prohibition is not yet in statutory form.

US courts have also recently begun to address the issue of physician-assisted suicide. Two important cases examining the constitutional validity of statutes prohibiting physician-assisted suicide - Compassion in Dying v. State of Washington and Quill v. Vacco et al - were decided by federal Courts of Appeal earlier this year. Both cases are discussed further below.

The Oregon Death With Dignity Act (1994)

The Oregon Death With Dignity Act (also known as 'Measure 16') was passed as the result of voter approval of Ballot Measure 16 in the Oregon general election in November 1994. The question posed by Ballot Measure 16 was: 'Shall law allow terminally ill adult patients voluntary informed choice to obtain physician's prescription for drugs to end life?'. This question was answered in the affirmative by 51% of voters and in the negative by 49% of voters.

The Oregon Death With Dignity Act authorises a specific kind of physician-assisted suicide: it allows a patient to obtain a physician's prescription for drugs to end the patient's life.
Unlike the Northern Territory's Rights of the Terminally Ill Act 1995, however, the Oregon legislation does not also permit a doctor to carry out active voluntary euthanasia. Under the Oregon Death With Dignity Act, only the patient may administer the medication to end his or her life; the legislation does not authorise 'a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia'.

Health care providers who assist a patient to die by prescribing lethal drugs in 'good faith compliance' with the Oregon legislation are immune from civil and criminal liability and from professional disciplinary action. The following conditions all must be satisfied before a patient can be lawfully assisted to die:

- The patient must be a resident of Oregon.
- The patient must be at least 18 years old.
- The patient must be suffering from a 'terminal disease'. This is defined as 'an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months'.
- The patient must have 'voluntarily expressed his or her wish to die'.
- The patient's decision must be sufficiently informed. This means that it is 'based on an appreciation of the relevant facts' and after being fully informed by the attending physician of: the patient's medical diagnosis and prognosis; the risks and results of taking the medication; and the feasible alternatives, including comfort care, hospice care and pain control.
- Two doctors must verify that the patient has a terminal disease, is capable, and has made a voluntary and informed decision. These doctors must be 'the attending physician' (the doctor with primary responsibility for the patient's care and treatment of the patient's terminal disease) and 'the consulting physician' (a doctor qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease).
- The patient must not be suffering from 'a psychiatric or psychological disorder, or depression causing impaired judgment'. If either the attending physician or the consulting physician believes the patient may be so suffering, that doctor is obliged to refer the patient for counselling by a state licensed psychiatrist or psychologist. No medication to end the patient's life can be prescribed until the psychiatrist or psychologist determines that the patient is not suffering in this way.
- The patient must make two oral requests, and one written request in the form prescribed by the legislation.
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- The written request must be witnessed by two people attesting that the patient is acting voluntarily. At least one witness must not be a relative or heir of the patient.

- The second oral request must be made to the attending physician no sooner than 15 days after the first oral request. When the patient makes the second oral request, the attending physician must offer the patient the opportunity to rescind the request.

- The prescription for medication to end the patient’s life must not be written sooner than 15 days after the patient’s initial oral request and 48 hours after the patient’s written request. When the prescription is written, the attending physician must offer the patient the opportunity to rescind the request.

- The attending physician must inform the patient that the patient may rescind the request at any time and in any manner. Such rescission by a patient will be effective ‘without regard to his or her mental state’.

- The attending physician must ask the patient to notify next of kin about the request. The patient, however, is under no obligation to do so.

- The doctors must document in the patient’s medical record that all requirements under the legislation have been met. Although these records shall not be available for inspection by the public, the Oregon State Health Division must annually review a sample of these records and produce statistical reports of information derived from its reviews.

This legislation does not impose any duty upon a doctor to participate in the provision of medication to end a patient’s life. If a doctor is unable or unwilling to so participate, however, and the patient transfers his or her care to another doctor, the legislation specifies that the first doctor must comply with the patient’s request to transfer a copy of relevant medical records to the new doctor.

The Oregon Death With Dignity Act has not yet come into operation as its operation has been suspended by injunction pending the results of a challenge to its constitutional validity. This legal challenge was initiated in November 1994 by a group of doctors, patients and operators of residential care facilities. In August 1995 the Oregon Federal District Court held that the legislation was unconstitutional and therefore invalid. The District Court concluded that the legislation violated the Equal Protection Clause of the Fourteenth Amendment to the US Constitution - which prohibits a state from denying ‘to any person within its jurisdiction the equal protection of the law’, unless the denial is justified according to a legitimate state interest. The District Court stated that the Fourteenth Amendment was violated because the legislation withheld from terminally ill persons the same legal protections from suicide that apply to other citizens of Oregon. The court concluded that this withholding was not rationally related to any legitimate state interest and therefore was not justified. The
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legislation was said to lack sufficient safeguards to ensure that the means to commit suicide was only provided in response to a voluntary request by a competent, terminally ill patient.

The District Court based its conclusion on the following criticisms of the legislation:

• The procedure for determining whether a terminally ill patient was competent to choose physician-assisted suicide was insufficiently rigorous to protect incompetent patients from being helped to commit suicide. The legislation did not require mental and social evaluations of competency by appropriately trained and independently appointed professionals - instead, too much reliance was placed on the assessment of the patient's mental state by the attending physician and consulting physician, neither of whom was required to be a psychiatrist, psychologist or counsellor. Nor did the legislation contain a mechanism for independent review of the patient's allegedly competent request. Nor did it contain the kind of safeguards used in comparable mental health situations, such as cases involving the detention of the mentally ill, to distinguish between competent and incompetent patients.

• The legislation protected a doctor from liability whenever the doctor's actions were taken 'in good faith'. One effect of this would be to allow a doctor to prescribe a lethal drug dose after negligently misdiagnosing a patient's condition or competence, provided this was done 'in good faith'. This would create an unjustified exception to the general legal requirement that doctors meet objectively reasonable standards when providing medical care to patients.

• The legislation did not require that the prescribed drugs be taken in the presence of a physician, at any particular time, or in any particular manner. The legislation therefore did nothing to ensure that the final decision to commit suicide by taking the lethal drugs - rather than the decision to obtain the prescription of those drugs - would be made voluntarily by a competent patient.

The decision of the District Court in this case is currently on appeal to the United States Court of Appeals for the Ninth Circuit. The result of that appeal may be influenced by the outcome in the two federal Court of Appeal cases discussed immediately below.

Compassion in Dying v. State of Washington

The question of whether a statutory prohibition on physician-assisted suicide violates an individual patient's rights under the United States Constitution was considered for the first time by a federal Court of Appeals in the recent case Compassion in Dying v State of Washington. The judgement in this case was delivered on 6 March 1996.
The case involved a challenge to the constitutional validity of a provision of a Washington statute that made it a crime to aid another person to attempt suicide. The parties who initiated the action - four doctors, three terminally ill patients and a Washington non-profit organisation called Compassion in Dying - contended that this statutory provision was invalid to the extent that it prohibited doctors from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths. They claimed the statutory provision was invalid on two bases:

- The provision impermissibly prevented the exercise by terminally ill patients of a constitutionally-protected liberty interest, in violation of the Due Process Clause of the Fourteenth Amendment to the US Constitution.
  
  The Due Process Clause prohibits a state from depriving 'any person of life, liberty or property without due process of law', unless the deprivation is justified according to a legitimate state interest. The U.S. Supreme Court has held that the 'liberty interest' protected under this clause gives rise to a constitutional right to privacy. The Supreme Court has used this right to restrict the power of state governments to interfere with personal decision-making in relation to matters such as contraception,175 marriage,176 abortion,177 family relationships,178 child rearing and education.179 The Supreme Court has offered the following justification for constitutional protection of these 'private' decisions:

  These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.180

- The provision impermissibly distinguished between similarly situated terminally ill patients, in violation of the Equal Protection Clause of the Fourteenth Amendment to the US Constitution. As explained above, the Equal Protection Clause prohibits a state from denying 'to any person within its jurisdiction the equal protection of the law', unless the denial is justified according to a legitimate state interest.

By a majority of 8:3, the federal Court of Appeals for the Ninth Circuit agreed that the Washington statutory provision was unconstitutional because it violated the Due Process Clause.

The majority judges reached this conclusion via a two stage process of legal analysis. First, they identified a liberty interest in choosing the time and manner of one's own death. They also described this interest as a "constitutionally recognised 'right to die". They deduced the existence of this liberty interest after examining historical attitudes towards suicide, current societal attitudes towards physician-assisted suicide and the manner of death, and previous
Supreme Court decisions addressing the scope of the liberty interest under the Due Process Clause.

The majority judges believed that two of these Supreme Court decisions in particular were 'fully persuasive' as to the existence of a due process liberty interest in controlling the time and manner of one's own death. In one of these cases, the 1992 case Planned Parenthood v. Casey the Supreme Court reaffirmed a woman's liberty interest in deciding whether or not to have an abortion, on the basis that such a decision was central to her personal dignity and autonomy. The majority judges in the instant case concluded that a terminally ill person's decision concerning how and when to die is at least as central to personal dignity and autonomy as the abortion decision. It considered that 'no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end'.

The other Supreme Court case on which the majority relied was the 1990 case Cruzan v. Director, Missouri Department of Health. That case involved a constitutional challenge to a Missouri statute prescribing that life-sustaining treatment, including artificial feeding and hydration, could not be withdrawn from a legally incompetent patient without 'clear and convincing evidence' that this is what the patient would have wanted in the circumstances. The Supreme Court in Cruzan held by a majority of 5:4 that this restriction did not violate patients' rights under the due process clause. In reaching this conclusion, however, four of the five majority judges averted to the existence of a competent person's constitutionally protected right to refuse any kind of unwanted medical treatment. One of the majority judges went further and explicitly affirmed the existence of such an interest, as did all four of the dissenting judges.

The majority of the federal Court of Appeals in Compassion in Dying v. State of Washington stated that it was 'clear that Cruzan stands for the proposition that there is a due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means'. As the Supreme Court in Cruzan had also recognised that refusal of treatment such as artificial feeding and hydration would inevitably lead to death, the Court of Appeals went on to conclude that Cruzan 'necessarily recognises a liberty interest in hastening one's own death'.

Having identified a due process liberty interest in choosing the time and manner of one's own death, the majority acknowledged that this did not mean an individual has 'a concomitant right to exercise that interest in all circumstances or to do so free from state regulation'. The second part of the majority's legal analysis therefore was an examination of whether Washington's statutory ban on assisting suicide was a constitutionally justified restriction on the exercise of the liberty interest.

The majority assessed the validity of the restriction by weighing the liberty interest of the individual against six countervailing and legitimate state interests. These were:
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• the state's general interest in preserving life

  The majority stated that, even though the protection of life is one of the most important functions of the state, this interest is not absolute. American law already recognised that the state's interest in preserving life is 'dramatically diminished' if the person it seeks to protect is terminally ill, or permanently comatose, and has expressed a wish (either himself or through a duly appointed representative) that he be permitted to die without further medical treatment. Accordingly, 'while the state may still seek to prolong the lives of terminally ill or comatose patients or, more likely, to enact regulations that will safeguard the manner in which decisions to hasten death are made, the strength of the state's interest is substantially reduced in such circumstances'.

• the state's more specific interest in preventing suicide

  The majority felt that, while the state has a legitimate interest in preventing suicide in general, that interest, like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die. The majority concluded this because, unlike many other people who might wish to commit suicide, terminally ill adults cannot be restored to a state of physical and mental well-being but can only be maintained in a debilitated and deteriorating state.

  The majority noted that the state had already recognised this by allowing competent, terminally ill patients to choose to hasten death by instructing a doctor to cease administering life-sustaining medical treatment (including artificial food and water), or by asking a doctor to administer death-inducing drugs for pain relief. The majority did not consider that there was any difference in kind, for either constitutional or ethical purposes, between physician-assisted suicide and these other forms of life-ending medical conduct that are not subject to legal or moral sanction. Any difference was one of degree only, and that difference was not enough to make the state's interest in preventing suicide substantially stronger in the case of physician-assisted suicide than it was in the case of other forms of death-hastening medical assistance.

  The majority went further, and doubted whether the state's interest in preventing suicide was even implicated in this case. It questioned whether deaths involving 'physician-assisted suicide' should be classified as suicides at all, when other situations involving a decision by a terminally ill patient to hasten by medical means a death already in process (such as deaths resulting from refusal of life-sustaining medical treatment) were not so classified.\[188\]

  The majority also referred to evidence that prohibiting assisted suicide in order to deter suicide could be counter-productive. The majority felt that some terminally ill
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patients would kill themselves before they became physically incapacitated, in order to avoid a situation where they were no longer able to end their own lives and where the law would not allow the medical profession to help them die in the manner of their choosing.

- the state's interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair or undue influence

  The majority acknowledged that a state has a legitimate interest in prohibiting assisted suicide, on the grounds that allowing others to help may increase the incidence of suicide, undermine society's commitment to the sanctity of life, and adversely affect the person providing the assistance. It felt, however, that this interest was at its weakest when the assistance was provided by or under direction of a doctor and the person being assisted was terminally ill.

  The majority also addressed the concern that allowing physician-assisted suicide would bring vulnerable people under undue pressure to end their lives. It dismissed as 'ludicrous' the argument that the poor, members of minority groups and the physically disabled would be pressured into committing physician-assisted suicide. It did consider, however, that there was a valid and serious concern that their lives needed safeguarding from 'callous, financially burdened or self-interested' relatives or others who have influence over them. At the same time, the majority was reluctant to say that it is improper for a competent and terminally ill adult to take the economic welfare of their loved ones into consideration when deciding when to die, particularly in 'a society in which the costs of protracted health care can be so exorbitant' and there is a lack of universal access to health care.

  The majority also felt that the involvement of a doctor in the decision-making process would provide an added safeguard against attempts by relatives to coerce the vulnerable to end their lives. The majority expressed the gravest doubts that doctors would assist a patient to die if there were any serious doubt about the patient's true wishes, as to do so would be 'contrary to the physicians' fundamental training, their conservative nature, and the ethics of their profession'.

  The majority nonetheless acknowledged that, while steps can be taken to minimise substantially the danger of patients being subject to undue influence, this danger cannot be wholly eliminated. The majority accordingly concluded that this state interest is of 'more than minimal weight' in this context, and should be treated seriously in balancing the competing interests of state and individual.

- the state's interest in protecting children, other family members and loved ones
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- The majority considered that the state's legitimate interest in safeguarding the interests of innocent third parties, such as minor children and other people dependent on a person who wishes to commit suicide, was reduced to almost negligible weight when that person is terminally ill. It considered that it would harm rather than further the interests of these third parties to witness a loved one being forced to suffer an unnecessarily painful and protracted death.

- The state's interest in protecting the integrity of the medical profession.

  - The majority did not accept that allowing doctors to engage in physician-assisted suicide would be at odds with their role as healers and thus erode their professional integrity. It considered that, to the contrary, permitting physician-assisted suicide would enhance the integrity of the medical profession. In the opinion of the majority, allowing doctors to help terminally ill patients hasten their deaths in this way, without the current need to act covertly and risk criminal sanction, would enable doctors better to fulfil their duty to help the sick. The majority noted that this opinion was shared by the growing number of doctors who openly support physician-assisted suicide.

  - The majority also concluded that the personal integrity of individual doctors would not be compromised by decriminalising physician-assisted suicide. Decriminalisation would instead enable doctors, as well as patients, to make decisions and act in a way consistent with their individual moral beliefs. Doctors whose personal beliefs would prevent them from assisting patients in this way would be free not to do so; and doctors whose personal beliefs would allow or require them to assist patients in this way similarly would be free to follow the dictates of their conscience. The majority felt that terminally ill patients could only benefit from the opportunity to choose to receive medical care from someone 'whose view of the physician's role comports with theirs'.

- The state's interest in avoiding the risk that legal recognition of a 'right to die' would lead to abuse and unacceptable extensions of that right

  - The majority examined the argument that recognising that competent, terminally ill patients have a right to physician-assisted suicide will place courts and society on a 'slippery slope', inevitably resulting in a situation where people are put to death without their consent.

  - The majority rejected this argument as 'nihilistic' and unsupported by empirical evidence. It rejected assertions that the experience in the Netherlands supports the 'slippery slope' argument. It conceded that recognition of any right creates the possibility of abuse, but pointed out that the Supreme Court has never refused to recognise a substantive due process liberty right or interest merely because there
were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly'.

- The majority emphasised that in this case it was only being asked to determine the narrow question of whether it was unconstitutional to prohibit doctors prescribing lethal medication for use by terminally ill patients who wished to hasten their death. It acknowledged, however, that legal recognition of a terminally ill patient's right to choose physician-assisted suicide might logically lead, in subsequent cases, to legal recognition of a terminally ill patient's right to choose physician-aid-in-dying. It did not consider, however, that such recognition necessarily would lead to courts approving the practice of ending people's lives without their consent:

We would be less than candid ... if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. In the first case - volitional death - the physician is aiding or assisting a patient who wishes to exercise a liberty interest, and in the other - involuntary death - another person acting on his own behalf, or, in some instances society's, is determining that an individual's life should no longer continue. We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end. [p16]

The majority concluded that all these state interests were at their weakest, and the liberty interest in choosing the time and manner and one's death was at its strongest, in the case of competent terminally ill individuals. The majority conceded that the state has a particularly strong interest in protecting individuals who are making life and death decisions from undue influence and other forms of abuse. It concluded that the state therefore has a wide power to regulate the exercise by a terminally ill person of the liberty interest in choosing the time and manner of one's death, but that this power does not allow the state to ban its exercise completely. The Washington statute prohibiting physician-assisted suicide did effectively prevent terminally ill people from choosing the time and manner of their own deaths, because most terminally ill people could not hasten their own deaths without the assistance of a physician. The Washington statute therefore imposed an unacceptable constraint on the liberty interest of terminally ill, competent adults who wished to hasten their deaths using medication prescribed by their physicians. To the extent that the statute imposed such a constraint, it violated the Due Process Clause and therefore was unconstitutional.

Having reached this conclusion, the majority considered it unnecessary to examine the argument that the Washington statute also violated the Equal Protection Clause. The majority stated, however, that it did not agree with the reasoning of the District Court of Oregon in *Lee v. State of Oregon* that lead that court to conclude that the Oregon Death With Dignity Act violated the Equal Protection Clause.\(^{189}\)

The three dissenting judges concluded that the Washington statute violated neither the Due Process Clause nor the Equal Protection Clause. In relation to the former, they denied that
the statute infringed a liberty interest in choosing to commit suicide. One dissenting judge categorically denied that there was any such interest. Another dissenting judge doubted that there was any such interest, but did not finally decide the question. The third dissenting judge accepted that there was a liberty interest in choosing to commit suicide, but characterised it as an interest of much less strength than the liberty interest in 'choosing the time and manner of one's own death' relied upon by the majority judges. The dissenting judges also concluded that the state interests competing against an individual's exercise of a liberty interest in this context were of much greater force than they were considered to be by the majority. The dissenting judges discussed four state interests:

- the state's interest in the preservation of life
  - The dissenting judges asserted that this state interest remains 'at full strength' in the case of a terminally ill person who wishes to commit assisted suicide. It was their opinion that the state's interest in preserving life is only weakened where continued medical treatment would do no more than postpone death, and where a patient therefore becomes 'nonviable' in the sense that the patient would die without life-sustaining treatment.

- the state's interest in the prevention of suicide
  - The dissenting judges concluded that the state's interest in the prevention of suicide does not diminish with the onset and advancement of terminal illness. They based this conclusion on the view that suicidal tendencies are a manifestation of medical and psychological suffering, and the state retains a continuing interest in addressing and relieving that suffering.

- the state's interest in maintaining the integrity of the medical profession
  - Physician-assisted suicide was seen by the dissenting judges to be wholly inconsistent with, and damaging to, the ethical integrity of the medical profession. They pointed to the fact that the American Medical Association's Code of Medical Ethics prohibits doctors from participating in physician-assisted suicide. They also noted that, aside from criminal sanctions, doctors are subject to professional sanctions and disciplinary action if they prescribe drugs to their patients to help them commit suicide.

- the state's interest in protecting the interests of innocent third parties
  - The dissenting judges considered that there was a considerable risk that the poor, the elderly, the disabled and minorities would be subject to undue pressure to commit physician-assisted suicide if it were legalised. This pressure could take the form of direct coercion or result from the inadequate treatment of pain and suffering. They considered that no safeguards - apart from maintaining 'a bright-line rule against
physician-assisted suicide' - could adequately protect these vulnerable groups. They cited the Dutch experience of euthanasia in support of their conclusion that safeguards could not ensure that vulnerable patients would not be killed without their knowledge or consent if physician-assisted suicide were permitted.

The dissenting judges also expressed a concern that a right to physician-assisted suicide 'could severely disrupt the economic interest of the relatives, partners and associates' of patients who died in this way, as life insurance policies and other methods of estate planning would not operate if the deceased committed suicide.

The dissenting judges concluded that any liberty interest in committing suicide, possessed by a competent, terminally ill adult, was legitimately restricted by the Washington statute. This was because the Washington statute rationally advanced the four legitimate and strong state interests identified above.\(^{191}\)

It is expected that the Supreme Court of the United States will hear an appeal against the ruling of the Ninth Circuit Court of Appeals in this case.

**Quill v. Vacco et al**

Shortly after the decision of the Ninth Circuit Court of Appeals in *Compassion in Dying v. State of Washington*, on 2 April 1996 the Second Circuit Court of Appeals delivered its judgment in *Quill v. Vacco et al*. That case also examined the constitutional validity of a statutory prohibition on physician-assisted suicide.

The provisions under scrutiny in this second case were the parts of the New York Penal Law that criminalised assisted suicide. The provisions were alleged to be unconstitutional to the extent that they prohibited doctors from prescribing lethal medication to be self-administered by a mentally competent, terminally ill adult in the final stages of terminal illness. The legal challenge was initiated by three doctors and three terminally ill patients.

The arguments advanced by the litigants in *Quill v. Vacco et al* were similar to those before the court in *Compassion in Dying v. State of Washington*. The New York statutory provisions were alleged to be unconstitutional on the basis that they violated both the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment.

The majority of the Second Circuit Court of Appeals refused to accept that the New York statutory provisions violated any fundamental liberty interest under the Due Process Clause - specifically, the asserted right of competent, terminally ill persons to assisted suicide in the final stages of their illness. They felt unable to conclude that this right to assisted suicide could be read into the Constitution, on the basis that the Supreme Court of the United States
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had not yet identified this new right and had also advised restraint in identifying new fundamental rights.\textsuperscript{192}

The two majority judges did accept, however, that the New York statutory provisions violated the Equal Protection Clause. They stated that these provisions clearly did not treat similarly situated citizens alike. This was because the law in New York allowed patients in the final stages of terminal illness who were attached to life-support systems to hasten their deaths by directing the removal of that life support, but did not allow patients who were in a similar situation - except for the previous attachment of life-support systems - to hasten their death by self-administration of prescribed drugs. The majority saw no valid difference, for the purposes of Equal Protection analysis, between the so-called 'passive' assistance in dying permitted by the law and the so-called 'active' assistance forbidden by the statutory provisions under scrutiny.

The majority further held that this unequal treatment was not rationally related to any legitimate state interest. This conclusion also rested on the fact that New York law allowed patients to hasten their deaths by ordering the withdrawal of life-sustaining treatment. The majority argued that if the state considered a patient's choice to hasten death in that context to be consistent with the interests of the state, it must also be consistent with those state interests to allow a patient to choose to hasten death by taking lawfully prescribed medication. These judges therefore concluded that the New York prohibition on assisted suicide violated the Equal Protection Clause to the extent that it applied to mentally competent, terminally-ill patients in the final stages of terminal illness who wished to self-administer lethal drugs.

The third judge in this case agreed that the New York statutory provisions should be struck down. His reasoning, however, differed from that of the majority. He concluded that the constitutional validity of the statutory prohibition in question was 'highly suspect' - both under the Due Process Clause and the Equal Protection Clause - but not clearly invalid under either clause. The constitutional validity of the prohibition depended largely on the strength of the state interests involved, but the New York legislature had not provided current and clear statements explaining which state interests the law aimed to protect. Accordingly, this judge was prepared to strike down these particular statutory prohibitions as unconstitutional - but took no position on the constitutional validity of similar provisions which might be enacted in the future and accompanied by clear explanations of the aims of the legislators.

An appeal against this decision of the Second Circuit Court of Appeals is expected. Should this case or \textit{Compassion in Dying v. State of Washington} reach the Supreme Court, it remains to be seen how the highest court in the United States of America would assess the arguments raised in these cases in relation to the Due Process Clause and Equal Amendment Clause.\textsuperscript{193}
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United Kingdom

The criminal law prohibits physician-assisted suicide and active voluntary euthanasia

Both physician-assisted suicide and active voluntary euthanasia are prohibited by the criminal law in the United Kingdom.

Physician-assisted suicide is prohibited in England and Wales by section 2 of the Suicide Act 1961 (UK). That section makes it a criminal offence to aid, abet, counsel or procure the suicide of another, or an attempt by another to commit suicide. The crime carries a maximum sentence of 14 years' imprisonment.

Active voluntary euthanasia comprises murder. Murder is a common law offence in the United Kingdom and carries a mandatory life sentence. A murder charge can be reduced to manslaughter if the defendant can invoke any one of three exceptions contained in the Homicide Act 1957 (UK): provocation, diminished responsibility and suicide pacts. None of these exceptions are likely to apply in a situation where a doctor has killed a patient at the patient's request.

Unsuccessful attempts to change the law

There have been a number of unsuccessful attempts in the United Kingdom to pass legislation to legalise physician-assisted suicide and/or active voluntary euthanasia.

The first attempt took place in 1936. Lord Ponsonby of Shulbrede introduced the Voluntary Euthanasia (Legalisation) Bill into the House of Lords as a Private Member's Bill. The Bill was promoted by the Voluntary Euthanasia Legalisation Society, which had been founded a year earlier. The Bill proposed allowing doctors, in strictly limited circumstances, to comply with a patient's request to end the patient's life. Only competent adult patients suffering from a fatal and incurable disease accompanied by severe pain would have been able to receive this assistance. The Bill contained procedural safeguards to ensure that euthanasia was voluntary. The patient would have needed to sign a prescribed form in the presence of two witnesses. This form and two medical certificates would then be sent to an official euthanasia referee appointed by the Minister of Health. The official euthanasia referee would then interview the patient to assess whether the patient's request was voluntary. Only then would euthanasia be performed, in the presence of an official witness - a justice of the peace, a barrister, a solicitor, a doctor, a minister of religion or a registered nurse. The Bill failed at its second reading stage, defeated by a vote of 35:14.
The House of Lords next debated the issue of active voluntary euthanasia in 1950, when Lord Chorley introduced a Motion 'to call attention to the need for legalising voluntary euthanasia'. The Motion was withdrawn without a vote after vigorous debate. In 1969 Lord Raglan introduced a Private Member's Bill into the House of Lords that sought to legalise active voluntary euthanasia in certain circumstances. The general purpose of the Bill was stated in its Explanatory Memorandum to be to authorise physicians to give euthanasia to a patient who is thought on reasonable grounds to be suffering from an irremediable physical condition of a distressing character, and who has, not less than 30 days previously, made a declaration requesting the administration of euthanasia in certain specified circumstances one or more of which has eventuated. This Bill was defeated at its second reading stage by a vote of 61:40.

In 1970 Hugh Gray MP presented the Voluntary Euthanasia Draft Bill in the House of Commons under the Ten Minute Rule. There was no division on the Bill and therefore no vote.

Baroness Wootton's Incurable Patients' Bill, defeated at its second reading in the House of Lords in 1976, emphasised the entitlement of an 'incurable patient' to 'take steps that may cause his own death'. This would have legalised physician-assisted suicide in certain circumstances.

In 1985 Lord Jenkins introduced the Suicide Act 1961 (Amendment) Bill into the House of Lords. The Bill aimed to introduce a defence to a prosecution for assisting suicide under the Suicide Act 1961, which would operate if the accused had 'behaved reasonably and with compassion and in good faith'. This Bill failed at its first reading stage in November 1985, by 48 votes to 15.

In May 1990 Roland Boyes MP sought leave to bring in a Bill under the Ten Minute Rule to legalise active voluntary euthanasia. The House of Commons refused leave by 101 votes to 35.

The most recent attempt to enact this kind of legislative reform took place in 1993. Piara Khabra MP introduced a Private Member's Bill into the House of Commons under the Ten Minute Rule. The Voluntary Euthanasia Bill sought to allow a doctor to accede to an incurably ill patient's written and witnessed request for help in hastening death. The Bill would have permitted a doctor to provide advice, counselling, assistance or euthanasia (defined as 'any act at the request of a person which procures directly or indirectly the rapid death of that person at their own hand or otherwise'). The Bill was withdrawn before any vote was taken.
In 1993, after the House of Lords handed down its decision in the important and controversial case *Airedale NHS Trust v. Bland*, a Select Committee was established to investigate the legal, ethical and social issues surrounding medical treatment decisions at the end of life. More specifically, the House of Lords Select Committee on Medical Ethics was required to consider:

- the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to give or withhold consent;

- whether, and in what circumstances, actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests; and

- in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole.

The Select Committee received written and oral evidence from a wide range of interested individuals and organisations. The report of the Select Committee was published in January 1994. In this report, the Select Committee recommended that there be no change to the current law prohibiting active voluntary euthanasia and physician-assisted suicide.

In relation to active voluntary euthanasia, it was the opinion of the Select Committee that the right to refuse medical treatment 'is far removed from the right to request assistance in dying'. Thus, although the Select Committee strongly endorsed the right of a competent patient to refuse consent to any medical treatment, it refused to countenance changing the law to permit 'euthanasia' (which it defined as 'a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering') at the patient's request.

The Select Committee similarly recommended against the creation of a new offence of 'mercy killing' that would excuse deliberate killing (by doctors or others) with a merciful motive. It did support, however, the recommendation of a previous House of Lords Select Committee that the mandatory life sentence for murder should be abolished.

The Select Committee did not consider that the arguments in favour of legalising voluntary euthanasia were 'sufficient reason to weaken society's prohibition of intentional killing' which it considered to be 'the cornerstone of law and of social relationships'. Whilst acknowledging that there are 'individual cases in which euthanasia may be seen by some to be appropriate', the Select Committee was of the opinion that these cases 'cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions.' The Select Committee considered that if the law were to be liberalised to permit voluntary euthanasia:
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• it would be 'next to impossible' to establish sufficient safeguards to ensure that all acts of euthanasia were truly voluntary;

• this exception to the general prohibition of intentional killing 'would inevitably open the way to its further erosion'; and

• vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death.\textsuperscript{112}

It was finally the opinion of the Select Committee that:

\ldots dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.\textsuperscript{113}

In relation to physician-assisted suicide, the Select Committee identified 'no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection'.\textsuperscript{114}

The Select Committee acknowledged that its rejection of voluntary euthanasia and physician-assisted suicide as options for the individual entails 'a compelling social responsibility to care adequately for those who are elderly, dying or disabled'.\textsuperscript{115} This responsibility exists '[d]espite the inevitable continuing constraints on health-care resources'.\textsuperscript{116} The Select Committee accordingly also recommended that:

• High-quality palliative care should be made more widely available. This should be done by: improving public support for the hospice movement; ensuring that all general practitioners and hospital doctors have access to specialist advice; and providing more support for relevant training at all levels.\textsuperscript{117}

• Research into pain relief and symptom control should be adequately supported.\textsuperscript{118}

• Training of health-care professionals should better prepare them for ethical responsibilities, by giving greater priority to health-care ethics and counselling and communication skills.\textsuperscript{119}

• Long-term care of dependent people should have special regard to the need to maintain the dignity of the individual\textsuperscript{120}
Government Response to the Report of the House of Lords Select Committee on Medical Ethics

The British Government responded to the report of the House of Lords Select Committee on Medical Ethics in May 1994. In relation to active voluntary euthanasia, the Government stated that it 'strongly supports the Committee's rejection of the case for the legalisation of euthanasia and endorses the reasoning by which it has arrived at its conclusion'. The Government accordingly stated that its 'firm view is that the deliberate taking of life should remain illegal'. The Government also agreed with the Select Committee's recommendation against creating a new offence of 'mercy killing', on the basis that the Government '[does] not believe that active intervention to end life should be excused on the basis of the motive or the victim's consent' and 'to do so would undermine the law's uncompromising attitude towards deliberate killing'. The Government also stated, however, that it was 'not persuaded' that the mandatory life sentence for murder should be abolished as recommended by the Select Committee.

In relation to assisted suicide, the Government agreed that the law should not be changed. It stated that such change 'would be open to abuse and put the lives of the weak and vulnerable at risk'.

The Government responded as follows to the Select Committee's assertion that rejection of euthanasia means society has a compelling responsibility to care adequately for those who are elderly, dying or disabled:

The Government agrees. The Patient's Charter affirms the right of every citizen of whatever age to receive health care on the basis of clinical need. Similarly local authorities are required to arrange appropriate community care services for everyone who needs them. We expect these services to be tailored as far as possible to the needs of the individual person receiving them.

The British Government has subsequently reiterated its opposition to changing the law in relation to active voluntary euthanasia and physician-assisted suicide, in written answers in Parliament in April 1995 and January 1996.

Current developments

The possibility of law reform in this area nonetheless remains alive in Great Britain. Public debate remains vigorous and may become even more so as the next General Election approaches. Future attempts to change the law are likely to concentrate initially on legalising physician-assisted suicide rather than active voluntary euthanasia.
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The Voluntary Euthanasia Society, which now has over 20,000 members, has prepared a Draft Bill to amend the Suicide Act 1961 to allow physician-assisted suicide in certain circumstances. The Draft Bill is currently being widely circulated for comment.

The Institute of Law & Ethics in Medicine at Glasgow University is currently nearing completion of a research project funded by the Scottish Voluntary Euthanasia Society. That research project has surveyed the attitudes of health care professionals and of the general public to the legal status of physician-assisted suicide. The results of this research will be published in August 1996. The report is expected to include a Draft Bill for the legalisation of physician-assisted suicide.

Since mid-1995, the Centre of Medical Law and Ethics at King's College London, University of London, has convened a multidisciplinary working party to assess legal and ethical issues in relation to physician-assisted suicide. This working party is expected to produce a report some time in the future.

Canada

The Rodriguez Case

Both physician-assisted suicide and active voluntary euthanasia are prohibited under the Canadian Criminal Code. The constitutional validity of the criminalisation of physician-assisted suicide was examined by the Supreme Court of Canada in 1993, in the well-publicised Rodriguez case.

The applicant in the Rodriguez case, Sue Rodriguez, was a competent 42 year old woman suffering from amyotrophic lateral sclerosis ('Lou Gehrig's disease'). This incurable disease destroys cells in the spinal cord and brain stem and progressively leads to paralysis. It usually leads to death by suffocation due to loss of control over lungs and diaphragm. As the disease does not ordinarily affect mental capacity, sufferers tend to remain competent and aware of their progressive physical deterioration.

Sue Rodriguez wanted to be able to choose to die, if and when she reached the point when she no longer wished to continue living with her disease. She anticipated that this would occur at a time when she lacked the physical capacity to end her own life. She therefore sought a court declaration that it would be lawful for a doctor 'to set up technological means by which she might, by her own hand, at the time of her choosing, end her suffering, rather than prolong her death'. She claimed that section 241(b) of the Canadian Criminal Code, which makes it an offence to aid or abet suicide, was invalid to the extent that it prevented a terminally ill person from committing physician-assisted suicide.
She argued that the prohibition in section 241(b) violated her rights under a number of sections of the *Canadian Charter of Rights and Freedoms* (hereafter, 'the Charter'):

- **section 7** - 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 right to security of the person encompasses notions of personal autonomy and the right to make choices concerning one's own body. Ms Rodriguez argued that this right therefore must include the right of a person to control the method, timing and circumstances of his or her own death.

- **section 12** - the right not to be subjected to any cruel and unusual treatment or punishment.

- **section 15(1)** - the right to equality before the law without discrimination on grounds including physical disability. Ms Rodriguez argued that the prohibition on physician-assisted suicide infringed this right, because it prevented persons physically unable to end their lives without assistance from choosing suicide, when that option was in principle available to other members of the public without contravening the law.

Ms Rodriguez's arguments were rejected by the British Columbia Supreme Court, the British Columbia Court of Appeal, and finally by a narrow majority (5:4) of the Supreme Court of Canada.

The majority of the Supreme Court of Canada conceded that section 241(b) of the Criminal Code deprived Ms Rodriguez of security of her person under section 7 of the Charter, because it deprived her of autonomy over her person and caused her physical pain and distress. The majority concluded, however, that this deprivation accorded with principles of fundamental justice and therefore did not violate section 7. The majority placed heavy reliance on its observation that there was social consensus in Canada (and beyond) that human life should be protected and respected. The majority stated that the blanket prohibition on assisted suicide was neither arbitrary nor unfair. Rather, it was an appropriate legal protection designed to protect vulnerable members of society who might otherwise be persuaded to commit suicide. The blanket prohibition was further justified by a need to ensure maintenance of a belief in the sanctity of human life, and by concerns that legalising physician-assisted suicide could not incorporate adequate safeguards against abuse. The majority therefore concluded that, in this context, society's interest in the preservation of all human life should prevail over Ms Rodriguez's personal security interest.

Three of the four dissenting judges disagreed on the above interpretation of section 7 of the Charter. They did not agree that the infringement of Ms Rodriguez's right to security of the person was justified under any principle of fundamental justice. The dissenting opinion of Madam Justice McLachlin contained a particularly forceful rejection of the argument that Ms Rodriguez should be denied individual choice in this matter:
... Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or to improperly sway them to suicide. She is asked to serve as a scapegoat.

The majority of the Supreme Court of Canada disposed of the argument that section 241(b) violated Ms Rodriguez's rights under section 12 of the Charter simply by concluding that 'a mere prohibition by the state on certain action, without more, cannot constitute 'treatment' under section12'. The dissenting judges did not address the section 12 issue.

For the purposes of argument, the majority judges assumed that section 241(b) violated Ms Rodriguez's right to equality under section 15(1) of the Charter. They went on to conclude, however, that the infringement of section 15(1) was justified under section 1 of the Charter. Section 1 provides that the rights and freedoms protected by the Charter can be subject 'to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'. The majority judges stated that the prohibition in s 241(b) was both reasonable and justified in order to give effect to the valid state objective of protecting the vulnerable from others who may wish to end their lives.

This was not the view of Chief Justice Lamer, whose dissenting judgement was based on section 15(1) of the Charter. He concluded that the discriminatory effect of section 241(b) - which denied physically disabled persons unable to commit suicide without assistance the right to choose that option, where it was lawfully available to the able bodied - was not justified under section 1 of the Charter. He did not consider that the prospect of abuse of those vulnerable to manipulation by others justified this discriminatory restriction on the rights of persons who were not vulnerable in that way, and who would voluntarily choose to die.

Despite loosing her legal action, Ms Rodriguez ended her own life in February 1994 in her home in British Columbia. She did so with the assistance of an unidentified doctor. No charges were laid against the doctor in relation to Ms Rodriguez's death.

Official Responses to the Rodriguez Case

Prosecution Guidelines Relaxed in British Columbia

Following the Supreme Court's decision in the Rodriguez case, in November 1993 the prosecution guidelines for cases where a doctor has complied with a patient's request to hasten death were relaxed in British Columbia. One commentator describes this relaxation as follows:
This change has opened the door to active euthanasia under certain circumstances. From an ethical perspective, it calls on a doctor to allow death with dignity and comfort when death of the body appears inevitable. The guidelines give public prosecutors broader discretion, on a case-by-case basis, to determine whether a doctor whose treatment for a terminally ill patient hastens death should be charged. Prosecutors are to consider two issues in deciding whether to recommend charges: substantial likelihood of conviction, and the public interest.

The public interest criterion under these guidelines requires the following factors to be considered:

- supporting professional and ethical standards for health care professionals;
- society's interest in protecting vulnerable persons; and
- society's interest in protecting the sanctity of human life, while recognising this does not require life to be preserved at all costs.

Report of the Special Senate Committee on Euthanasia and Assisted Suicide

The Rodriguez case also provided an impetus for the setting up in February 1994 of a Special Committee of the Senate of Canada to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The report of this committee - entitled Of Life and Death - was tabled on 6 June 1995. The report contains recommendations relating to palliative care, pain control and sedation practices, withholding and withdrawal of life-sustaining treatment, advance directives, assisted suicide and euthanasia (divided into three categories: 'nonvoluntary euthanasia', 'voluntary euthanasia' and 'involuntary euthanasia').

The recommendations most pertinent to the situation addressed in the Rodriguez case are those relating to 'assisted suicide'. encompassing physician-assisted suicide:

- The majority of the committee recommended against any change to the prohibition on counselling, aiding or abetting suicide contained in section 241 of the Canadian Criminal Code.
- The majority also recommended that research be undertaken into how many people are requesting assisted suicide, why it is being requested, and whether there are any alternatives that might be acceptable to those making the requests.
- The minority of the committee recommended that an exemption be added to section 241(b) of the Criminal Code, to protect those who assisted another's suicide provided it was done in accordance with 'clearly defined safeguards'. The minimum recommended safeguards were:
  - The individual must be suffering from an irreversible illness at an intolerable stage.
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- The request for assistance must be free, informed and made without coercion.
- The individual must be fully informed about and must fully understand his or her condition, prognosis, other options available, and that he or she at all times has a right to rescind the request.
- A health care professional must confirm all the above conditions are met.
- No-one should be under a duty to assist in a suicide.
- In order to avoid abuse, procedural safeguards must provide for review both prior to and after the act of assisted suicide.

The recommendations relating to 'voluntary euthanasia', meaning active voluntary euthanasia, are also relevant:

- The majority of the committee recommended that voluntary euthanasia remain a criminal offence. It further recommended, however, that the Criminal Code should be amended to allow for a less severe penalty 'in cases where there is the essential element of compassion or mercy'. It recommended that Parliament consider introducing a new third category of murder, or a separate offence of 'compassionate homicide', that would carry a less severe penalty than the current penalty for murder.

- The majority also recommended that research be undertaken into how many people are requesting euthanasia, why it is being requested, and whether there are any alternatives that might be acceptable to those making the requests.

- The minority of the committee recommended that the Criminal Code be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide. It recommended that this amendment be subject to the same or similar minimum safeguards as recommended by the minority in relation to assisted suicide.

Endnotes

1 'From Tragedy to Victory: Wide Reaction to World First,' Canberra Times, 26 May 1996.
2 Ibid.
3 'Kennett Flags Right-to-Die Bill.' The Age, 26 May 1996.
4 'Lobbyists Call it a Test Law.' The Age, 26 May 1996.


9 N. Cica, Euthanasia - the Australian Law in an International Context; Part 1: Passive Voluntary Euthanasia, Canberra, Department of the Parliamentary Library, 1996

10 See ibid.

11 See Re J [1993] 4 Med LR 21 (English Court of Appeal). This is the case whether the patient requests the treatment contemporaneously, makes a valid anticipatory request for treatment, or has the request made on his or her behalf by an agent appointed under an enduring power of attorney.

12 See further below.


15 R v. (Bodkin) Adams [1957] Crim LR 354 per Devlin J.

16 M. Otlowski, supra note 5, p 22.


19 The charge was attempted murder rather than murder because the prosecution were unsure whether they could prove that Ms Boyes had died from the potassium chloride injection rather than from her underlying medical condition, particularly as her body had already been cremated.

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I. Kennedy and A. Grubb, supra note 12, p 1207; Airedale NHS Trust v. Bland [1993] 2 WLR 316 per Lord Goff. This rationale seems to underlie the following statement by the World Health Organization.

There is ... no excuse for failure to use available methods to control pain adequately. If shortening of life results from the use of adequate doses of ana analgesic drug, this is not the same as intentionally terminating life by overdose. Any hastening of death that is linked to adequate pain control measures simply means that the patient could no longer tolerate the therapy necessary for a bearable and dignified life.


M. Otlowski, supra note 5, p 23.

M. Otlowski, supra note 5, p 25.

See I. Kennedy, supra note 9; M. Otlowski, supra note 5, pp 20 and 23, 26.

I. Kennedy, supra note 9.

M. Otlowski, supra note 5, p 25. A similar argument is contained in I. Kennedy, supra note 9.

See M. Otlowski, supra note 5, pp 11 and 26. Note that surveys indicate that a substantial number of Australian doctors who have been asked by a patient to hasten his or her death have acceded to the patient's request by performing active voluntary euthanasia. A 1987 survey of doctors in Victoria indicated that 29 per cent of respondents had, on at least one occasion, taken active steps to end a patient's life: see H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 Medical Journal of Australia 263. A more recent survey of doctors in New South Wales and the Australian Capital Territory similarly indicated that 28 per cent of respondents had performed active voluntary euthanasia: see P. Baume and E. O'Malley 'Euthanasia: Attitudes and Practices of Medical Practitioners' (1994) 161 Medical Journal of Australia 137. See also Stevens and Hassan, 'Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia' (1994) 20 Journal of Medical Ethics 41.

See M. Otlowski, supra note 5, pp 16 and 25-27.

Australian law does not currently recognise necessity as a defence to murder: see D. Lanham, supra note 5 at 149.

See G. Williams, Sanctity of Life and the Criminal Law, London, Faber and Faber, 1958, pp 286 and 289; M. Otlowski, supra note 5, p 23 n 40.

For discussion of the efficacy of pain relief see House of Lords, supra note 12, paras 146-155.

Note that Dutch courts have developed and applied a 'necessity' defence to exonerate doctors who have engaged in physician-assisted suicide or active voluntary euthanasia, provided certain criteria are satisfied (see further below). It seems unlikely that the

33 See further below.

34 M. Otlowski, supra note 5, pp 19-20 and 24.

35 M. Otlowski, supra note 5, p 19.


37 Section 17(1).

38 Section 17(3).

39 Section 4(2).

40 Section 5(2).

41 Section 5(2).

42 Section 3.

43 Section 23(1).

44 Section 23(2).

45 For a critical assessment of the new section 82, see R. Scott, 'When is Medical Treatment for Abortion, Pain Relief or Euthanasia Actionable? (Section 82 New Criminal Code)' (1995) Queensland Law Society Journal 449.

46 Compare the more restrictive wording of the following provision, the adoption of which was recommended in the Final Report of the Criminal Code Committee as the appropriate formulation of the law relating to administration of pain relief:

A person is not criminally responsible if he or she gives such palliative care as is reasonable in the circumstances, for the control or elimination of a person's pain and suffering even if such care shortens that person's life, unless the patient refuses such care.

(emphasis added).


49 Ibid at 13, n 9.

50 Ibid.

51 Ibid at 12.
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52 e.g. R v. Larkin, unreported, Victorian Supreme Court, 14 April 1983; R v. Den Heyer, unreported, NSW District Court (Parramatta), 28 September 1990; R v. Savage, unreported, NSW District Court (Newcastle), 27 March 1982. These cases are discussed in M. Otlowski, supra note 41 at 25-6.

53 See M. Otlowski, supra note 41 at 11-12.

54 Ibid. at 18, 36-7.

55 R v. Lim, WA Court of Petty Sessions, No 56036 of 1988, discussed in M. Otlowski, supra note 5, p 12 n 15.

56 R v. Barnes, unreported, NSW Supreme Court, 16 November 1981, discussed in M. Otlowski, supra note 41 at 20.

57 M. Otlowski, supra note 41 at 10.

58 M. Otlowski, supra note 41 at 13. Cases where these mechanisms have been utilised include: a 1983 case in the ACT where the Commonwealth Attorney-General decided not to proceed with a murder charge against a woman who had killed her terminally ill sister, who had expressed a wish to die (defendant's name suppressed); R v. Austen, unreported, NSW Supreme Court, 5 March 1990; R v. Larkin, unreported, Victorian Supreme Court; R v. Thiel, unreported, NSW Supreme Court, 27 September 1990; R v. Johnstone, unreported, SA Supreme Court, 21 January 1987; R v. Kelly, unreported, Queensland Supreme Court, 12 May 1989; R v. Hollinrake, unreported Victorian Supreme Court, 29 June 1992. These cases are discussed in detail in M. Otlowski, supra note 41.
For these purposes, the doctor must 'hold a qualification in a medical specialty related to the terminal illness of the patient recognised by a medical specialist college in Australia and which entitles the medical practitioner to fellowship of that college.': Regulation 3 of the Rights of the Terminally Ill Regulations 1996 (NT).

See section 3 for the definition of 'qualified psychiatrist'.

Section 10(4); Regulation 4 and Schedule 1 of the Rights of the Terminally Ill Regulations 1996 (NT).

Definition of 'assist' in section 3.

Section 7(2); Regulation 4 and Schedule 1 of the Rights of the Terminally Ill Regulations 1996 (NT).

Ibid.

Sections 14 and 15.

Section 20.

Section 6.
For discussion of the social and political background to the passing of this legislation, see T. Campbell, N. Cica and M. Storey, 'Euthanasia Legislation: Australian Developments', paper presented on 11 July 1996 at Socio-Legal Studies Conference, University of Strathclyde, Glasgow, UK.

See discussion of the legal position in Oregon and the Netherlands, below.


Section 9 of the Northern Territory (Self-Government) Act 1978 (Cth) empowers the Governor-General to disallow legislation passed by the Legislative Assembly, in part or in its entirety, within six months of the Administrator's assent to the legislation. Alternatively, the Governor-General can recommend amendments to the legislation. Disallowance by the Governor-General repeals the legislation. These powers have never been used to disallow any Northern Territory legislation.

Rights of the Terminally Ill Amendment Act 1996 (NT).

See Rights of the Terminally Ill Amendment Act 1996 (NT), sections 3 (amending section 3 of the principal legislation) and 4 (amending section 7(1)(c) of the principal legislation).

See Rights of the Terminally Ill Amendment Act 1996 (NT0, section 4 (amending section 7(4) of the principal legislation).

See Northern Territory Parliamentary Debates (Legislative Assembly), 20 February 1996 (on the Rights of the Terminally Ill Amendment Bill 1996 (NT)), and 15 March 1996 (on the Respect for Human Life Bill (Serial 111) 1996 (NT), introduced by Mr Bell).

The action against the Commonwealth has since been discontinued with the Commonwealth's consent.


Ibid, pp 33-34.


Ibid, pp 38-41.


Ibid, p 41.


Ibid, pp 20-21 and 36.

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118 Ibid, p 22.
119 Ibid, p 63.
120 Ibid, p 62.
121 Ibid.
123 Ibid, p 36.
124 For discussion of the provisions of this Bill, see G. Griffith and M. Swain, *ibid* note 25, pp 27-28.
125 'Way cleared for a vote on euthanasia', *Sydney Morning Herald*, 31 May 1995.
126 See 'NT mercy killing law a mess, says Carr', and 'Editorial', *Sydney Morning Herald*, 15 April 1996.
127 For discussion of the differences between this draft Bill and the Northern Territory law, see G. Griffith and M. Swain, *ibid* note 25, pp 38-40.
129 House of Lords, *supra* note 12, para 119.
131 P. Van der Maas, J. Van Delden and L. Pijnenborg, 'Euthanasia and Other Medical Decisions Concerning the End of Life - Volume 2' (1992) 22(2) *Health Policy* (Special Issue), p 3.
132 See further House of Lords, *supra* note 12, Appendix 3, p 67 and para 126.
135 Euthanasia is defined in the Netherlands for these purposes as intentionally acting to take the life of a person upon his or her explicit request, the act being performed by someone
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136 See discussion below of the Chabot case.

137 J. Griffiths, supra note 25 at 232 n 1:

There is a translation difficulty in connection with the legal concept noodtoestand. The technically correct translation is 'situation of) necessity', and the defence of necessity is, in general terms, the same in Dutch law as in the common law. However, in the case of euthanasia the 'necessity' which has been recognised by the Dutch courts is not a general necessity but a specifically medical one, measured in terms of the state of medical knowledge and the professional norms of doctors, and it seems clear that no one but a doctor can successfully invoke it. There is, therefore, an argument to be made for translating the term as 'medical necessity'.


139 J Keown, supra note 126 at 56. These criteria were first articulated by the Dutch courts in 1986, in the Alkmaar case (Dutch Supreme Court).

140 See discussion below of the Chabot case, June 1994.

141 The Van Weerd case, March 1995.

142 See discussion below of the Chabot case.

143 P. Van der Maas et al, supra note 121 at 671.

144 Ibid at 671.

145 Ibid at 671-672.

146 Ibid at 672.

147 Ibid at 672.

148 Ibid at 672-673.

149 Ibid at 671.

150 Ibid at 672.

151 G. Van der Wal, Euthanasie en Hulp bij Zelfdoding door Hisartsen [Euthanasia and Assisted Suicide by Family Doctors], Rotterdam, 1992.

152 Remmelink Commission, Medische beslissingen rond het levensinde [Medical decisions in t connection with the end of life: advice of the Commission appointed to carry out research concerning medical practice with respect to euthanasia], 1991, The Hague, Sdu Uitgeverij Plantijnstraat.
See B. Pollard, 'Euthanasia in Holland' (1992) 16(2) Quadrant 42.

J. Griffiths, supra note 25 at 247; see similar cautions by the Remmelink researchers, J. Van Delden, L. Pijnenborg and P. Van der Maas, 'Dances With Data' (1993) 7(4) Bioethics 323.

See J. Griffiths, supra note 25; H. Leenen, 'Dutch Supreme Court about Assistance to Suicide in the Case of Severe Mental Suffering' (1994) 1 European Journal of Health Law 377; J. Griffiths supra note 128 at 368-369.

J. Griffiths, supra note 25 at 235.

Four psychiatrists, a clinical psychologist, a general practitioner and a Christian professor of ethics.

This conforms with conclusions reached earlier by:

- the Commission on the Acceptability of Termination of Life of the Royal Dutch Medical Association (in its fourth discussion paper on the termination of life in the case of non-competent patients, issued in 1993: Hulp bij zelfdoding bij psychiatrische patiënten [Assistance With Suicide in the Case of Psychiatric Patients]);

- the Dutch Inspectorate for Mental Health (in its 1993 report De meddingsprocedure euthanasie/hulp bij zelfdoding en psychiatrische patiënten [The reporting procedure for euthanasia/assistance with suicide and psychiatric patients]); and


The Supreme Court did not specify, however, whether that independent colleague must be a psychiatrist. Nor did it specify details of the independent consultation requirements in a case where the doctor receiving the request for assistance was (unlike Dr Chabot) not a psychiatrist. Nor did it make it clear whether the independent colleague must agree with the first doctor's assessment of the patient. See J. Griffiths, supra note 25 at 242.

J. Griffiths, 'Assisted Suicide in the Netherlands: Postscript to Chabot' (1995) 58 Modern Law Review 895. Griffiths notes that, like the Supreme Court, the Medical Disciplinary Tribunal held that it can be legitimate for a doctor to assist the suicide of a person whose unbearable suffering is of non-somatic origin. It also agreed that a doctor must ensure that the patient is examined by another, independent doctor before the doctor can accede to the patient's request. Unlike the Supreme Court, however, it did not consider that a doctor could help a patient die if the patient is refusing treatment that could possibly improve his or her condition.

J. Griffiths, supra note 25 at 247.

J. Griffiths, supra note 25 at 246.

The Prins case, 7 November 1995.

The Royal Dutch Medical Association plans to set up a 'help desk' panel, which doctors in the Netherlands will be able to consult for advice on matters relating to euthanasia. This should include provision of advice about the proper ways to perform euthanasia and information about how to locate doctors who are willing to be involved in the procedure.

Of these jurisdictions, 34 states (Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Washington and Wisconsin) and 2 territories (Puerto Rico and the Virgin Islands) currently have statutes imposing criminal sanction for aiding, assisting, causing or promoting suicide. Three further states (Idaho, Nevada and West Virginia) and the District of Columbia do not impose explicit criminal sanctions on assisted suicide, but nonetheless condemn assisted suicide in statutes allowing withdrawal of medical treatment. In three further states (Alabama, Iowa and Wyoming), the definition of criminally negligent homicide are sufficiently broad to encompass aiding, assisting, causing or promoting suicide. In four other states (Massachusetts, Ohio, South Carolina and North Carolina) criminal penalties for assisting suicide are imposed under case law.


In 1995 Bills proposing the legalisation of physician assisted suicide were introduced in twelve states. A model statute to effect this kind of legal change has been drafted: see Baron et al, 'A Model State Act to Authorise and Regulate Physician-Assisted Suicide' (1996) 33 Harvard Journal of Legislation 1.

In 1995 Bills were introduced in four states to create such a legislative prohibition. One recent example of the successful introduction of this kind of legislation occurred in Michigan in 1993, in response to the well-publicised activities of Dr Jack Kevorkian. Dr Kevorkian was a physician who was assisting patients to die using a 'suicide machine' that killed by administering potassium chloride intravenously. The machine was activated by the patient pressing a switch. Criminal charges could not be brought successfully against Dr Kevorkian in relation to the death of patients who used this machine, because murder prosecutions against the doctor failed on the basis that the patients had caused their own deaths (by pressing the switch themselves) and because in Michigan there was no specific crime of assisting suicide. The Michigan legislature passed a law making it a crime intentionally to provide another with the physical means to commit suicide. A challenge to the constitutional validity of this new law failed in the Michigan Supreme Court: *People v. Kevorkian* (1994) 447 Mich 436.

United States Court of Appeals for the Ninth Circuit, 6 March 1996.

United States Court of Appeals for the Second Circuit, 2 April 1996.


United States Court of Appeals for the Ninth Circuit, 6 March 1996.


(1990) 497 US. 261.

Rhenquist CJ, delivering the majority opinion, stated that 'the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions': (1990) 497 US 261 at 278. For the purposes of the case before the Court, however, the majority only explicitly affirmed the existence of a constitutionally protected liberty interest in rejecting life-sustaining hydration and nutrition: 'Although we think the logic of the cases discussed above would embrace [a liberty interest in refusing unwanted medical treatment], the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition': at 279.

O'Connor J rejected any legal distinction between artificial feeding and hydration and other forms of life-sustaining medical treatment:

Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.


Brennan Marshall, Stevens and Blackmun JJ.

For criticism of the similar conclusion by the trial judge in the instant case (Rothstein CJ, District Court for the Western District of Washington, reported as Compassion in Dying v. State of Washington (1994) 850 F Supp 1454), see B. Bix, supra note 166 at 408:

The District Court's quick and untroubled conclusion that there is no legally (constitutionally) significant difference between assisted suicide and the termination of
medical treatment is also somewhat troubling. ... [It is]... contrary to the historical underpinning of the 'right to die' judgements. These judgments were grounded in the common law position that unconsented-to medical treatment, like other unconsented-to touchings, is an assault or battery, and therefore patients have a presumptive right to refuse medical treatment. Whatever the merits of extending this doctrine to the extreme at which medical treatment can be refused in all circumstances, even when death is the likely result (as most United States courts have held), there is no means in logic to extend the right to refuse treatment to include the right to insist on harmful treatment, however little the difference may be in real-life consequences or however formalistic the distinction may seem to some.

The Court of Appeals for the Ninth Circuit did attempt at some length to justify its extension of the right to refuse treatment to include the right to insist on harmful treatment. That justification, however, appears under its later discussion of whether the state's interest in preventing suicide should defeat the pre-existing liberty interest in choosing the time and manner of one's own death, not under its discussion of the scope of the liberty interest itself.

187 Note that Australian courts have not articulated a 'state interests' doctrine of this kind.

188 See N. Cica, supra note 1.

189 They stated the following:

The Oregon District Court's reasoning conflicts squarely with the reasoning of this opinion and with the legal conclusions we have reached. Here, we determine that a statute that prohibits doctors from aiding terminally ill persons to hasten their deaths by providing them with prescription medications unconstitutionally burdens the liberty interests of the terminally ill. The benefit we conclude the terminally ill are entitled to receive in this case - the right to physician-assisted suicide - is precisely what Judge Hogen determined to be a burden and thus unlawful. In short, Lee treats a burden as a benefit and a benefit as a burden. In doing so, Judge Hogan clearly erred. Lee not only does not aid us in reaching our decision, it is directly contrary to our holding.

190 Beezer CJ identified a liberty interest under the due process clause in committing suicide, but refused to describe it as 'fundamental'. He thereby refused to categorise it as the kind of privacy right which the Supreme Court has identified as deserving of greatest protection from state interference. He instead described this liberty interest (and, moreover, the right to abortion affirmed in Casey and the right to refuse unwanted medical treatment affirmed in Cruzan) as 'nonfundamental' and therefore more easily outweighed by competing state interests.

Beezer CJ justified his refusal to categorise this liberty interest as fundamental by referring to the Supreme Court's unwillingness to identify new fundamental rights protected under the Due Process Clause. He therefore applied the restrictive test that the Supreme Court had used in Bowers v. Hardwick 478 US. 186 (1986) to reject the claim that homosexuals have a fundamental constitutional right to engage in private sexual conduct. Under that test, a new fundamental right will only exist if is deeply rooted in the nation's traditions and history,
and if it can be considered so implicit in the concept of ordered liberty that neither liberty nor justice would exist if it were sacrificed. Beezer CJ concluded that the purported right to assisted suicide failed both limbs of this test.

Note that the majority judges were highly critical of the Supreme Court's approach in *Bowers v. Hardwick*, describing it as 'aberrant.'

191 Having concluded that the liberty interest in question was not 'fundamental', Beezer CJ employed what is known as the 'rational relationship test' to assess whether the Washington statute violated the due process clause. Under that test, a statute is constitutional if it rationally advances some legitimate government purpose. Beezer CJ also indicated, however, that had he employed the more stringent tests that are used when a 'fundamental' liberty interest is under threat (either the 'strict scrutiny test', or the 'balancing test' used by the majority), the strength of the state interests involved here would have lead him to the same conclusion.

192 Echoing the (dissenting) approach of Beezer CJ in *Compassion in Dying v. State of Washington*, the majority noted the general reluctance of the Supreme Court of the United States to expand the list of fundamental rights protected by the Constitution, and its particular reluctance to identifying new liberty interests encompassed by the right to privacy derived from the Due Process Clause. Given this reluctance, the majority felt it would be inappropriate for a court lower in the judicial hierarchy to take a more expansive approach to identifying new fundamental due process rights. The majority therefore used the *Bowers v. Hardwick* test to reject the asserted right to assisted suicide:

As in *Bowers*, the right contended for here cannot be considered too implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true.


194 This Act does not apply in Scotland, where the legal position is less clear. Note the ruling of the European Commission on Human Rights in *R. v. United Kingdom* (1983) 6 EHRR 50. In that case, the European Commission rejected the claim by a member of the Voluntary Euthanasia Society that his conviction under section 2, for referring people seeking assistance in suicide to a doctor who was prepared to help them, violated Article 8 of the European Convention on Human Rights (right to respect for his private life).

195 Suicide and attempted suicide are no longer crimes in the United Kingdom.

196 English courts have established that the common law crime of murder is committed where a person 'unlawfully kills any reasonable creature in being and under the Queen's peace with intent to kill or cause grievous bodily harm the death following within a year and a day.'
The Voluntary Euthanasia Legalisation Society has been in existence ever since. It is now known as the Voluntary Euthanasia Society; since 1980, there has also been a separate Voluntary Euthanasia Society of Scotland.


See *ibid* pp 44-48.

See *ibid* pp 136-144 for the Explanatory Memorandum and text of the Bill.

[1993] 2 WLR 316. In this case, the House of Lords authorised the withdrawal of artificial hydration and nutrition from Anthony Bland, a patient who had been in a persistent vegetative state since being injured in the Hillsborough disaster in 1989.


See *ibid*, pp 3-6.

*Ibid*, para 236.


Following the passing of the Death With Dignity Act 1994 in Oregon.

On 16 January 1996 the Parliamentary Secretary of the Lord Chancellor's Department was asked what response the Government intended to make to the Law Commission's Report on Mental Incapacity (discussed above). The response included the following: 'The Government wish to emphasise that they fully support the views of the House of Lords Select Committee on Medical Ethics that euthanasia is unacceptable and have no plans to change this policy'.


Under section 241 of the Canadian Criminal Code: Every one who:
(a) counsels a person to commit suicide; or
(b) aids or abets a person to commit suicide; and
Whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.


Sopinka J wrote the joint judgment of the five majority judges: Sopinka, La Forest, Gonthier, Iacobucci and Major JJ.
McLachlin, L'Heureux-Dubé and Cory J. The other dissenting judge, Lamer CJ, did not address this issue.

P. Thompson, supra note 220 at 243.

M. Smith et al, supra note 223, p 10.