3 August 2015

Dear Committee Members

Submission to the Victorian Legislative Council Standing Committee on Legal and Social Issues: 
Inquiry into End of Life Choices

Executive summary

In this submission, we make the following recommendations:

1. The law in Victoria relating to end of life requires reform, particularly in relation to withholding and withdrawing life-sustaining treatment from adults who lack decision-making capacity; euthanasia and assisted dying for a narrowly defined cohort of individuals; the provision of palliative care; and voluntary palliated starvation.

2. The law regarding withholding and withdrawing life-sustaining treatment from adults who lack decision-making capacity requires reform to ensure greater clarity, remove anomalies and reduce complexity for both medical professionals and the community.

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

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

5. A broad legislative defence, based on the common law doctrine of double effect, should be enacted to protect medical professionals who provide palliative care with the intention of relieving pain.

6. We also draw the Committee’s attention to the practice of voluntary palliated starvation, and its increasing emergence as an option for patients wishing to end their lives. The Victorian law should allow for this practice to occur, and protect medical professionals who provide palliative care to an individual who is dying as a result of his or her decision to refrain from eating and drinking.
Background

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

End of life is one of the Centre’s three research programs. Within that program, 10 of our Centre’s 18 health law academics undertake research which explores legal, ethical and policy issues in death, dying and decision-making, including: withholding and withdrawing life-sustaining medical treatment; provision of futile treatment at the end of life; advance care planning; palliative care; euthanasia and assisted suicide; and coronial systems and regulation.

Our research has examined the issues relating to death, dying and decision-making at the end of life in all Australian jurisdictions, including Victoria. Two of our current Australian Research Council funded research projects include collaborative partnerships with the Public Advocate Victoria, the Victorian Civil and Administrative Tribunal and the Cancer Council Victoria, and involve specific consideration of end of life law and practice in Victoria. We therefore provide this submission to outline some key areas of legal reform for the law at end of life in Victoria which we have identified in our research.

Withholding and withdrawing life-sustaining treatment

The Victorian law governing decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity is problematic both for members of the community and medical professionals, creating unnecessary complexity and confusion. While medical professionals play a critical clinical role in the provision of medical treatment at end of life, they also play a significant legal role in the process. For example, doctors must assess whether a patient has capacity to make a treatment decision, determine who an authorised decision-maker is if the patient lacks capacity, and know whether a patient’s previously expressed wishes comprise a valid advance directive. Despite the significance of these issues, our research has identified that there are some critical knowledge gaps among doctors who practise in the end of life field about the law on withholding and withdrawing life-sustaining treatments from adults who lack decision-making capacity.

Our recent survey of doctors from seven specialties in Victoria, New South Wales and Queensland (867 responses) found doctors do not possess sufficient legal knowledge in relation to aspects of the law such as the validity and effect of advance directives, and the authority of substitute decision-makers. Significant consequences can result to patients from a failure by doctors to know and comply with the law, such as life-sustaining treatment being unlawfully withheld or withdrawn.

Further, medical professionals could be criminally responsible where treatment is withheld or

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2 Ibid.
3 Ibid, 232.
4 Ibid.
withdrawn unlawfully, or without consent.\textsuperscript{5} Conflict may also arise where doctors and patients’ families or friends have little or no legal knowledge, or different understandings of the law.\textsuperscript{6}

Our findings indicate that doctors involved in making end of life decisions, as well as the community, should improve their knowledge of the law.\textsuperscript{7} Legal reform, improved education, training and resources, and a shift in doctors’ attitudes are required in order to address this issue. These issues and areas for reform are discussed further in our article Ben White, Lindy Willmott, Colleen Cartwright, Malcolm H Parker and Gail Williams, ‘Doctors’ knowledge of the law on withholding and withdrawing life-sustaining medical treatment’ (2014) 201(4) Medical Journal of Australia 229-232, which we table for the Committee’s consideration.

We submit that the following areas of Victorian law (identified and discussed comprehensively in the article Lindy Willmott, Ben White, Malcolm Parker and Colleen Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: part 3 (Victoria)’ (2011) 18(4) Journal of Law and Medicine 773-797, which we also table for the Committee’s consideration) also require reform:

- The Victorian legislation (the Medical Treatment Act 1988 (Vic) and the Guardianship and Administration Act 1986 (Vic)) provides for four different types of substitute decision-makers, each with different powers. For example:
  - a person responsible and an enduring guardian do not have power to refuse treatment but can provide consent to treatment, or withhold consent to treatment,\textsuperscript{8}
  - an agent appointed under an enduring power of attorney (medical treatment) can refuse treatment (as well as provide consent),\textsuperscript{9} and
  - a guardian appointed by the Victorian Civil and Administrative Tribunal may refuse treatment if the Tribunal confers on the guardian the power to do so.\textsuperscript{10}

This situation is problematic as some substitute decision-makers have power to refuse treatment but others only have power to withhold consent to treatment. These distinctions create considerable difficulties for Victorian doctors, who are required to identify the relevant substitute decision-maker, and know whether their role carries with it the power to consent to treatment or withhold consent, or whether they can refuse treatment. This distinction is a fine one and unlikely to be understood and complied with by many Victorian medical professionals. It also creates a gap in the law as a default decision-maker does not have the power to refuse treatment. It is submitted this distinction be removed so that all

\textsuperscript{5} Ibid.
\textsuperscript{6} Ibid.
\textsuperscript{7} Ibid.

\textsuperscript{8} EK (Guardianship) [2005] VCAT 2520; AV (Guardianship) [2005] VCAT 2519; Guardianship and Administration Act 1986 (Vic)) s42H(2); Guardianship and Administration Act 1986 (Vic) Pt 4A and s35B.
\textsuperscript{9} Medical Treatment Act 1988 (Vic) s5A.
\textsuperscript{10} Medical Treatment Act 1988 (Vic) s5A(1)(b).
substitute decision-makers under both Victorian statutes have the power to refuse treatment.

- Substitute decision-making about health care is contained in two statutes (the Medical Treatment Act 1988 (Vic) and the Guardianship and Administration Act 1986 (Vic)) which sit awkwardly together, creating confusion and complexity. Further, two decision-makers are able to be appointed by an adult (an enduring guardian and an agent) under the two overlapping pieces of legislation, adding unnecessary duplication and complexity. If all substitute decision-makers were granted power to refuse treatment, it would be possible to deal with substitute decision-making comprehensively and consistently in a single statute i.e. by incorporating and adapting the relevant aspects of the Medical Treatment Act 1988 (Vic) into the Guardianship and Administration Act 1986 (Vic).

- The Medical Treatment Act 1988 (Vic) and the Guardianship and Administration Act 1986 (Vic) contain four different terms for determining when an adults will have or lack capacity (i.e. when an adult is or is not able to make his or her own decisions), leading to confusion for both medical professionals and the community. It is submitted a single definition of capacity (reflecting the functional approach to capacity) should be adopted and introduced to the Guardianship and Administration Act 1986 (Vic).

- The status of common law advance directives in Victoria is currently uncertain. It is submitted that the law should be clarified to recognise common law advance directives as this gives greater weight to individual autonomy.

Finally, we submit there is an urgent need for a national approach to the law at end of life, with either uniform laws or harmonisation required. Currently each State and Territory has its own laws governing end of life issues including guardianship, advance directives and withholding and withdrawing life-sustaining treatment. There have long been calls for a single Australian legislative framework in order to reduce complexity and confusion, and enhance both the community and medical professionals’ knowledge and understanding of the law at end of life.11 Most recently, the Australian Law Reform Commission recommended: ‘State and territory governments should review laws and legal frameworks concerning individual decision-making……’ and that regard should be had to ‘… consistency between jurisdictions, including in terminology’ and ‘maximising cross-jurisdictional recognition of arrangements’ .12 As Australia’s population rapidly ages and patients at the end of life demand quality care, the law at end of life will become increasingly relevant and utilised. National consistency of these laws is timely to improve end of life outcomes for patients, families, medical professionals and the community as a whole.


Voluntary euthanasia and assisted suicide

Voluntary euthanasia and assisted suicide are unlawful in Victoria (under the Crimes Act 1958 (Vic)) and in all Australian States and Territories. These issues are complex and give rise to a range of competing considerations for regulation and legal reform. The current position of the law across Australia, key arguments in favour of and against legalising voluntary euthanasia and assisted suicide, and a proposed framework for considering regulatory options of these acts are considered in detail in Ben White and Lindy Willmott, ‘How should Australia regulate voluntary euthanasia and assisted suicide’ (2012) 20 Journal of Law and Medicine 410-438. We table this article before the Committee to enable consideration of those issues.

We believe it is possible to create a system that permits regulated assisted dying, with legislative safeguards, drawing on international evidence that protects the rights and interests of the vulnerable in our community.13 Regulations and safeguards which could be enacted are discussed further in the article noted above, as well as the report Bob Douglas, Lindy Willmott & Ben White, The Right to choose and assisted death: Time for legislation? (2013) Australia21, Weston, ACT, which we table for the Committee’s consideration.

Though we consider the introduction of a legislative system that permits regulated assisted dying preferable, an alternative option for legal reform in this area is to develop prosecutorial guidelines that deal specifically with when voluntary euthanasia and assisted suicide will and will not be prosecuted.14 In Australia, prosecutors have a discretion not to charge or prosecute a person where to do so would not be in the public interest. In England and Wales, the Director of Public Prosecutions has a policy on assisted suicide which specifies when it will and will not be in the public interest to prosecute such cases.15 This reform option would continue to recognise the criminality of such conduct but create a discretion for the criminal law not to be enforced in appropriate cases.16

Model prosecutorial guidelines designed for the Australian situation are set out in Ben White and Jocelyn Downie, ‘Prosecutorial guidelines for voluntary euthanasia and assisted suicide: Autonomy, public confidence and high quality decision-making’ (2012) 36 Melbourne University Law Review 656-705, which we tender for the Committee’s consideration. There is also further discussion of this option in the article Ben White and Lindy Willmott, ‘How should Australia regulate voluntary euthanasia and assisted suicide’ (2012) 20 Journal of Law and Medicine 410-438 (tendered above).

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Palliative Care

We consider it essential that seriously ill patients in the final stages of life should have access to high quality palliative care to manage pain and suffering and relieve symptoms. However, it is possible for the levels of medication required to relieve pain to have the unintended effect of hastening a patient’s death, posing a legal dilemma: while not wanting to sanction causing a person’s death, the law does not wish that a person be deprived of medication needed to relieve pain and suffering. To date, the law’s response to this has been to recognise the doctrine of double effect – that is, if the primary intention of the person administering the palliative care is to relieve pain, and not cause death, then that person will not be criminally responsible for a death that might follow, even if it is foreseen.17

Given the doctrine of double effect forms part of the common law in the United Kingdom and other common law jurisdictions including the United States, Canada and New Zealand, we consider it is likely that it forms part of the common law of Australia,18 and, therefore, Victoria. Some Australian states have also enacted in legislation19 a modified version of the doctrine of double effect, or an excuse that applies to the provision of palliative care, but Victoria has not.

Despite the protection provided by the doctrine of double effect, there is some anecdotal evidence that some health professionals are reluctant to administer palliative care due to concerns about legal repercussions such as civil litigation, criminal prosecution or disciplinary action where a patient’s death results from the pain relief provided. These concerns have been identified in Australia as a factor in the under-treatment of pain. For example, evidence provided by clinicians to an Australian Commission on Safety and Quality in Health Care (ACSQHC) consultation process on end of life care suggests ‘Fears held by clinicians about complaints or possible litigation stemming from involvement in end-of-life care ... can result in avoidance of dealing with dying patients’.20 The anecdotal evidence suggests that fears may be based on clinicians’ lack of understanding about the legal distinction between the provision of adequate pain control causing death and euthanasia. An Alzheimer’s Australia study into end of life care for people living with dementia also noted that ‘Anecdotal reports indicate that care professionals are at times reluctant to use medications, such as morphine, over fear that they may hasten the death of the person they are caring for’.21 This study revealed significant shortcomings in the legal knowledge of professionals caring for dementia patients: ‘Consistent with previous reports, 27% of care professionals did not think adequate pain control (if it might also hasten death) was a legal choice for people in Australia or were unsure’.22 Similarly, Swerissen & Duckett noted ‘Concerns about voluntary euthanasia and assisted dying often clouds discussion about end of life care. This makes it more difficult to address much more common situations of withdrawing treatment and

17 R v Adams (Unreported, Central Criminal Court, Develin J, 9 April 1957); R v Cox (1992) 12 BMLR 38.
18 We note the case of Re Baby D (No 2) (2011) 45 Fam LR 313, which provides some implicit support for the doctrine in Australian common law.
19 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s17; Criminal Code 1899 (Qld) s282A and Criminal Code 1913 (WA) s259.
22 Ibid.
increasing pain relief’.\(^{23}\) Other literature has also noted that dying patients in Australia are not receiving adequate pain relief due to doctors’ fears of hastening death, and misconceptions about legal consequences.\(^{24}\)

We invite the Committee to consider introducing a legislative defence in Victoria, based on the doctrine of double effect, to protect medical professionals providing palliative care. Such a defence would provide greater clarity and certainty for medical professionals that they will not be criminally or civilly responsible where the patient’s death occurs following the administration of appropriate palliative care, and would ensure patients receive necessary and appropriate relief from pain and suffering as they approach the end of life. In doing so however the Committee should consider the limitations of the legislative defences in Queensland, South Australia and Western Australia.

In those States, the defences generally provide more limited protection than the doctrine of double effect at common law – for example, they require adherence by medical professionals to a higher standard of medical practice than is required to obtain the defence at common law, and require that doctors obtain consent from a patient or their substitute decision-maker to provide the palliative care. Accordingly, the defences in those States offer less protection to doctors administering palliative care than medical professionals operating in Victoria and other States where the common law doctrine of double effect operates.\(^{25}\) In light of these difficulties, we submit that a broad legislative defence should be enacted in Victorian legislation, thereby providing to doctors, through statute, the same protection afforded to them through the common law by the doctrine of double effect.

**Voluntary Palliated Starvation**

Finally, we draw the Committee’s attention to the concept of voluntary palliated starvation (VPS) and its increasing emergence as an option for patients wishing to end their lives. VPS occurs when a competent adult refuses to eat or drink and receives palliative care to relieve any suffering she or he experiences from dying due to a lack of food and water.\(^{26}\) It is well accepted in Australia and internationally that patients have a right, at common law, to refuse artificial hydration and nutrition, even if it leads to the person’s death.\(^{27}\) Some scholars have observed that patient refusal of


\(^{25}\) These issues are considered in detail in Ben White, Lindy Willmott and Michael Ashby, ‘Palliative care, double effect and the law in Australia’ (2011) 41(6) *Internal Medicine Journal* 485-492, which we table. We also table the following chapter from *Health Law in Australia* (2nd ed), which provides a comprehensive overview of the current case law and legislation relating to palliative care in all Australian States and Territories: Ben White and Lindy Willmott, ‘Double effect and palliative care excuses’ in Ben White, Fiona McDonald and Lindy Willmott (eds.) *Health Law in Australia* (2nd ed) (2014) (Thomson Reuters, Pyrmont, NSW), 593-608.


\(^{27}\) Schloendorff v New York Hospital (1914) 211 NY 125; Secretary of the Department of Health and Community Services v JWB (Marion’s case) (1991) 175 CLR 218; Brightwater Care Group v Rossiter (2009) 40 WARR 84 at [26]; Hunter and New England Area Health Service v A (2009) 74 NSWLR 88 at [4]-[22]; H Ltd v J (2010) 107 SASR 352 at [35]-[36].
hydration and nutrition may be used by some individuals as an alternative to physician-assisted suicide.\textsuperscript{28}

We consider that in some circumstances such a death would be lawful for both the patient and doctors involved, and consistent with principles of medical ethics.\textsuperscript{29} We also consider that it is both lawful and ethical to provide palliative care to reduce the suffering associated with self-induced dying.\textsuperscript{30} VPS will undoubtedly continue into the future, and consideration may need to be given to how the legal and health systems respond to this. Further discussion of these issues is contained in the article Ben White, Lindy Willmott and Julian Savulescu, ‘Voluntary palliated starvation: A lawful and ethical way to die’ (2014) 22 Journal of Law and Medicine 276-386, which we table before the Committee.

We also noted that while the law that governs VPS is clear in some cases, there may be legal uncertainty in other cases. For example, whether the individual’s substitute decision-maker can continue the refusal of food and drink when the person loses capacity; and whether an individual can make a binding advance directive refusing food and drink. The practices surrounding VPS and the legal and ethical implications of such practices should be explored further.

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

Yours sincerely

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Professor Ben White
Director, Australian Centre for Health Law Research

\textsuperscript{28} JL Bernat, B Gert and RP Mogielnicki, ‘Patient refusal of hydration and nutrition: An alternative to physician-assisted suicide or voluntary active euthanasia’ (1993) 153(24) Archives of Internal Medicine 2723.

\textsuperscript{29} Ibid n26, 386.

\textsuperscript{30} Ibid.
Professor Julian Savulescu
Adjunct Professor, Australian Centre for Health Law Research
Director, Oxford Uehiro Centre for Practical Ethics
Oxford University
Doctors’ knowledge of the law on withholding and withdrawing life-sustaining medical treatment

Abstract

Objectives: To examine doctors’ level of knowledge of the law on withholding and withdrawing life-sustaining treatment from adults who lack decision-making capacity, and factors associated with a higher level of knowledge.

Design, setting, and participants: Postal survey of all specialists in emergency medicine, geriatric medicine, Intensive care, medical oncology, palliative medicine, renal medicine and respiratory medicine on the AMPCo Direct database in New South Wales, Victoria and Queensland. Survey initially posted to participants on 18 July 2012 and closed on 31 January 2013.

Main outcome measures: Medical specialists’ levels of knowledge about the law, based on their responses to two survey questions.

Results: Overall response rate was 32.8%. For the seven statements contained in the two questions about the law, the mean knowledge score was 3.26 out of 7. State and specialty were the strongest predictors of legal knowledge.

Conclusions: Among doctors who practise in the end-of-life field, there are some significant knowledge gaps about the law on withholding and withdrawing life-sustaining treatment from adults who lack decision-making capacity. Significant consequences for both patients and doctors can flow from a failure to comply with the law. Steps should be taken to improve doctors’ legal knowledge in this area and to harmonise the law across Australia.

Methods

This study explored doctors’ knowledge of the law relevant to end-of-life care in New South Wales, Victoria and Queensland. These states have both similarities and differences between legal regimes, which allowed us to explore whether the different regimes affected levels of knowledge.

Data were collected through a survey instrument, developed over 18 months, informed by a detailed review of the law in each state, focus groups, pretesting, and piloting of the instrument with specialists. The accuracy of the legal questions and responses were confirmed by independent legal experts in each state.

The sample cohort comprised all specialists in emergency medicine, geriatric medicine, intensive care, medical oncology, palliative medicine, renal medicine and respiratory medicine who were on the AMPCo Direct (a subsidiary of the Australian Medical Association) database in the three states at the time the instrument was distributed (n = 2858). These specialties were chosen as these specialists are likely to be involved in making decisions about whether to withhold or withdraw life-sustaining treatment.

This was determined by a review of relevant literature, interviews and an analysis of pilot results. Although general practitioners are commonly involved in end-of-life decision making, they were excluded from our study, which focused on the acute care setting.

AMPCo Direct administered the survey mailout, which began on 18 July 2012. Recruitment strategies included having the survey instrument professionally designed, providing incentives (continuing professional development [CPD] points, educational material and a chance to win one of six prestige bottles of wine), engaging with all the colleges and specialist societies of the target specialties (except the emergency medicine society given the overlap with the college) and publishing editorials in relevant professional journals to request participation in the study. Two follow-up requests were sent to non-responders and the survey was closed on 31 January 2013.

The project was approved by the human research ethics committees at the...
Preliminary analyses examined descriptive statistics and bivariate associations by $\chi^2$ tests. Mean scores were calculated to assess differences in knowledge among subgroups and linear trends associated with ordinal variables. Formal comparison of mean scores was performed using a general linear model, assuming a normal distribution for scores. Variables examined as predictors of knowledge were state, age, sex, main specialty, religion, years of practice, country of birth, country of degree, self-perceived knowledge of the law, number of decisions made in relation to withholding and withdrawing life-sustaining treatment, and CPD training. Mean scores for subgroups were compared with the sample average using the Nelson–Hsu method within the SAS Statistics GLM procedure, which also adjusts for multiplicity of comparisons. Linear trends associated with ordinal variables, such as self-perceived knowledge, were assessed by modelling these as continuous. Likelihood ratio tests (LRTs) were used to assess each variable overall. Adjusted means were obtained from a linear model that included selected covariates, and similarly compared.

## Results

The final overall response rate was 32% (867/2702): 29% (335/1147) from NSW, 33% (314/957) from Victoria and 36% (218/598) from Queensland. Response rates by specialty by state ranged from 75% for palliative medicine specialists in Victoria to 22% for oncologists in NSW.

The mean correct response for the knowledge of law questions overall was 3.26 (out of a possible score of 7), with a standard deviation of 1.32.

State and specialty were the strongest predictors of knowledge (Box 1), with LRTs giving $P_{LRT} < 0.001$ for both variables. NSW showed the highest scores and Queensland the lowest. All pairwise differences were statistically significant at $P < 0.001$. After adjustment for state, specialists in geriatric medicine ($P = 0.001$) and in palliative medicine ($P = 0.033$) had significantly higher scores than average, and specialists in emergency medicine ($P = 0.035$) and respiratory medicine ($P < 0.001$) had significantly lower scores than average. Medical

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### Mean correct responses to seven statements relating to knowledge of the law regarding end-of-life care, and number of respondents scoring $> 4$, by doctor characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of respondents</th>
<th>Mean correct score (SD)</th>
<th>Adjusted mean score*</th>
<th>No. of respondents scoring $&gt; 4$ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>667</td>
<td>3.26 (1.32)</td>
<td></td>
<td>365 (42.3%)</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>335</td>
<td>3.65 (1.24)</td>
<td></td>
<td>185 (55.2%)</td>
</tr>
<tr>
<td>Victoria</td>
<td>314</td>
<td>3.17 (1.38)</td>
<td></td>
<td>124 (39.5%)</td>
</tr>
<tr>
<td>Queensland</td>
<td>218</td>
<td>2.79 (1.18)</td>
<td></td>
<td>56 (25.7%)</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>107</td>
<td>3.89 (1.28)</td>
<td>3.77</td>
<td>61 (57.0%)</td>
</tr>
<tr>
<td>Palliative medicine</td>
<td>52</td>
<td>3.71 (1.49)</td>
<td>3.69</td>
<td>27 (51.9%)</td>
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<tr>
<td>Intensive care</td>
<td>125</td>
<td>3.48 (1.35)</td>
<td>3.44</td>
<td>63 (50.4%)</td>
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<tr>
<td>Renal medicine</td>
<td>80</td>
<td>3.37 (1.33)</td>
<td>3.28</td>
<td>37 (46.3%)</td>
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<tr>
<td>Emergency medicine</td>
<td>270</td>
<td>3.09 (1.27)</td>
<td>3.04</td>
<td>103 (38.7%)</td>
</tr>
<tr>
<td>Medical oncology</td>
<td>80</td>
<td>3.07 (1.23)</td>
<td>3.00</td>
<td>29 (36.3%)</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>98</td>
<td>2.72 (1.34)</td>
<td>2.68</td>
<td>25 (25.5%)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>567</td>
<td>3.18 (1.30)</td>
<td>3.08</td>
<td>232 (40.9%)</td>
</tr>
<tr>
<td>Female</td>
<td>298</td>
<td>3.43 (1.35)</td>
<td>3.26</td>
<td>132 (44.3%)</td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>517</td>
<td>3.35 (1.32)</td>
<td>3.41</td>
<td>231 (44.7%)</td>
</tr>
<tr>
<td>Other English speaking</td>
<td>151</td>
<td>3.23 (1.42)</td>
<td>3.23</td>
<td>65 (43.0%)</td>
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<tr>
<td>Asia</td>
<td>120</td>
<td>3.12 (1.38)</td>
<td>3.08</td>
<td>45 (37.5%)</td>
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<tr>
<td>Europe</td>
<td>31</td>
<td>2.87 (1.31)</td>
<td>3.01</td>
<td>7 (22.6%)</td>
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<tr>
<td>Other</td>
<td>43</td>
<td>3.12 (1.35)</td>
<td>3.14</td>
<td>15 (34.9%)</td>
</tr>
</tbody>
</table>

* Adjusted mean scores for specialty were adjusted for state; for each of sex and country of birth, they were adjusted for state and specialty and each other. 155, 2 and 5 respondents did not state main specialty, sex and country of birth, respectively.

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Queensland University of Technology, the University of Queensland and Southern Cross University.

**Measures**

The survey instrument had six sections: perspectives about the law; education and training; knowledge of the law; practice of and compliance with the law; experience in making end-of-life decisions; and demographics. The knowledge section contained two questions. The first comprised six items: three concerning the validity of an advance directive, two concerning consent from and the authority of substitute decisionmakers, and one dealing with both issues. All questions were to be answered True, False or Don’t Know in relation to the relevant state law. The second question asked which of four plausible decisionmakers had legal authority to make medical decisions for a patient without capacity. Participants could score correct responses on a scale of 0 to 7 (Don’t Know was scored as an incorrect response). Doctors were asked how much knowledge of the relevant law they felt that they currently had: very little; some; moderate; or considerable.

To determine any correlation between decision making and knowledge, doctors were asked how many decisions to withhold or withdraw life-sustaining treatment they were directly involved in as a member of the treating team in the previous 12-month period, including situations where such decisions were considered but treatment was ultimately provided or continued.

To determine any correlation between the extent of CPD training received in this area and knowledge, doctors were asked whether they had received such training and, if so, when.

**Statistical analysis**

Questionnaires were coded and double-entered into an Access database and transferred to SPSS Statistics 20 (IBM) and SAS 9.3 (SAS Institute Inc) for analyses.
oncologists had a lower mean score than average but this was not significant (P = 0.53), because of the small number of medical oncologists.

Sex and country of birth were weaker predictors of knowledge. Women and Australian-born doctors scored somewhat higher than other groups. The sex effect is reduced when adjusted as described in Box 1, but remains significant (P$_{adj}$ = 0.05). Country of birth was also a significant predictor after adjustment (P$_{adj}$ = 0.042). The difference between Australian-born doctors and others was significant after adjustment for state, specialty and sex (P = 0.017).

Years of practice, age, country of degree and religion did not predict knowledge (data not shown).

The results demonstrated a highly significant and linear association between doctors’ perception of and actual knowledge of the law in this area (Box 2; P < 0.001). This effect remained after adjusting for state, specialty, sex and country of birth (P = 0.008).

Doctors who had received CPD training had greater knowledge than those who had not, and the association between knowledge and recency of training was significant and linear (Box 2; P = 0.007 for linear trend in mean scores, after adjusting for state, specialty, sex and country of birth).

### Discussion

Our results demonstrate critical gaps in the legal knowledge of many doctors who practise end-of-life medicine. Before considering the consequences of these gaps, and the implications of these results, we make two general observations.

First, doctors in NSW had the highest level of knowledge, followed by those in Victoria and then Queensland. Research into reasons for the disparity between states is needed and may provide guidance for successful education and training strategies. Is the law easier to understand in some jurisdictions? Does the law reflect good medical practice to a greater extent in some jurisdictions? Are doctors in some jurisdictions better trained in the law? Further, respondents in some specialties were more knowledgeable than those in other specialties.

Second, the results indicate that doctors have an accurate perception of their level of knowledge. This may be useful if doctors are persuaded that it is important to be familiar with the law in the course of their clinical practice. As they have insight into their level of knowledge, they will know whether further efforts are needed to augment that knowledge.

There are limitations to research of this kind. Doctors with an interest in law may be more likely to respond, so our sample may be more legally knowledgeable than the wider medical population. Also, not all aspects of legal knowledge about withholding or withdrawing treatment can be tested. However, two important aspects of the law were explored: validity and effect of advance directives and the authority of substitute decisionmakers. The results show that many doctors do not possess sufficient legal knowledge to determine whether an advance directive presented to them is valid. Further, even if they are confident that it is valid, many doctors do not know whether they are legally obliged to follow a directive that refuses treatment in a situation when providing treatment is clinically indicated. The results also indicate doctors’ lack of knowledge in determining the legally authorised decisionmaker for medical treatment where there are various people who have an interest in the wellbeing of a patient.

Significant consequences for patients can flow from a failure to know and comply with the law. Life-sustaining treatment may be unlawfully withheld or withdrawn; for example, where the purported decisionmaker lacks legal authority. For patients, the outcome of such decisions is that, at least as a matter of law, their lives are being ended wrongly. Conversely, life-sustaining treatment may be unlawfully provided; for example, despite a lawful refusal of treatment through an advance directive or by a substitute decisionmaker. This may infringe a patient’s legal rights, including their right to bodily integrity, and cause patients to survive...
with poor quality of life, which they had sought to avoid.  

For medical professionals, criminal responsibility could arise for murder or manslaughter (where treatment is withheld or withdrawn unlawfully) or for assault (where treatment is provided without appropriate consent or authorisation). A lack of legal knowledge will not excuse a medical professional from liability. Claims of civil liability may also flow from such actions, along with disciplinary or coronial proceedings.

In addition, conflict may arise where medical professionals and patients’ family or friends have little or no legal knowledge, or different understandings of what the law requires, leading to adverse consequences for everyone involved.

Our findings strongly suggest that doctors in a specialty involving end-of-life decision making should improve their knowledge of the law, in the interests of their patients and for their own protection. To achieve this goal, three things must occur: legal reform; improved training and resources; and a shift in doctors’ attitudes to knowing the law.

We have argued elsewhere that there are problems with the law in NSW, Victoria and Queensland, and have identified aspects that could be simplified. Some level of legal complexity in this area is unavoidable, but where it is unnecessary, the law should be reformed. There is also an urgent need for a national approach to the law in this area. For medical professionals, a single Australian legislative framework, or a harmonised national approach, is likely to be easier to know and understand.

Training in medical law remains uneven and unsystematic at all stages of medical education. This is reflected in the general knowledge deficits and variations by specialty demonstrated by our research, only partly offset by knowledge gained by practical involvement (the number of decisions).

Nevertheless, the correlation between knowledge level and recent CPD training is promising. Even if a harmonised national approach to the law in this area were to be achieved, the need for a substantial increase in educational effort would remain to ensure that all doctors involved in end-of-life care know and understand the applicable law. We advocate a broad approach to improving doctors’ knowledge of the law across the three main stages of medical education and note those with responsibility for change:

- undergraduate training in basic ethical principles and the related law at the end of life, within a wider framework of dedicated coursework in ethics, law and professional practice (universities and medical schools, Australian Medical Council);
- continuing training for interns and junior doctors in the hospital setting, in relevant rotations, as components of educational packages under accreditation requirements (hospital executives, directors of clinical training, medical education officers, specialist consultant leaders, internal training accreditation bodies, Medical Board of Australia); and
- specialist college-sponsored, non-elective training programs in all specialties concerned with end-of-life decision making (specialist colleges, Australian Medical Council).

However, providing training opportunities and resources — even in the format and at the times most desired by doctors — is not enough. Attitudes must also shift; doctors who are under ever-increasing time pressures must be satisfied that knowing the law is valuable. Learning about and understanding the law that applies at the end of life will require significant intellectual engagement and commitment of time. The challenge is convincing doctors that it is worth the effort. A good start is to ensure that doctors recognise that lack of legal knowledge places their patients’ interests and rights at risk — and them at legal risk.

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10 Hunter and New England Area Health Service A (2009) 74 NSWLR 88 [40].
12 Inquest into the Death of Jane Wio (Unreported, Queensland Coroners Court, State Coroner Barnes SM, 1 Jun 2000).
The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)

Lindy Willmott, Ben White, Malcolm Parker and Colleen Cartwright

This is the final article in a series of three that examines the legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. This article considers the position in Victoria. A review of the law in this State reveals that medical professionals play significant legal roles in these decisions. However, the law is problematic in a number of respects and this is likely to impede medical professionals' legal knowledge in this area. The article examines the level of training that medical professionals receive on issues such as refusal of treatment certificates and substitute decision-making, and the available empirical evidence as to the state of medical professionals' knowledge of the law at the end of life. It concludes that there are gaps in legal knowledge and that law reform is needed in Victoria. The article also draws together themes from the series as a whole, including conclusions about the need for more and better medical education and about law reform generally.

INTRODUCTION

This is the third and final article of this series which examines the legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. The focus of this article is Victoria. In line with the goals of this series, this article argues that medical professionals play a significant legal role in these decisions, but that the state of the law in this area is problematic, and this contributes to deficits in the legal knowledge of medical professionals.

The article begins by examining the relevant Victorian legal framework, specifically the Guardianship and Administration Act 1986 (Vic) and the Medical Treatment Act 1988 (Vic). It concludes that medical professionals play significant legal roles in this area and also that there are problems with the law that are likely to impede medical professionals knowing and understanding it. It then considers what medical professionals do know of Victorian law. The formal training in medical school and beyond is considered, along with some limited empirical evidence which suggests that medical professionals' knowledge in this area is lacking.

The final part of this article considers the problems identified earlier in relation to Victorian law and suggests reforms. It also concludes the series of articles as a whole and so also makes some conclusions about the need for more and better medical education and about law reform generally.

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observations about all three jurisdictions. In particular, the complexity of the law is discussed and there are also some recommendations as to how education might be improved to enhance medical professionals’ understanding of the law in this area.

**THE LAW IN VICTORIA**

**MEDICAL CONTEXT AND LEGAL DECISION-MAKING MECHANISMS**

The first article in this series provided the foundation for how the law in each of the three jurisdictions would be examined. The legal position depends on two variables. The first variable that a medical professional must consider is the *medical context*, which includes the condition of the adult, and three categories of context were devised as possibly arising in relation to decisions to withhold or withdraw life-sustaining treatment. The first is where the medical professional would consider it medically appropriate to offer life-sustaining treatment to an adult. The second is where the medical professional regards life-sustaining treatment to be futile. The third category is where an urgent decision about whether or not to provide life-sustaining treatment is required. Each of these three categories was illustrated by an example in the first article.

Having determined the relevant medical context, the medical professional then needs to consider the appropriate *legal decision-making mechanism*. These mechanisms could include where the adult has made the decision herself or himself in advance, where an adult has appointed an agent to make the decision or where the Victorian Civil and Administrative Tribunal (VCAT) appoints a guardian. These medical contexts and their corresponding legal decision-making mechanisms in Victoria are considered below.

**GUARDIANSHIP LAW IN VICTORIA**

**The legal framework: An overview**

The relevant legislation in Victoria is the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic). The *Guardianship and Administration Act 1986* (Vic) deals generally with decision-making for adults who lack capacity. It provides for the appointment of a guardian by VCAT on a plenary basis or on a more limited basis, eg, to consent to “health care” that is in the adult’s best interests. The legislation also facilitates the appointment by an adult of an enduring guardian. Further, the legislation provides for a “person responsible” to consent to “medical or dental treatment”. “Health care” is not defined in the legislation but the relevant aspect of “medical treatment” is defined to include:

- any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care ... normally carried out by, or under, the supervision of a registered practitioner.

This definition does not refer to refusing life-sustaining treatment and neither does the *Guardianship and Administration Act 1986* (Vic) specifically address this issue. Instead, the *Medical Treatment Act 1988* (Vic) deals with the refusal of treatment, and sets out a mechanism for a competent adult to complete a refusal of treatment certificate. That legislation also facilitates that refusal being given by an agent who has been appointed by the adult under an enduring power of attorney (medical treatment) pursuant to the Act, or by a guardian who has been conferred with power under an “appropriate” order of VCAT. The *Medical Treatment Act 1988* (Vic) defines “medical treatment” in the following terms:

- *medical treatment* means the carrying out of –
  - (a) an operation; or
  - (b) the administration of a drug or other like substance; or

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2. *Guardianship and Administration Act 1986* (Vic), s 3(1).
The legal role of medical professionals in life-sustaining treatment: Part 3 (Victoria)

(c) any other medical procedure
but does not include palliative care.

The term “palliative care” is also defined as including:

(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or
(b) the reasonable provision of food and water.5

This area of law is presently under review by the Victorian Law Reform Commission (VLRC) as part of its Guardianship Review. The VLRC’s terms of reference include:6

the appropriateness of the current requirements for and criteria pertaining to, the treatment of a represented person under the Act, including a consideration of the existing provisions dealing with medical research, non-medical research, medical and other treatment, the appropriateness of the existing “person responsible” model in . . . the Act and a consideration of any area of overlap between the operation of the Act and the Medical Treatment Act 1988 . . .

However, issues relating to end-of-life decision-making other than those that are currently dealt with by the Medical Treatment Act 1988 (Vic) are expressly excluded from the review.7 The Victorian Parliament Law Reform Committee has also recently completed a review of some relevance to this article on powers of attorney. That inquiry included consideration of enduring guardians appointed under the Guardianship and Administration Act 1986 (Vic), although enduring powers of attorney (medical treatment) under the Medical Treatment Act 1988 (Vic) were not included in the inquiry’s terms of reference.8

Capacity

Decisions about health care only need to be made on behalf of an adult if he or she lacks capacity. Although not expressly stated in either Victorian statute, it is likely that the common law presumption that an adult has capacity will be applied.9

There are four different terms used for determining when an adult will have or lack capacity. Part 4A of the Guardianship and Administration Act 1986 (Vic), which provides for a person responsible to give consent to medical or dental treatment, applies when an adult “is incapable of giving consent”.10 This arises when:

(a) the person is incapable of understanding the general nature and effect of the proposed treatment; or
(b) the person is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment.

Under the Medical Treatment Act 1988 (Vic), a person must be of “sound mind” to be able to complete a refusal of treatment certificate12 but there is no express requirement that a person must have lost capacity before the certificate can come into effect.13 The position is different for an agent appointed under that Act as it is only once the adult “becomes incompetent” that the agent is able to complete a refusal of treatment certificate.14 This term is not defined.

5 These terms were subject to judicial consideration in Re BWV; Ex parte Gardner (2003) 7 VR 487.
7 Victorian Law Reform Commission, n 6, p 6.
9 See eg AC (Guardianship) [2009] VCAT 753 at [33].
10 Guardianship and Administration Act (Vic), s 36(1)(b).
11 Guardianship and Administration Act (Vic), s 36(2).
12 Medical Treatment Act 1988 (Vic), s 5(1)(d).
13 Note that if common law advance directives continue to exist in Victoria (see discussion below), that potentially gives rise to another test for capacity. The test for capacity at common law is discussed in White, Willmott, Trowse, Parker and Cartwright, n 6 at 507.
14 Medical Treatment Act 1988 (Vic), s 5A(2)(b).
Finally, for a guardian to be appointed by VCAT\textsuperscript{15} or for an enduring guardian’s power to commence,\textsuperscript{16} the adult must be “unable by reason of [the/a] disability to make reasonable judgments” in relation to the decisions that need to be made. Disability is defined as meaning “intellectual impairment, mental disorder, brain injury, physical disability or dementia”.\textsuperscript{17}

**Role of medical professional**

A medical professional will need to assess an adult’s capacity in relation to the relevant decision, which here is to refuse life-sustaining treatment. To determine whether an adult lacks this capacity (except where a guardian has been appointed by VCAT for the matter as then a finding of incapacity has already been made), the medical professional will need to select and apply the correct legal definition outlined above depending on the decision-making mechanism that applies.

**Category 1: Medical professional considers offering life-sustaining treatment to be medically appropriate**

The authors now turn to consider the three categories of medical context referred to above and the relevant decision-making mechanisms that apply to each, beginning with those cases where the medical professional considers that it is medically appropriate to offer life-sustaining treatment.

**The adult has completed a refusal of treatment certificate**

While still of “sound mind”, an adult in Victoria is able to complete a refusal of treatment certificate. The Medical Treatment Act 1988 (Vic) permits the refusal to extend to medical treatment generally, or only to medical treatment of a particular kind.\textsuperscript{18} One limitation on an adult’s ability to refuse treatment in such a certificate is the requirement that the refusal relate to a current condition of the adult. This means that a refusal of treatment certificate cannot be completed in anticipation of contracting a disease or illness or of suffering a sudden catastrophic injury.

**Role of medical professional**

Although the adult is the decision-maker herself or himself through the refusal of treatment certificate, the medical professional has an important role to play in the completion of the certificate. The certificate must be witnessed by a medical professional (and another person) who must be satisfied that:\textsuperscript{19}

- the adult has clearly expressed a decision to refuse treatment for a current condition;
- this decision has been made voluntarily and without inducement or compulsion;
- the adult has been informed about her or his condition to enable a decision to be made about treatment, and the adult appears to have understood this information; and
- the adult is of sound mind and at least 18 years old.

Further, the medical professional would need to determine that the refusal of treatment certificate applies to the situation that had arisen, that the certificate has not been cancelled,\textsuperscript{20} and that the adult’s medical situation has not “changed to such an extent that the condition in relation to which the certificate was given is no longer current”.\textsuperscript{21}

\textsuperscript{15} Guardianship and Administration Act 1986 (Vic), s 22(1)(b). To appoint a guardian, VCAT is also required to be satisfied that the adult has a disability and is in need of a guardian: Guardianship and Administration Act 1986 (Vic), s 22(1). In relation to this test, see Public Advocate v RCS (Guardianship) [2004] VCAT 1880, and see also XYZ v State Trustees Ltd (2006) 25 VAR 402; [2006] VSC 444 (although in relation to the appointment of an administrator).

\textsuperscript{16} Guardianship and Administration Act 1986 (Vic), s 35B(1)-(2).

\textsuperscript{17} Guardianship and Administration Act 1986 (Vic), s 3(1).

\textsuperscript{18} Medical Treatment Act 1988 (Vic), s 5.

\textsuperscript{19} Medical Treatment Act 1988 (Vic), s 5(1). Although s 5(1) refers to the certificate being “witnessed” by a medical practitioner, the prescribed form refers to the medical practitioner “certifying” certain facts to be correct and makes provision for the medical practitioner to “sign” the form.

\textsuperscript{20} Medical Treatment Act 1988 (Vic), s 7.

\textsuperscript{21} Medical Treatment Act 1988 (Vic), s 7(3).

776 (2011) 18 JLM 773
Common law advance directives

Whether common law advance directives (which were examined in the first article of this series) continue to have force in Victoria remains uncertain. The Office of the Public Advocate appears to take the view that advance directives would not be recognised by the common law. While the position is not clear cut, the authors prefer the opposite view.

The statutory regime for refusing treatment as set out in the Medical Treatment Act 1988 (Vic) is stated not to “affect any right of a person under any other law to refuse medical treatment”. It is not clear what is meant by “other law” in this provision. It may be a reference to the common law right of a competent adult to give a contemporaneous refusal of medical treatment. On a plain reading, it would also appear to preserve an adult’s common law right to refuse treatment in advance of the medical situation arising. This would mean that a decision made by a competent adult to refuse treatment by way of a common law advance directive would continue to be binding on those who provided treatment.

While the Medical Treatment Act 1988 (Vic) purports to retain common law rights, four arguments can be advanced in favour of the view that the force of common law directives might be negated because of the substitute decision-making regime established by the Guardianship and Administration Act 1986 (Vic). First, the Guardianship and Administration Act 1986 (Vic) facilitates a decision about medical treatment being made on behalf of a person who lacks capacity. The Guardianship and Administration Act 1986 (Vic) requires the substitute decision-maker to take the views of the adult (eg, as expressed in an advance directive) into account, but is not bound to make a decision that is consistent with these views. Secondly, there is no express statement in the Guardianship and Administration Act 1986 (Vic) or the Medical Treatment Act 1988 (Vic) that the previously existing common law right of a competent person to refuse medical treatment through an advance directive remains despite the enactment of the substitute decision-making regime by the Guardianship and Administration Act 1986 (Vic). Thirdly, the consent regime established by the Guardianship and Administration Act 1986 (Vic) provides that consent given under that Act has the same effect as if “the patient had been capable of giving consent to the carrying out of the procedure or consent” and the “procedure or treatment had been carried out with the consent of the patient”. Therefore, because an adult with capacity can override her or his prior advance directive, so too can a substitute decision-maker who is granted the same powers. Fourthly, the Guardianship and Administration Act 1986 (Vic) provides that a medical professional must not carry out treatment on the basis of substitute consent if “a refusal of treatment is in force in accordance with [the Medical Treatment Act 1988]”. Refusal of treatment, in this context, is likely to refer to the ways that treatment can be refused as prescribed by that Act, rather than a reference to the common law. By failing to refer to the common law, it could be argued that a common law advance directive would not prevail over consent given under the Guardianship and Administration Act 1986 (Vic).

The alternative position, and one that the authors consider is the better view, is that the common law governing advance directives still applies, notwithstanding the implementation of the guardianship regime. This view can be supported on two bases. First, there is a presumption that express words or

22 White, Willmott, Trowse, Parker and Cartwright, n 6 at 508-509.
23 Office of the Public Advocate, Advocacy and Decision-making in Relation to Medical and Dental Treatment and Other Health Care at [6.5], http://www.publicadvocate.vic.gov.au/about-us/200 viewed 11 November 2010: “In circumstances where a person when competent, indicated in some way (verbally or in writing in some format) that they did not want particular treatment, including to be resuscitated, then this will be a common law advance directive. In Victoria, it would seem to be that the common law regarding advance directives will be respected. However, once a person is defined as incompetent, their advance directive holds a much weaker position.”
24 Medical Treatment Act 1988 (Vic), s 4.
26 Guardianship and Administration Act 1986 (Vic), s 40(a).
27 Guardianship and Administration Act 1986 (Vic), s 40(b).
28 Guardianship and Administration Act 1986 (Vic), s 41.
necessary implication are required before a statute is regarded as abolishing previously held common law rights. This is particularly so given the fundamental nature of the right to bodily integrity that is embodied in an ability to make an advance directive. Yet, express words are not used in the Guardianship and Administration Act 1986 (Vic) to suggest that the common law right to make an advance directive that refuses treatment is abolished by the statute and neither is such an outcome required by necessary implication. Secondly, the Medical Treatment Act 1988 (Vic) is legislation that deals specifically with the refusal of treatment, and contains an express statement about other rights being unaffected by the Act. The Guardianship and Administration Act 1986 (Vic) deals more generally with guardianship issues and not specifically with the refusal of treatment. Application of the statutory principle that the specific should prevail over the general (generalia specialibus non derogant) would mean that the specific provision in the Medical Treatment Act 1988 (Vic) preserving other rights to refuse medical treatment would prevail.

Role of medical professional

If the first interpretation outlined above is correct, the adult is not able to give a legally binding common law advance directive and a medical professional will not need to consider this possibility. However, if the second interpretation is correct and the common law continues to operate, the medical professional will need to know this and also fulfil the same roles discussed in the first article.

A person has been appointed by the Victorian Civil and Administrative Tribunal to make health care decisions on the adult’s behalf

VCAT is empowered to appoint a guardian on behalf of an adult who lacks capacity. The Medical Treatment Act 1988 (Vic) provides that a guardian appointed by way of an “appropriate order” under the Guardianship and Administration Act 1986 (Vic) may refuse treatment. A VCAT order will be an “appropriate order” for the purpose of the Medical Treatment Act 1988 (Vic) if the power conferred on the guardian is sufficiently broad to include the power to refuse treatment. It is therefore necessary to consider the kinds of appointment that VCAT can make.

- **Plenary guardian:** A person who is appointed as a plenary guardian has “all the powers and duties which the plenary guardian would have if he or she were a parent and the represented person his or her child”. This power is broad enough to authorise the guardian to refuse life-sustaining treatment for the adult. As such, a plenary order is an “appropriate order” under the Medical Treatment Act 1988 (Vic).

- **Limited guardian with power to make decisions about medical treatment:** Functions under the Guardianship and Administration Act 1986 (Vic) must be performed in a way that is least restrictive of an adult’s freedom of decision. Therefore, a plenary appointment will not be made if it is sufficient for a guardian to be appointed with more limited powers.

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30 Smith v The Queen (1994) 181 CLR 338 at 348 (Mason CJ, Dawson, Gaudron and McHugh JJ).

31 White, Willmott, Trowse, Parker and Cartwright, n 6 at 508-509.

32 Guardianship and Administration Act 1986 (Vic), s 22(1). For the criteria for appointing a guardian, see n 15. In addition to appointing a guardian, VCAT may appoint a person to make a decision in relation to the proposed procedure or treatment: Guardianship and Administration Act 1986 (Vic), s 37(1)(b).

33 Medical Treatment Act 1988 (Vic), s 5A(1)(b).

34 Guardianship and Administration Act 1986 (Vic), s 24(1).


36 Guardianship and Administration Act 1986 (Vic), s 4(2)(a).

37 Guardianship and Administration Act 1986 (Vic), s 22(2), (4).
the Medical Treatment Act 1988 (Vic).\(^{38}\) In other words, the appointment of a limited guardian with power to make decisions about medical treatment is an “appropriate order” under the Medical Treatment Act 1988 (Vic).

- **Limited guardian with power to consent to health care:** A distinction is made between the appointment of a guardian to “make decisions about medical treatment” (above) and the appointment of a guardian to “consent to health care”. While the former appointment is regarded as sufficient to authorise the guardian to refuse treatment under the Medical Treatment Act 1988 (Vic), the latter is not.\(^{39}\)

**Criteria applicable to the decision**

One of the following two criteria must be satisfied before a guardian appointed by VCAT (either by way of a plenary appointment or appointed with authority to make decisions about medical treatment) is entitled to complete a refusal of treatment certificate under the Medical Treatment Act 1988 (Vic) on behalf of an adult:

- the medical treatment would cause unreasonable distress to the adult; or
- there are reasonable grounds for believing that the adult, if competent, and after giving serious consideration to her or his health and wellbeing, would consider that the medical treatment is unwarranted.\(^{40}\)

**Role of medical professional**

A medical professional will first need to determine whether a guardian has been appointed by VCAT and whether that guardian has power to refuse treatment. If so, although it is the guardian who is the relevant decision-maker, the medical professional has an important role in the completion of the refusal of treatment certificate. The certificate must be witnessed by a medical professional (and another person) who must be satisfied that:

- the guardian has been informed about the adult’s condition to an extent that would be necessary for the adult, if competent, to have made a decision about refusing treatment; and
- the guardian appears to have understood this information.\(^{41}\)

A medical professional also has an important role if he or she has concerns that treatment is being improperly refused by a guardian. This would occur, eg, if the medical professional is not of the view that either of the criteria set out above (that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted) is satisfied.\(^{42}\) In such a case, the medical professional may apply to VCAT under its power to hear applications generally in relation to medical or dental treatment\(^{43}\) or for a reassessment of the guardian’s appointment.\(^{44}\)

\(^{38}\) See eg EK (Guardianship) [2005] VCA T 2520; BK (Guardianship) [2007] VCA T 332; BWV [2003] VCA T 121; and Korp (Guardianship) [2005] VCA T 779 where a guardian was appointed in each case with power to make decisions about medical treatment in situations where an end-of-life treatment decision was contemplated.

\(^{39}\) See also EK (Guardianship) [2005] VCA T 2520 and AV (Guardianship) [2005] VCA T 2519 although the distinction between consent to health care and refusing treatment in these cases was being considered in the context of the powers of a “person responsible”. A limited guardian with power only to consent to health care may, however, withhold such consent and the effect of this is considered in more detail below at 781-782 when examining the powers of a person responsible.

\(^{40}\) Medical Treatment Act 1988 (Vic), s 5B(2).

\(^{41}\) Medical Treatment Act 1988 (Vic), s 5B(1).

\(^{42}\) Also, as discussed above in relation to refusal of treatment certificates generally, the medical professional would need to determine that the adult’s medical situation has not “changed to such an extent that the condition in relation to which the certificate was given is no longer current”: Medical Treatment Act 1988 (Vic), s 7(3).

\(^{43}\) Guardianship and Administration Act 1986 (Vic), s 42N. Although this power is expressed to apply to matters, questions or disputes arising under Pt 4A of the Act, a request for consent by a medical professional under this Part which is then refused by a guardian would be sufficient to give rise to the exercise of this power.

\(^{44}\) Guardianship and Administration Act 1986 (Vic), s 61.
The adult has appointed an agent to make health care decisions on the adult’s behalf

There are two avenues that an adult can adopt to appoint another to make health decisions on her or his behalf. One is where the adult executes an instrument to appoint an enduring guardian. The authority conferred by this appointment will only take effect once the adult loses capacity. The powers of an enduring guardian will depend on the nature of the appointment. It is possible for the adult to confer very broad powers on an enduring guardian, including a power in relation to health care and the power to consent to medical treatment. However, even the conferral of broad powers or specific powers in relation to health care would not appear to be sufficient to authorise an enduring guardian to refuse life-sustaining treatment.

This is because the right of an agent to refuse treatment on behalf of an adult is governed by the Medical Treatment Act 1988 (Vic) and the only agent authorised by that statute to refuse treatment is an agent appointed pursuant to an enduring power of attorney (medical treatment). An appointment under such a document can only be authorised by the Medical Treatment Act 1988 (Vic).

Accordingly, while an agent under an enduring power of attorney (medical treatment) can refuse treatment, an enduring guardian appointed under an enduring power of guardianship pursuant to the Guardianship and Administration Act 1986 (Vic) cannot.

Criteria applicable to the decision

An agent appointed under an enduring power of attorney (medical treatment) pursuant to the Medical Treatment Act 1988 (Vic) can refuse treatment by completing a refusal of treatment certificate. The agent must be satisfied of the same criteria that apply to a guardian appointed by VCAT discussed above, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted.

Role of medical professional

A medical professional will need to ascertain whether an enduring guardian or an agent appointed under an enduring power of attorney (medical treatment) has been appointed, and know that the enduring guardian lacks the power to refuse treatment but that an agent does have such power. Where an agent is seeking to complete a refusal of treatment certificate, the medical professional’s role is the same as for a guardian appointed by VCAT, namely to witness that the agent has been appropriately informed and understands that information. As with guardians appointed by VCAT, a medical professional also has a legal role where he or she is concerned that treatment is being refused by an

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45 Guardianship and Administration Act 1986 (Vic), s 35A. The instrument appointing the enduring guardian must be in the form of, or to the effect of, Form 1 in Sch 4: Guardianship and Administration Act 1986 (Vic), s 35A(2)(a).
46 Guardianship and Administration Act 1986 (Vic), s 35B(1).
47 Guardianship and Administration Act 1986 (Vic), s 35B(2).
48 If the instrument does not specify the matters for which the enduring guardian will have decision-making power, the enduring guardian will have all the powers of a guardian who has been given a plenary appointment by VCAT: Guardianship and Administration Act 1986 (Vic), s 35B(2).
49 Medical Treatment Act 1988 (Vic), s 5A.
50 An enduring guardian is, however, able to consent to medical treatment or withhold such consent under Pt 4A of the Guardianship and Administration Act 1986 (Vic). The effect of withholding such consent is considered in more detail below at 781-782 when examining the powers of a “person responsible”.
51 Medical Treatment Act 1988 (Vic), s 5B.
52 Medical Treatment Act 1988 (Vic), s 5B(1).
agent improperly. In such a case, the medical professional may apply to VCAT under its power to hear applications generally in relation to medical or dental treatment\(^{53}\) or for suspension or revocation of the agent’s appointment.\(^{54}\)

**A person is nominated by the legislation as person responsible (“default decision-maker”)**

The Victorian statutory scheme also enables consent to “medical or dental treatment” to be given by a “person responsible”.\(^{55}\) “Person responsible” is defined to include the formal appointees discussed above: an agent under an enduring power of attorney (medical treatment), a guardian appointed by VCAT and an enduring guardian or person appointed in writing by the adult.\(^{56}\) In the absence of a formal appointment, the person responsible will be the first of the following who is reasonably available and willing and able to make the relevant health care decision:

- the adult’s spouse or domestic partner (if the relationship is close and continuing and the spouse or domestic partner is not under guardianship);\(^{57}\)
- the adult’s primary carer;
- the adult’s nearest relative.\(^{58}\)

A person responsible does not have power to refuse treatment under the *Medical Treatment Act 1988* (Vic).\(^{59}\) Rather, the power of a person responsible is limited to providing consent to treatment, or withholding consent to that treatment.\(^{60}\)

**Criteria applicable to the decision**

In deciding whether to consent to treatment or withhold that consent, the person responsible must act in the adult’s best interests.\(^{61}\) In determining whether medical treatment is in the adult’s best interests, the person responsible is required to consider a list of factors including the wishes of the adult and her or his family, and the nature and degree of any significant risks associated with the treatment and any alternative treatment.\(^{62}\)

**Role of medical professional**

Considered here is the way in which the limited power of the person responsible to withhold consent to treatment (as opposed to refusing that treatment) operates and the implications this has for medical professionals. Given that “person responsible” is defined to include guardians appointed by VCAT (who sometimes will be appointed without power to refuse treatment) and enduring guardians

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53 Guardianship and Administration Act 1986 (Vic), s 42N. Although this power is expressed to apply to matters, questions or disputes arising under Pt 4A of the Act, a request for consent by a medical professional under this Part which is then refused by an enduring guardian would be sufficient to give rise to the exercise of this power.

54 Medical Treatment Act 1988 (Vic), s 5C(2)(b). The ability of a medical professional to make such an application was recognised by Morris J in *Re BWV; Ex parte Gardner* (2003) 7 VR 487 at [88]. An unusual feature of this provision is that the test applied under s 5C of the *Medical Treatment Act 1988* (Vic) to remove an agent is “best interests”. This is different from the criteria that an agent is required to apply which is more closely linked with a substituted judgment approach, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted: *Medical Treatment Act 1988* (Vic), s 5B. This creates the possibility that an agent could be exercising her or his authority diligently in accordance with the Act but nevertheless have her or his appointment revoked or suspended.

55 Guardianship and Administration Act 1986 (Vic), s 39(1).

56 Guardianship and Administration Act 1986 (Vic), s 37(1)(a), (c)-(e).

57 Guardianship and Administration Act 1986 (Vic), s 37(4)(a).

58 Guardianship and Administration Act 1986 (Vic), s 37(1)(f)-(h). “Nearest relative” is defined in the Guardianship and Administration Act 1986 (Vic), s 3(1).

59 EK (Guardianship) [2005] VCAT 2520; AV (Guardianship) [2005] VCAT 2519.

60 Section 42H(2) of the Guardianship and Administration Act 1986 (Vic) contemplates the possibility of consent being withheld as it refers to “whether or not to consent to medical or dental treatment”.

61 Guardianship and Administration Act 1986 (Vic), s 42H. See also Guardianship and Administration Act 1986 (Vic), s 4(2), which sets out a list of principles which decision-makers under the Act must apply.

62 Guardianship and Administration Act 1986 (Vic), s 38.
appointed by the adult (who will never have power to refuse treatment), this discussion will apply to
all substitute decision-makers whose power is limited to withholding consent to treatment.

The role of the medical professional will be to identify the relevant person responsible in the
hierarchy and to know that this role carries with it only the power to consent to treatment or withhold
that consent, and not to refuse treatment. Where a person responsible exercises that power to withhold
consent to recommended medical treatment, a medical professional may respond to that decision in
one of two ways. The first is for the medical professional to accept that withholding of consent. This
means that the treatment will not be given as consent or some other authorisation is required to
provide treatment. The withholding of consent by the person responsible will be given effect.

The second option when confronted with a withholding of consent is for the medical professional
to seek authorisation to provide the treatment from another source and the Guardianship and
Administration Act 1986 (Vic) provides a mechanism for obtaining such authority. 63 It permits a
medical professional who is confronted with a withholding of consent, to serve the person responsible
(and the Public Advocate) with a statement – a “section 42M form” – that advises of the medical
professional’s intention to provide the treatment for which consent is being withheld. 64 The person
responsible may then, if he or she chooses to do so, make an application to VCAT for it to consider the
matter. If such action is not taken within seven days, the medical professional may then provide
treatment.

A medical professional will need to be aware of these two options and the necessary procedural
steps that accompany the second option. The medical professional will also need to be aware that in
these circumstances, he or she is effectively the de facto decision-maker. He or she is able to accept
that withholding of consent and not provide treatment, or he or she can follow a procedure which, if
not contested, will allow her or him to ignore that withholding of consent and provide treatment.

A medical professional will also need to know how the distinction between the power to withhold
consent and refuse treatment impacts upon withdrawing treatment as opposed to withholding
treatment. The provision of treatment requires consent or some other authorisation. Accordingly, the
withholding of consent by a person responsible is capable of preventing that treatment being instituted
(subject to the medical professional taking the steps described above). However, once consent or
authorisation is obtained and treatment instituted, further consent or authorisation may not be required.
In this case, a person responsible who does not wish for treatment to continue will not be in a position
to prevent that treatment continuing if there is already in place lawful justification for treating. To
require that treatment be withdrawn, it would be necessary to have a power to refuse treatment and
require that it be stopped. Accordingly, a medical professional will need to be aware of how a power
to withhold consent may operate differently where treatment is being withdrawn as opposed to
withdrawal.

Finally, as was the case with other decision-makers, a medical professional who is concerned
about a proposed decision may apply to VCAT under its power to hear applications generally in
relation to medical or dental treatment. 65

**Decision by the Public Advocate**

The Guardianship and Administration Act 1986 (Vic) establishes a statutory of fice, the Public
Advocate. 66 The Public Advocate’s functions include acting as a guardian for an adult when appointed
by VCAT, 67 therefore, depending on the nature of the appointment, he or she may have power to

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63 See Guardianship and Administration Act 1986 (Vic), ss 42L, 42M.
64 The requirements of that statement are set out in Guardianship and Administration Act 1986 (Vic), s 42M.
65 Guardianship and Administration Act 1986 (Vic), s 42N. Although this power is expressed to apply to matters, questions or
disputes arising under Pt 4A of the Act (which does not grant power to persons responsible to refuse treatment), a request for
consent by a medical professional under this Part which is then refused by a person responsible would be sufficient to give rise
to the exercise of this power.
66 Guardianship and Administration Act 1986 (Vic), s 14.
67 Guardianship and Administration Act 1986 (Vic), ss 16, 23(4).
refuse life-sustaining treatment when acting in that role. Unlike in Queensland, however, the Victorian legislation does not contain equivalent provisions that enable the Public Advocate to intervene and make decisions where there is a disagreement as to what decision should be made or where decisions are being made inappropriately. 68

Criteria applicable to the decision

The criteria that must be applied by the Public Advocate in refusing treatment as guardian is the same as that applied by any other person acting in that role, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted. 69

Role of medical professional

Again, the role of the medical professional in this situation is the same as for guardians generally discussed above. 70

Order of the Victorian Civil and Administrative Tribunal

The Guardianship and Administration Act 1986 (Vic) confers on VCAT very wide powers in relation to medical treatment of an adult upon the making of an application to it. 71 In addition to being able to appoint a person to make decisions concerning medical treatment, VCAT is able to provide declaratory relief regarding the validity of a medical treatment decision. VCAT is also able to give an advisory opinion concerning the best interests of an adult, and make any other orders considered to be in the best interests of an adult. VCAT also has power generally to give directions to substitute decision-makers. 72

Despite the broad nature of these powers, VCAT itself is not empowered to order that life-sustaining treatment be withheld or withdrawn from an adult. It has power to consent under Pt 4A of the Guardianship and Administration Act 1986 (Vic) 73 in the same way that a person responsible does, as discussed above, but not power to refuse medical treatment. Having said that, a decision by VCAT that treatment should not be given (with the result that consent is therefore withheld) is likely to act as a de facto refusal of treatment. In practice, however, where such a decision may be required, VCAT has tended to appoint the Public Advocate as guardian to make the relevant treatment decision. 75

Criteria applicable to the decision

The criteria applicable to the decision depend on which of the various VCAT powers are exercised, but will include best interests, as noted above. In relation to what appears to be VCAT’s usual approach in these situations (the appointment of a guardian), the criteria for such an appointment are discussed above, as are the criteria to be employed by the guardian who then makes the decision. 78

69 See above at 779.
70 See above at 779.
71 Guardianship and Administration Act 1986 (Vic), s 42N(6).
72 Guardianship and Administration Act 1986 (Vic), ss 30, 35E, 42I.
73 Guardianship and Administration Act 1986 (Vic), s 39(1)(a).
74 See above at 781.
75 See eg BK (Guardianship) [2007] VCAT 332; Korp (Guardianship) [2005] VCAT 779; EK (Guardianship) [2005] VCAT 2520; BWV [2003] VCAT 121.
76 In determining whether medical treatment is in the adult’s best interests, consideration must be given to the factors listed in s 38 of the Guardianship and Administration Act 1986 (Vic). See also Guardianship and Administration Act 1986 (Vic), s 4(2), which sets out a list of principles which decision-makers under the Act must apply.
77 See n 15 above.
78 See above at 779.
Role of medical professional

The medical professional will need to know that it is possible to apply to VCAT in cases where there is a dispute or where he or she has concerns about the treatment decisions being made.

Category 2: Medical professional considers life-sustaining treatment to be futile

The statutory regime in Victoria does not alter the common law in relation to futile treatment. Thus, a medical professional is under no obligation to provide treatment to an adult where “no benefit at all would be conferred”. Treatment regarded as futile is not considered to be in a person’s best interests and so need not be provided. Disputes as to assessments of futility can arise and those close to the adult may wish to challenge a medical professional’s determination of futility in the Supreme Court in its parens patriae jurisdiction (discussed below).

Role of medical professional

The medical professional is the initial decision-maker in this context and must therefore be aware that the law does not require provision of futile treatment. He or she also needs to be aware of avenues for legal review before VCAT and the Supreme Court.

Category 3: Urgent decision about life-sustaining treatment is required

A medical professional is authorised by the Guardianship and Administration Act 1986 (Vic) to provide medical treatment without consent if he or she believes on reasonable grounds that the treatment is necessary, as a matter of urgency, to save the adult’s life, or to prevent serious damage to the adult’s health, or to prevent the adult from suffering or continuing to suffer significant pain or distress. The Victorian legislation does not address the situation where a decision to withhold or withdraw treatment may need to be made on an urgent basis. However, if the treatment is futile as discussed above, there is no obligation to treat.

Role of medical professional

In the context of an urgent decision concerning life-sustaining treatment, the medical professional is the legal decision-maker. While he or she is not expressly authorised to withhold or withdraw treatment in an emergency situation, if the treatment is assessed as being futile, it can be lawfully withheld under the common law. If treatment is not futile, the medical professional has power to provide treatment without consent.

ORDER OF THE SUPREME COURT EXERCISING ITS PARENS PATRIA JURISDICTION

In addition to the statutory mechanisms so far considered, the Victorian Supreme Court has power to make decisions in relation to life-sustaining treatment for adults who lack capacity by virtue of its parens patriae jurisdiction. This jurisdiction was discussed in more detail in the second article in this series. It is sufficient here to note that the parens patriae jurisdiction continues in Victoria despite the...

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80 See eg in Victoria, Re Herrington [2007] VSC 151.

81 See at 784-785.

82 Guardianship and Administration Act 1986 (Vic), s 42A. Note, however, that the medical professional is not empowered to do so if treatment has been refused pursuant to the Medical Treatment Act 1988 (Vic): Guardianship and Administration Act 1986 (Vic) s 41.

83 This was the basis on which Slaveski v Austin Health [2010] VSC 493 and Re Herrington [2007] VSC 151 were heard.

84 Willmott, White, Parker and Cartwright, n 68 at 535-537.
enactment of guardianship legislation and that the criterion employed by the court is “the protection of the best interest of the health and welfare of the person the subject of its exercise”.

**Role of medical professional**

The role of the medical professional is that he or she (or the relevant treating hospital) may bring an application to the Supreme Court for its consideration.

**CONCLUSIONS ON THE LAW**

**Some problems with the law in Victoria**

The above examination of the law that governs withholding and withdrawing life-sustaining treatment from adults who lack capacity demonstrates that it is problematic in some respects. As with the other articles in this series, this section does not review comprehensively all of the problems with Victorian law in this area, only those relevant to the focus of this article, namely problems that are likely to act as obstacles to medical professionals knowing the law. This section also does not address the issue of the complexity of the law generally as this is considered below.

**Distinction between withholding consent and refusing treatment**

As discussed above, the law in Victoria distinguishes between the power to withhold consent to treatment and the power to refuse that treatment. There are a number of problems that flow from this. The first is that this distinction is a fine one and is unlikely to be understood by medical professionals. The submission of the Office of the Public Advocate to the VLRC’s review of guardianship law reported its experience that “even skilled practitioners are unable to distinguish withholding consent to treatment from refusing treatment” and noted this distinction is subject to “widespread uncertainty”. The VLRC’s Information Paper also identifies this distinction as a source of confusion.

A second problem for medical professionals’ knowledge of the law is that this distinction creates a situation where some substitute decision-makers will have power to refuse treatment but others only power to withhold consent. This will present challenges for medical professionals seeking to know and comply with the law. This is particularly so in relation to a guardian appointed by VCAT as this type of decision-maker can have the relevant power needed to refuse treatment but will not always do so. A medical professional will need to know this and check the scope of the guardian’s appointment.

A third problem is that this distinction creates a gap in the law in that the default decision-maker does not have power to refuse treatment. While there is a mechanism to resolve disputes where consent to treatment is being withheld by a substitute decision-maker through the giving of a “section 42M form”, it appears that this process, which is described by the VLRC as “rather complex”, is not being utilised by medical professionals. To illustrate, the relevant form must be

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85 Re BWV; Ex parte Gardner (2003) 7 VR 487 at 510.
86 Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549 at 554; and Slavesski v Austin Health [2010] VSC 493 at [34], referring to the criterion as discussed by the High Court in Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion’s Case) (1992) 175 CLR 218 at 240, 249, 252, 270-273, 295, 300, 316. There are many other formulations of this criterion. See eg Re Herrington [2007] VSC 151 at [22]; Melo v Superintendent of Royal Darwin Hospital (2007) 21 NTLR 197; [2007] NTSC 71 at [25]; Messiha v South East Health [2004] NSWSC 1061 at [25].
88 Office of the Public Advocate, n 87, p 35.
89 Victorian Law Reform Commission, n 6, p 38. See also evidence to this effect in Victorian Parliament Law Reform Committee, n 8, pp 161-162.
90 See above at 782.
91 Victorian Law Reform Commission, n 6, p 32.
92 Office of the Public Advocate, n 87, pp 33-34.
filed with the Office of the Public Advocate but none were filed in the last financial year.\(^93\) Instead, it is suggested that medical professionals are initiating guardianship applications, which is undesirable as it is contrary to the least restrictive approach.\(^94\) While the authors are not aware of any empirical research that has been carried out on this point, it may also be the case that treatment is being provided in the absence of the appropriate consent or authorisation.

A fourth problem is that this distinction adds further complexity because it treats withholding treatment differently from withdrawing treatment. As discussed above, a person responsible has the ability to withhold consent to the commencement of life-sustaining treatment which may lead to the measure being withheld if it is not challenged by the medical professional, but withholding consent to treatment that has commenced and is being lawfully provided will not, of itself, lead to that treatment being stopped. An awareness not only of the distinction between withholding consent and refusing treatment is required by medical professionals, but also of the way in which that distinction plays out in practice depending on whether the relevant treatment has been started or not.

**Health care substitute decision-making spread over two statutes**

A related problem is that the law that governs health care substitute decision-making is contained in two statutes: the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic). One deals with substitute decision-making generally (including decisions about health care) and grants power to consent to treatment, while the other deals with decisions about medical treatment and specifically provides for refusal of that treatment. The two pieces of legislation are the source of the problematic distinction between withholding consent and refusing treatment discussed above.

The existence of this parallel legislation has been identified by the VLRC as being a potential source of confusion\(^95\) and the relationship between the two statutes has been described as “complex”.\(^96\) This is likely to be an impediment to a medical professional’s knowledge of the law. Contributing to this confusion is that the two pieces of legislation do not sit well together. For example, there are different definitions of “medical treatment”\(^87\) and different approaches are taken to capacity.\(^98\)

A particular problem is that both pieces of legislation provide for the appointment by the adult of a substitute decision-maker: an enduring guardian under the *Guardianship and Administration Act 1986* (Vic) and an agent under the *Medical Treatment Act 1988* (Vic). The VLRC has noted that this “overlap creates confusion amongst medical practitioners and the community”.\(^99\) Adding to the confusion is that it is only the agent who has power to refuse treatment; an enduring guardian may only withhold consent.

**Multiple definitions of capacity**

Another challenge for medical professionals seeking to know Victorian law in this area is the multiple definitions of “capacity”. The various approaches described above,\(^100\) depending on the legal context, are that an adult “is incapable of giving consent”; an adult is of “sound mind”, an adult “becomes incompetent”, and that an adult is “unable by reason of [the/a] disability to make reasonable judgments” in relation to the decisions that need to be made. A medical professional would be required to know these different definitions and which one to apply depending on the legal context. Although its review focused on powers of attorney, the Victorian Parliament Law Reform Committee noted, in the context of its review, that the “different approaches to capacity contained in the various statutes

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\(^{93}\) Office of the Public Advocate, n 87, p 33.

\(^{94}\) Office of the Public Advocate, n 87, p 34.

\(^{95}\) Victorian Law Reform Commission, n 6, p 53.

\(^{96}\) Victorian Law Reform Commission, n 6, p 31.

\(^{97}\) Office of the Public Advocate, n 87, pp 31-33.

\(^{98}\) See at 786-787.

\(^{99}\) Victorian Law Reform Commission, n 6, p38.

\(^{100}\) See above at 775-776.
cause widespread confusion and uncertainty”.101 The Australian Medical Association submission to that inquiry also described the current definitions of capacity as “varied and erratic” and “unhelpful to a donor, witness, [and] doctor”.102

**Uncertain status of common law advance directives**

While the Medical Treatment Act 1988 (Vic) makes provision for refusal of treatment certificates, it is unclear whether advance directives at common law still have legal force in Victoria. The arguments for and against recognition of such directives are discussed above.103 Uncertainty as to the legal effect of a statement refusing medical treatment that is not contained in a refusal of treatment certificate is likely to make knowing the law in this area more difficult for medical professionals.

**Legal role of medical professionals**

The above analysis of the law in Victoria also demonstrates that medical professionals play a significant legal role in these decisions. As in the articles on New South Wales and Queensland, the legal roles of medical professionals can be characterised in three ways.

**Medical professional as legal decision-maker**

There is no duty to provide futile treatment so if a medical professional reaches the view that treatment can be characterised in this way, he or she is the legal decision-maker and may decline to treat. The Victorian legislation also grants the medical professional decision-making power to provide life-sustaining treatment in an emergency situation. Finally, it can be argued that a medical professional may act as a de facto decision-maker in circumstances where a substitute decision-maker withholds consent to treatment. As noted above, the medical professional may choose not to treat or alternatively may decide to treat after filing a s 42M form.

**Medical professional making decisions about how to apply the law**

Medical professionals also play a range of other formal legal roles that affect how or what law is applied in these decisions. First, a medical professional will often be required to make an assessment as to the adult’s capacity. This will determine whether or not the substitute decision-making regime described above applies or whether the adult can make her or his own decisions. Secondly, if an adult lacks capacity, a medical professional will need to determine the appropriate decision-making mechanism that applies, whether that be a valid refusal of treatment certificate or a substitute decision-maker. Thirdly, it will also be necessary to establish that the relevant decision-making mechanism has the requisite authority to refuse life-sustaining treatment. This means that medical professionals will need to know whether substitute decision-makers possess the power to refuse treatment (as opposed to merely withholding consent) and whether refusal of treatment certificates, are applicable to the situation (eg, ascertaining whether the adult continues to have a “current condition”).

**Medical professional as legal gatekeeper**

A medical professional also plays a gatekeeper role for decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. Where concerns arise that improper decisions are being made, a medical professional is empowered to approach VCAT or the Supreme Court to scrutinise the proposed course of action. There is also scope for review of the appropriateness of the appointment of a substitute decision-maker.

Medical professionals also play a gatekeeping role at an earlier stage in decision-making, namely when a refusal of treatment certificate is completed. They are required to be satisfied of certain matters before witnessing the document and so, eg, are able to prevent such certificates being completed without sufficient information to understand the nature of the decision being made. Of course, the extent to which medical professionals are able to exercise these roles depends on their being aware of these legal gatekeeping functions.

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101 Victorian Parliament Law Reform Committee, n 8, p 108.
102 Victorian Parliament Law Reform Committee, n 8, p 110.
103 See above at 777-778.
MEDICAL PROFESSIONALS’ KNOWLEDGE OF THEIR LEGAL ROLE

WHAT ARE MEDICAL PROFESSIONALS TAUGHT ABOUT THIS AREA OF LAW?

Medical education in Victoria has undergone the same changes in recent decades as described in the first two articles in this series, in relation to medical ethics and health law.104 Students are made aware of the expectations of the community and of the profession in relation to their individual and collective obligations in the numerous fields that raise ethical questions and that are governed, inter alia, by either or both legislation and the common law. The end-of-life area has seen a significant body of legislation passed in recent decades, and it has begun to receive considerable exposure in undergraduate medical education.

There are now three medical schools in Victoria. The authors received responses from all of these schools to their informal survey requesting information on teaching in the areas of decision-making capacity and capacity determination, ethical and legal aspects of withdrawing and withholding treatment (patients with and without capacity), substitute decision-making and guardianship, and advance care planning. Two schools provide significant coverage of ethical and legal aspects of withdrawing and withholding treatment, with one requiring students specifically to understand the legal requirements of appointing a guardian or an agent pursuant to an enduring power of attorney (medical treatment) under the Guardianship and Administration Act 1986 (Vic) and the Medical Treatment Act 1988 (Vic), the role of guardians and appointed agents, and indeed to recognise the complexities regarding the law in withdrawal of treatment. The third school also covered these areas, but in less depth. As with schools in the other States considered in this series of articles, whether they responded to the survey or not,105 these topics are covered formally in the earlier years of the programs of the Victorian schools. This is mainly as a result of the structure of medical education which universally sees year cohorts receiving lectures together in the earlier phases, but much more separated in the clinical years, making systematic provision of instruction more difficult at the time when it would seem more relevant. Again, the depth of knowledge attained via these undergraduate teaching sessions will not be equivalent to what has been described in this series of articles as necessary for medical professionals to practise in compliance with the relevant legal regimes. At the earlier stages of medical education, instruction is, necessarily and correctly, more introductory and theoretical.

One responding Victorian university also has a strong postgraduate program in Health and Medical Law, provided by the law school. In 2010, in three of the courses offered, there were two, three and three medical professionals enrolled.106 It is not certain, although it is likely, that one or two of those enrolled were the same medical professionals across the courses. These medical professionals will clearly become very well versed in the details of the law at the end of life but they are, of course, individuals who have specific interests, often based in occupational roles, in developing their knowledge in the medical and health law area. As was the case in the other two States described in the previous articles, there is no systematic teaching in these areas for junior doctors, specialist trainees, or those in private practice in Victoria.

It can be reasonably assumed that in recent times and from now on, medical students have and will continue to graduate to practice with at least a sound theoretical grounding in the ethical and legal requirements of decision-making at the end of life, including those focused on in this series. However, the lack of knowledge possessed by, and of education provided for, medical professionals generally was emphasised in the recent inquiry into powers of attorney by the Victorian Parliament Law Reform Committee. The committee stated that it “did not receive any evidence that such education is being provided to health care professionals in relation to the types of powers of attorney under review in this

104 White, Willmott, Trowse, Parker and Cartwright, n 1 at 518-520; Willmott, White, Parker and Cartwright, n 68 at 540.
105 Personal communication with teaching colleagues.
106 Personal communication with program director, Professor L Skene.
Inquiry”, but that participants in the inquiry “were generally strongly supportive of providing more education about powers of attorney for GPs and staff in hospitals and aged care facilities”.  

**WHAT DO MEDICAL PROFESSIONALS KNOW OF THIS AREA OF LAW?**

Although there is only limited evidence available as to what medical professionals know of this area of law, the position in Victoria appears similar to that described in New South Wales and Queensland: there are clear knowledge gaps. Some of the anecdotal evidence discussed above when identifying problems in the law suggests this is the case. For example, the submission by the Office of the Public Advocate to the VLRC’s Guardianship Review recorded the uncertainty of medical professionals in relation to the distinction between withholding consent and refusing treatment. There was also a suggestion that refusal of treatment certificates were being completed in circumstances outside those permitted by the legislation which could reflect a lack of legal knowledge by the medical professionals witnessing them. Finally, the Office of the Public Advocate also called for an education campaign targeted at medical professionals to advise them of the “section 42M form” process discussed above.

Gaps in medical professionals’ knowledge of the law in this area are also revealed in what the authors believe to be the only empirical study on the topic in relation to Victorian law. In 1998, Darvall et al conducted a survey of Victorian general practitioners as to their knowledge of three areas of law, one of which was substitute decision-making under the *Medical Treatment Act 1988* (Vic). A questionnaire, developed through four focus groups, was sent to a random sample of 983 general practitioners in Victoria, to which there was a 55% response rate.

While the research revealed that nearly all respondents knew that a legally appointed guardian had power to provide consent on behalf of an adult who lacked capacity, “considerable error and uncertainty existed in relation to the legal status of consent obtained from patients’ spouses, other family members and friends”. For example, 74% of respondents thought that an adult’s spouse could provide a valid consent on behalf of the adult and 62% believed that consent could be provided by an adult child – both of which were incorrect as the law stood at the time. This lack of understanding is also consistent with respondents’ self-perception of their legal knowledge in this area: 44% of respondents described themselves as having no or little understanding of the “legal effects of *Medical Treatment (Enduring Power of Attorney) Act*” while a further 48% described themselves as having only “some” knowledge.

While the results of this research reveal that medical professionals’ knowledge of the law in this area is lacking, it should be noted that the law has changed significantly since 1998. There may be limits on the extent to which these findings reflect legal knowledge of medical professionals of the current law. For example, an adult’s spouse and adult children are now capable of providing

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107 Victorian Parliament Law Reform Committee, n 8, p 278.
108 See above at 785-787. See also Victorian Parliament Law Reform Committee, n 8, p 278.
109 Office of the Public Advocate, n 87, pp 35-36.
110 Office of the Public Advocate, n 87, p 36.
111 Office of the Public Advocate, n 87, p 34.
113 Darvall, McMahon and Piterman, n 112 at 176.
114 Darvall, McMahon and Piterman, n 112 at 177. It should be noted that it appears from the article that general practitioners were asked about the amending Act (the *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic)) rather than the *Medical Treatment Act 1988* (Vic) itself (see the above quote as to what respondents were asked). The goal was to assess legal knowledge specifically in relation to the appointment of an agent under an enduring power of attorney (medical treatment) and the provisions governing such appointments were introduced by this amending Act. However, it is possible, depending on the wording used in the questionnaire, that this reference to the amending Act may have confused respondents. For example, some respondents may have known about the *Medical Treatment Act 1988* (Vic) and felt they understood the relevant provisions relating to the appointment of agents but were confused by the reference to this later amending Act and so lowered their rating of knowledge.
CONCLUSIONS ABOUT VICTORIAN LAW

The focus of this article is on medical professionals’ knowledge of the law in relation to withholding or withdrawing life-sustaining treatment and four problems were identified above where the law was likely to impede this knowledge. The authors make some observations here as to possible reform guided by the focus of this article to improve medical professionals’ knowledge of the law. They are not undertaking a wider analysis and justification of the reforms suggested below.

In relation to the first problem, namely the distinction made in Victorian law between withholding consent and refusing treatment, it is suggested that this distinction be removed. As discussed above, this is a long-standing and entrenched source of confusion for medical professionals and leads to a number of undesirable outcomes. Granting all substitute decision-makers the power to refuse treatment would avoid the need for this distinction. The principal concern that is raised in response to this is the potential for improper decisions to be made by people who gain decision-making power through being the person responsible. There is no evidence that these concerns have played out in Queensland where all decision-makers, including the default decision-maker (statutory health attorney), have power to refuse treatment. Further, as this article has demonstrated, there are a number of safeguards on decision-making, the most significant of which is the legal gatekeeping role played by medical professionals. If medical professionals are worried about such decisions, they have a range of legal avenues at their disposal to raise their concerns and have decisions scrutinised.

The second problem with Victorian law identified above was that substitute decision-making about health care is spread across two statutes that sit awkwardly together. A partial solution to this is to widen the powers of an enduring guardian to include refusing treatment so at least the two health substitute decision-makers that an adult can appoint under Victorian law would have the same power. The authors would endorse such an approach but, as stated above, would also go further and propose that all substitute decision-makers should have such power. Adopting such an approach would mean it is possible to deal with health substitute decision-making comprehensively and consistently in a single statute, eg, by incorporating and adapting the relevant aspects of the Medical Treatment Act 1988 (Vic) into the Guardianship and Administration Act 1986 (Vic).

The Victorian Parliament Law Reform Committee considered the related issue of whether there should be a single Act dealing with all powers of attorney (including non-enduring powers of attorney and those in relation to financial matters): Victorian
reviewing the Medical Treatment Act 1988 (Vic). Nevertheless, this would undoubtedly make knowing the law easier for medical professionals (and the community generally).

The third problem with Victorian law was the inconsistent approach to defining capacity. Outlined above were four definitions of when an adult is not able to make her or his own decisions spread across the Medical Treatment Act 1988 (Vic) and the Guardianship and Administration Act 1986 (Vic). This is obviously undesirable and likely to confuse medical professionals. Accordingly, the authors suggest that a single definition of capacity be adopted, and preferably in the consolidated Guardianship and Administration Act 1986 (Vic), as proposed above. That definition should reflect the functional approach to capacity as part of taking the least restrictive approach and this is a position that one of the authors has argued for elsewhere.

The fourth and final problem identified as likely to impede medical professionals’ knowledge of the law was the uncertain status of common law advance directives. The authors favour resolving this uncertainty by recognising common law advance directives primarily because, as elsewhere two of them have argued, this gives greater weight to individual autonomy. They recognise, however, that this “two-tiered approach” does introduce the possibility of confusion for medical professionals and others in that they would have to be aware that an adult could refuse treatment in both a refusal of treatment certificate and a common law advance directive.

However, the authors consider that clarifying the law to exclude common law directives would also cause confusion and uncertainty. For example, this would mean that medical professionals would need to respect a contemporaneous refusal of treatment given by an adult but not if that was given at a time sufficiently prior to the treatment choice arising such that it constituted an advance directive. But the dividing line between these two concepts is unclear. For example, how long before surgery does a refusal of blood transfusions need to be made to count as a contemporaneous refusal rather than an advance directive? Requiring a medical professional to know of this distinction and be able to apply it in practice is not reasonable. On balance, they favour clarifying the law to recognise common law advance directives.

CONCLUSIONS FOR THE SERIES OF ARTICLES

Four claims of this series of articles

It is appropriate at this point to return to the four claims the authors sought to make in this series of articles. The first was that medical professionals play significant legal roles in relation to decisions to withhold or withdraw life-sustaining treatment. In each of the jurisdictions reviewed, three categories of legal roles for medical professionals were identified and discussed:

- when the medical professional is the legal decision-maker;
- when the medical professional is making decisions as to how to apply the law; and
- when the medical professional acts as a legal gatekeeper.

Parliament Law Reform Committee, n 8, pp 33-35. Whether this should occur involves consideration of issues wider than withholding and withdrawing life-sustaining treatment and so is beyond the scope of this article; it is sufficient to say here that substitute decision-making about health care should not be spread across two inconsistent pieces of legislation.

For example, the terms of reference for the recent review of powers of attorney did not include considering enduring powers of attorney (medical treatment) under the Medical Treatment Act 1988 (Vic): Victorian Parliament Law Reform Committee, n 8, pp iv, 3.

See also Office of the Public Advocate, n 87, pp 15-17, which favours a broadly functional approach to defining capacity (in the context of the test for appointing a guardian). Likewise, the Victorian Parliament Law Reform Committee recommends a functional test (although the report does not use this term): Victorian Parliament Law Reform Committee, n 8, recommendations 34, 35.


White B and Willmott L, “Will You Do as I Ask?” (2004) 4 QUTLJJ 77. The authors consider this to be particularly important given that only people who are experiencing a current condition can complete a refusal of treatment certificate. It is unclear, eg, where a failure to recognise common law directives leaves Jehovah’s Witnesses who are not experiencing a current condition but may wish to refuse blood transfusions.
It was demonstrated that these are important legal roles and they have a significant impact on who makes these decisions, and how, in New South Wales, Queensland and Victoria.

The second claim was that it is important that medical professionals know the law in this area. An ability to fulfil the significant legal roles that medical professionals play in these decisions depends on having sufficient knowledge of the law. Further, in the first article, it was explained as part of setting the context for this series that a lack of knowledge can lead to non-compliance with the law. This can lead to adverse outcomes for the adult, either by being unlawfully deprived of treatment or by being subject to treatment that has been lawfully refused. Non-compliance can also have negative consequences for the medical professionals involved, including potential criminal, civil or disciplinary liability, and for the adult’s family and the state.

The third claim of the series was that there are gaps in what medical professionals know of the law in this area. It is not possible to be definitive as to this claim as only relatively limited evidence exists. However, such evidence as there is points strongly to medical professionals’ knowledge of the law being lacking. In New South Wales, anecdotal evidence from a New South Wales Health report suggested problems in understanding this area of law and this was supported by the only empirical study that the authors are aware of in this State. It concluded that there were significant gaps in medical professionals’ knowledge and that further education was required.

In Queensland, there are no empirical studies directly on medical professionals’ knowledge of the law in this area. However, a Queensland Health report found evidence that medical and health professionals’ legal knowledge and understanding of the relevant legislative framework was lacking. Further, a case review of medical and health professionals’ assessments of capacity suggested a lack of knowledge of the law as did the coronial case where a medical professional made a “not-for-resuscitation” order without the required consent of the substitute decision-maker on the basis of his legal understanding. That this decision occurred in a major tertiary hospital whose policy on this area was out of date suggests that this inaccurate view of the law is unlikely to be isolated.

The scope of the problem in Victoria is somewhat clearer. The VLRC and the Office of the Public Advocate have pointed to anecdotal evidence of a lack of understanding of the various components of health substitute decision-making in that State. Also, an empirical study which considered the legal knowledge of medical professionals in this area found considerable uncertainty and error in their understanding of the law. While further research is required in this area, there is a sufficient body of evidence to conclude that there are gaps in medical professionals’ legal knowledge in this area in these three jurisdictions. This conclusion is consistent with the discussion of how the law in this area has been taught in the various medical schools (and in other formal training) in the three States.

The fourth and final claim in this series was that the current state of the law is likely to impede medical professionals’ knowledge. In relation to each of the three States, problems with the law that are likely to impede medical professionals’ knowledge were identified. There are five main types of problems that present barriers to medical professionals’ knowledge. One is that sometimes it is uncertain as to what the law is. An example of this is the uncertain status of common law advance directives in Queensland and Victoria. It is difficult to know the law when what it requires is uncertain. Another type of problem is that the law deals with matters inconsistently. An example of this is the multiple definitions of “capacity” in New South Wales and Victoria. If medical professionals are required to know multiple definitions for the same concept and when and how to apply them, that is a barrier to accurate legal knowledge. A third type of problem is where the law is inconsistent with good medical and ethical practice, an example being the requirement to obtain consent to withhold or withdraw futile treatment in Queensland. Medical professionals might reasonably expect the law would follow what is relatively settled medical and ethical practice, and it presents challenges for them when this is not the case. A fourth type of problem in the law is where distinctions are made that are counterintuitive or regarded as unnecessarily fine. The distinction between withholding consent and refusing treatment in New South Wales and Victoria falls into this category.

The fifth type of problem with the law in this area, and one that has not been specifically considered to date, is that the law is generally complex. This issue was flagged in each of the articles but is dealt with here because it is a generic issue that spans all three jurisdictions. Although the other
problems identified above exacerbate this situation, the current state of the law on its own also presents challenges for medical professionals wishing to know it. This emerges clearly from the extended discussion in each of the three articles needed to state the law. First, medical professionals would need to know that the legal position varies depending on which of the three categories of medical context applies. Second, spanning across these contexts, complexity arises from there being a range of potential decision-makers (the generic terms are used here) with power to withhold or withdraw life-sustaining treatment, or at least power to withhold consent for such treatment: a medical professional, an adult through an advance directive, a guardian, an agent, a default decision-maker, the tribunal and the Supreme Court. Finally, the criteria employed by decision-makers may also vary depending on who is deciding and in what context.

The authors argue therefore that the current state of the law is likely to make it difficult for medical professionals to know it. There is also some evidence that goes further and crystallises this link between the state of the law and gaps in medical professionals’ knowledge. In New South Wales, the Conflict Resolution in End of Life Settings report states that a lack of clarity in the law was adversely impacting upon the legal knowledge of medical professionals in this area.124 In Queensland, the Acute Resuscitation Plan Implementation Report notes the complexity of the law in this area and that it is “not surprising” that there is inconsistent understanding of the legal position.125 In Victoria, as noted above, both the VLRC and the Office of the Public Advocate have suggested that the legal distinction between withholding consent and refusing treatment results in uncertainty and confusion.126 The existence of parallel legislation in the Guardianship and Administration Act 1986 (Vic) and the Medical Treatment Act 1988 (Vic) has been identified by the VLRC as being confusing, particularly given the ability of an adult to appoint different decision-makers (an enduring guardian or an agent respectively) under these Acts.127 The Victorian Parliament Law Reform Committee also concluded that the different approaches to capacity being considered in that review caused widespread confusion and uncertainty.128 Accordingly, the authors argue that the current state of the law is problematic and that this impedes medical professionals seeking to know it.

Having considered the four claims made by this series of articles, the authors turn now to their conclusions, namely that, in light of what has been discussed, law reform and more and better education of medical professionals is needed.

Conclusions as to medical education

Eight of the 14 medical schools in the three States responded to an informal survey of teaching in the areas under review in this series of articles. The authors established that, while teaching and assessment are inevitably variable, it is likely that there is reasonably strong emphasis across undergraduate medical education on issues including decision-making capacity, consent to and refusal of treatment, informed decision-making, futile treatment, and withdrawing and withholding treatment. This focus is a component of the increased emphasis over the past two decades on teaching and assessment in medical ethics, law and professional issues, against a social and cultural background of increased individual and patient rights, increased levels of community education, and a level of erosion of professional and clinical autonomy in the medical profession.

The authors thus identified a generational change in undergraduate medical education, together with a range of evidence of a lack of knowledge of the law on the part of currently practising medical

126 Office of the Public Advocate, n 87, pp 35-36. Victorian Law Reform Commission, n 6, p 38. See also evidence to this effect given to Victorian Parliament Law Reform Committee, n 8, pp 161-162.
127 Victorian Law Reform Commission, n 6, pp 38, 53.
professionals, derived from case reports, \(^{129}\) a New South Wales Health report, \(^{130}\) a Queensland Health report, \(^{131}\) a report of the Victorian Parliament Law Reform Committee, \(^{132}\) a small number of empirical studies, \(^{133}\) and anecdotal reports.

Law is complex, and medical law is no exception. The law governing the withholding and withdrawing of life-sustaining treatment from adults who lack capacity is not only complex, it is also at times uncertain, internally inconsistent, inconsistent with good medical and ethical practice, and counterintuitive. \(^{134}\) As suggested above, the current state of the law in this area is a distinct barrier to medical professionals’ mastering its principles and application, and simplification and other reform of the law would improve this situation considerably, as discussed below. Together with reforms to the law itself, the authors contend that a range of educational reforms will enable medical professionals to more validly and consistently apply the law in practice. To this end, they identify two desirable cultural changes and make a further six specific suggestions in relation to improving medical education. We consider that these general and specific improvements are related (often causally) and advances in specific strategies will help drive change in the broader, cultural areas.

The traditions and cultures of medical and legal education and practice do not evolve rapidly. While we have identified inter-generational changes in medical education, with a greater emphasis on and integration of medical ethics and law, there remains considerable scepticism on the part of many practising clinicians towards these curricular components, which they see as having usurped valuable training time once reserved for the scientific and clinical aspects of medicine. We respond to that scepticism with the claim that the relevant knowledge and skills for effective and safe clinical practice must include ethical, legal and professional matters; these are simply inevitable and crucial aspects of practice. This is so because medicine is no longer an autonomous professional enterprise, but a social endeavour occurring within social, cultural and legal frameworks.

A related change advocated in relation to medical culture (but also seen as inevitable) is the change from the perception by the medical profession of the law as adversarial and oppositional to a more sanguine or even positive view of law as facilitative of safe, ethical practice. While elements of the traditional perception will probably continue as long as fault-based negligence and other procedures remain in force, it is to be hoped that this will be diluted by increasing familiarity with those facilitative aspects of the law. One way that this change is currently being augmented is by adopting an approach to the law in undergraduate medical education that emphasises its role in representing community ethical consensus in preference to the “risk management” approach that is still commonly adopted in postgraduate continuing medical education. This change posits the avoidance of legal trouble as a side-benefit of ethical medical practice, rather than seeing risk management strategies as the primary educational focus.

This broad educational emphasis can be supported by a number of specific strategies. First, the relevant legal knowledge and skills for effective and safe clinical practice in the area of interest here should be strongly integrated into teaching about the end of life, so that discussions of the technical skills of pain and symptom management, communication and psychosomatic support \(^{135}\) is linked to relevant legal matters. Knowledge of the relevant law should not be conceived as a technical addition

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\(^{130}\) New South Wales Health, n 124.

\(^{131}\) Queensland Health, n 125, p 12.

\(^{132}\) Victorian Parliament Law Reform Committee, n 8, p 108.


\(^{134}\) See above at 792-793.

to the central discussion, to be considered separately, but an integral component of clinical care. At the undergraduate level, this integration is already occurring to a significant, but still somewhat variable, extent in current programs. Secondly, the core curriculum document referred to in the first article in the series should be reviewed and rewritten to emphasise, inter alia, not just the importance of the role of the law, particularly in end-of-life care, but also the importance of closely integrating ethical and legal considerations in clinical teaching.

Thirdly, one of the perennial difficulties of undergraduate medical programs is increasing the integration of areas like basic science and ethics and law, that are dealt with almost exclusively in the earlier, pre-clinical years, into the later clinical years. At this latter stage, student cohorts are dispersed, fragmented, focused on clinical work, and in the hands of clinicians who are not well versed in the law and usually not motivated to encourage students to include it in their clinical considerations. While the cultural changes discussed above will improve integration at this stage, these structural features will continue to make it extremely difficult. Smaller, more cohesive cohorts that can be brought together periodically, are easier to reach in these later clinical years, but other strategies including concerted efforts at staff development and developing generic curricular elements may help improve the situation.

Fourthly, to build on the more theoretical teaching about capacity in the pre-clinical years, there should be specific teaching of capacity assessment in the later undergraduate program, and again in the junior doctor training period. This is a good example of integration between the theoretical and practical elements, which repeats a theme also applicable to the scientific aspects of practice. There is considerable discussion of improving educational continuities between the undergraduate and early postgraduate phases of medical education, and (fifthly) medical law should be no exception to this endeavour.

Sixthly, the authors advocate greater systematisation of postgraduate medical education in the area of medical law generally, and the law concerning capacity and withdrawing and withholding treatment specifically. Postgraduate medical education councils are responsible to the Medical Board of Australia for accrediting intern and junior doctor training programs, and the accreditation process should become increasingly mindful of the place and importance of continuing legal education in the workplace. The same applies to specialist college training programs, with more specific emphasis in those colleges whose fellows deal with these end-of-life issues.

**Final conclusions as to law reform**

In each of the three articles in this series, suggestions have been made as to how the specific problems identified as being likely to impede medical professionals’ knowledge of the law could be addressed. The purpose of this section is to move beyond law reform in each of the three jurisdictions and to make some more general observations on this topic.

The first observation relates to the complexity of the law in this area generally. This was noted above as being an issue of significance for all three jurisdictions. To some extent, some level of complexity may be unavoidable. For example, it is not desirable to reduce the number of ways in which decision-making can occur. The authors consider it appropriate that an adult can complete an advance directive and appoint another to make decisions on her or his behalf. Likewise, it is important that the relevant tribunal is able to appoint a substitute decision-maker where necessary (or make this decision itself) and the availability of a default decision-making mechanism is valuable because this helps to avoid drawing adults into the formal guardianship system unnecessarily. Finally, they are not suggesting that the Supreme Court’s parens patriae jurisdiction be removed.

However, while acknowledging that some level of complexity may not be avoidable, where complexity is unnecessary the law should be reformed. Obvious examples discussed in this article that

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136 A Working Group, on Behalf of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools (ATEAM), “An Ethics Core Curriculum for Australasian Medical Schools” (2001) 175(4) MJA 205.

arise in Victoria are the complication added by having two decision-makers able to be appointed by an adult (an enduring guardian and an agent) and having two overlapping pieces of legislation. Neither duplication is necessary and both add to the complexity of the law.

The need to avoid unnecessary complexity is particularly important in areas like adult guardianship law and end-of-life decision-making. They are areas of law that are regularly used – and intended to be used – by non-lawyers, including medical professionals. As shown in this series, it is specifically contemplated that medical professionals will play significant legal roles in these decisions. It is critical that governments, law reform agencies and others charged with reform efforts keep this in mind when reframing new laws.

A second general comment that emerges from this review of these three jurisdictions is the merit of a national approach to the law in this area. There have been repeated calls for either uniform laws or harmonisation in this field. For example, the federal House of Representatives Standing Committee on Legal and Constitutional Affairs report, *Older People and the Law*, recommended that the Australian Government encourage the Standing Committee of Attorneys-General to work towards the implementation of nationally consistent guardianship and other relevant legislation throughout Australia.\(^{138}\) For medical professionals, a single Australian legislative framework, or at least a harmonised approach nationally, is likely to be easier to know and this is particularly so given the high mobility rate of medical professionals working in different jurisdictions within Australia.

Although all three jurisdictions share a framework that is broadly similar at a global level for these decisions, it is noteworthy how different the three legal regimes are. One illustration is the legal regulation of advance directives (and for the moment, putting aside the issue of recognition of common law advance directives in Queensland and Victoria). In New South Wales, advance directives are recognised only by the common law and there is no statutory directive. In Queensland, an adult can complete an advance health directive under the *Powers of Attorney Act 1998* (Qld) but the circumstances in which it can operate are limited in a range of ways and a medical professional is entitled to disregard a directive when he or she reasonably believes its directions are inconsistent with good medical practice. Victoria has statutory refusal of treatment certificates but they are limited to adults refusing treatment in relation to a current condition. It is hard to imagine that the medical context in which these laws are operating is so different in these three States that the law should be regulated in such different ways.

A concluding observation is to note that the time is now ripe for reform. As has been discussed in each article, all three jurisdictions have either ongoing or very recent reform inquiries in this area. New South Wales has had the Legislative Council’s Standing Committee on Social Issues report, *Substitute Decision-Making for People Lacking Capacity*,\(^{139}\) Queensland has the Queensl Law Reform Commission’s Guardianship Review,\(^{140}\) and Victoria has had its Parliament Law Reform

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The legal role of medical professionals in life-sustaining treatment: Part 3 (Victoria)

Committee’s *Inquiry into Powers of Attorney*¹⁴¹ and its current review of guardianship law by the VLRC.¹⁴² In addition to these three States, South Australia and the Northern Territory have also been reviewing aspects of their guardianship law.¹⁴³

There are two features of these sorts of law reform inquiries that are significant. The first is that they provide an opportunity for considered and thoughtful reflection on the future of this area of law. In particular, law reform commissions approach their task as bodies that are independent from the government of the day. These are important aspects of law reform given that the law that governs decisions to withhold or withdraw life-sustaining treatment is often regarded as controversial and politically sensitive. The nature of the law in this area can sometimes inhibit a careful and rational inquiry into how it can be improved. The second feature is that these sorts of inquiries provide an opportunity for looking at the law anew and reconsidering how legal frameworks are structured. This can be contrasted with much law reform which is incremental in nature and merely adds to, subtracts from or otherwise tinkers with the existing legal framework. The opportunity for law reform in these three (or more) jurisdictions is rare and must be seized to improve what is an important area of law for patients and their families, medical professionals and the community as a whole.

**POSTSCRIPT**

After submission of this article for publication, the VLRC released its consultation paper: Victorian Law Reform Commission, *Guardianship, Consultation Paper 10* (February 2011). The consultation paper considers a range of issues discussed in this article but of particular significance are Chs 8 (Personal Appointments), 9 (Documenting Wishes about Your Future), 10 (VCAT Appointments and Who They are For), 14 (Automatic Appointments – the Person Responsible) and 16 (Medical Treatment).

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How should Australia regulate voluntary euthanasia and assisted suicide?

Ben White and Lindy Willmott*

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

INTRODUCTION

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

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

2 See eg Voluntary Euthanasia Bill 2012 (SA); Rights of the Terminally Ill Bill 2011 (NSW); Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011 (SA); Voluntary Euthanasia Bill 2010 (SA); Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA); Voluntary Euthanasia Bill 2010 (WA). For further discussion, see below at 414-415.

3 In the New South Wales Legislative Council on 23 October 2012, Cate Faehrmann (Australian Greens) signalled the introduction of the Rights of the Terminally Ill Bill into Parliament in 2013.
The issue of how we, as a society, regulate voluntary euthanasia and assisted suicide arises in a particular social, demographic and medical context. For example, Australia has an ageing population and the “baby boomer” generation is now (and will increasingly be) involved in medical decisions as they come to the end of their lives. This generation will not be passive recipients of paternalistic medical practices, and will insist on greater input in and control over their dying process. At the same time, voluntary euthanasia and assisted suicide are issues that are of significant interest to the public and, as considered in this article, are issues about which there is majority public support for reform. Further, this debate occurs in the context of ongoing advances in medicine. Lives can be sustained in circumstances that have never previously been contemplated, and decisions must be made about whether to provide life-sustaining treatment, or allow the individual to die. There have also been significant improvements in palliative care which have enabled pain in dying patients to be managed to the extent that has not been possible in the past.

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

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

DEFINITIONS AND SCOPE OF ARTICLE

It is important to be clear about the meaning of the terms used in this article and the scope of issues it is considering. A failure to define terms and articulate clearly the issues being discussed can lead to confusion through people talking at cross-purposes as well as generating conflict where, in fact, none exists. Table 1 lists the terminology used in the article.

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


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

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthanasia</td>
<td>For the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person.</td>
<td>A doctor injects a patient with a lethal substance to relieve that person from unbearable physical pain.</td>
</tr>
<tr>
<td>Voluntary euthanasia</td>
<td>Euthanasia is performed at the request of the person whose life is ended, and that person is competent.</td>
<td>A doctor injects a competent patient, at their request, with a lethal substance to relieve that person from unbearable physical pain.</td>
</tr>
<tr>
<td>Competent</td>
<td>A person is competent if he or she is able to understand the nature and consequences of a decision, and can retain, believe, evaluate, and weigh relevant information in making that decision.</td>
<td></td>
</tr>
<tr>
<td>Non-voluntary euthanasia</td>
<td>Euthanasia is performed and the person is not competent.</td>
<td>A doctor injects a patient in a post-coma unresponsive state (sometimes referred to as a persistent vegetative state) with a lethal substance.</td>
</tr>
<tr>
<td>Involuntary euthanasia</td>
<td>Euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she not die.</td>
<td>A doctor injects a competent patient who is in the terminal stage of a terminal illness such as cancer with a lethal substance without that person’s request.</td>
</tr>
<tr>
<td>Withholding or withdrawing life-sustaining treatment*</td>
<td>Treatment that is necessary to keep a person alive is not provided or is stopped.</td>
<td>Withdrawing treatment: A patient with profound brain damage as a result of a heart attack is in intensive care and breathing with the assistance of a ventilator, and a decision is made to take her or him off the ventilator because there is no prospect of recovery. Withholding treatment: A decision is made not to provide nutrition and hydration artificially (such as through a tube inserted into the stomach) to a person with advanced dementia who is no longer able to take food or hydration orally.</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>A competent person dies after being provided by another with the means or knowledge to kill herself or himself.</td>
<td>A friend or relative obtains a lethal substance (such as Nembutal) and provides it to another to take.</td>
</tr>
<tr>
<td>Physician-assisted suicide</td>
<td>Assisted suicide where a doctor acts as the assistant.</td>
<td>A doctor provides a person with a prescription to obtain a lethal dose of a substance.</td>
</tr>
</tbody>
</table>

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

The scope of this article also requires clarification. It considers only the arguments that relate to voluntary euthanasia and assisted suicide so far as they apply to requests from a competent adult for death or assistance to die. There are two main reasons for limiting the article in this way. First, different (and possibly even more ethically problematic) issues arise where the person is competent and does not request euthanasia, is incompetent so unable to express a view, or is a minor. Secondly, all of the attempts to reform the law in Australia have been limited to voluntary euthanasia and assisted suicide, as has the vast majority of public debate. Accordingly, although some may argue that euthanasia and assisted suicide should extend to other situations, such issues are not explored here. As such, this article does not consider euthanasia and assisted suicide for

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

CURRENT AUSTRALIAN LEGAL LANDSCAPE AT THE END OF LIFE

Voluntary euthanasia and assisted suicide are unlawful

Voluntary euthanasia and assisted suicide are unlawful in all States and Territories in Australia.\(^7\) Ending another person’s life is murder or manslaughter under the criminal law. Assisting a person to end their own life is also a criminal offence and is described in different jurisdictions in terms such as aiding and abetting suicide.\(^8\) (It is not unlawful, however, for a person to end, or attempt to end, their own life.) A person will still be criminally responsible for her or his actions even if he or she is motivated by compassion or if the deceased consented to her or his own death.\(^9\)

Withholding or withdrawing life-sustaining treatment can be lawful

While taking active steps to end a person’s life (or assist them to do so themselves) is unlawful, the law does permit life-sustaining treatment to be withheld or withdrawn in certain circumstances.\(^10\) One situation is where a person who is competent to make her or his own decisions refuses that treatment. This right to refuse medical treatment is underpinned by respect for bodily integrity. The law protects a person from interference with their body – including by way of medical treatment – unless there is some recognised legal justification for doing so. A person’s decision to not receive treatment must be respected even if that treatment is necessary to stay alive and even if the refusal of treatment is contrary to medical opinion.\(^11\)

Decisions to withhold or withdraw life-sustaining treatment can also be made by and for a person who lacks decision-making competence. One way this can be done is through an advance directive. This is where a person makes decisions while they are competent about what medical treatment they want or do not want when they lose their ability to decide for themselves. Most Australian jurisdictions have enshrined this common law right into legislation.\(^12\) A second way to make decisions when a person lacks competence is through substitute decision-making. Adult guardianship legislation throughout Australia establishes mechanisms for people (generally those close to the patient) to be empowered to make decisions about health care when a patient cannot decide for themselves.\(^13\) The criteria substitute decision-makers need to consider when making decisions to withhold or withdraw life-sustaining treatment vary across Australia but the patient’s best interests is generally an integral factor.\(^14\) Thirdly, parents can make this decision for their children who do not yet have decision-making competence. The relevant criterion for such a decision is the child’s best interests.\(^15\)

In addition to patients, substitute decision-makers and parents being able to refuse life-sustaining treatment in certain circumstances, it is also possible for doctors to make this decision to withhold or withdraw treatment. The law generally does not impose a duty on doctors to provide treatment that will not benefit a patient. Where a doctor determines that treatment is not in a patient’s best interests, ....

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


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


\(^15\) Willmott, White and Then, n 10 at [13.280]-[13.290].
he or she is not required to provide it even if it is needed for the patient to stay alive.\textsuperscript{16} Sometimes this decision is framed in terms of treatment being “futile”.

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

**Provision of appropriate palliative care is lawful**

Australian law is also very likely to recognise that the provision of appropriate palliative care is lawful, even if it might hasten death.\textsuperscript{17} This is despite the fact that providing this treatment could be seen as taking active steps to end a patient’s life and therefore be in breach of the criminal law. This legal protection arose in response to concerns that otherwise appropriate palliative care could accelerate death (eg, opioids suppressing respiration) although many argue that properly administered palliative care does not do this.\textsuperscript{18}

Of greatest significance for Australian law is a health professional’s intention. To be lawful, palliative care must be provided with the intention to relieve pain and not to cause or hasten death, although that death may be foreseen. In the three States that have enshrined this protection in statute, regard must also be had to other factors such as good medical practice.\textsuperscript{19}

The central role of intention raises questions for how the law operates in this area. A doctor’s intentions when providing certain treatment are easy to obscure or can be ambiguous. It is possible for the same act to be done, namely hastening a patient’s death, with different intentions. For example, a doctor may provide medication with the intention of hastening death, or instead with the intention of relieving pain and only foreseeing (rather than intending) the likely death.\textsuperscript{20} While the statement of law may be clear, its operation in practice is not.\textsuperscript{21}

**Legislative reform attempts in Australia**

Australia has witnessed continual and numerous attempts to reform the law governing voluntary euthanasia and assisted suicide. These attempts have occurred in all Australian States and Territories except Queensland. In the past, most Bills have been introduced by members of the Australian Greens, Australian Democrats and Independent members, although some recent attempts since 2010 have come from a Labor Member of Parliament. Table 6 in the Appendix lists legislative attempts to reform the law regarding voluntary euthanasia and/or assisted suicide of which the current authors are aware, along with details of who introduced the Bill and when, and in which House of Parliament this occurred. While the vast majority of these Bills sought to effect change in the substantive law governing voluntary euthanasia and assisted suicide, there were also Bills dealing with other issues in this area such as seeking a referendum on the topic and restoring the powers of Territories to legislate on the issue.

The history of failed attempts at legislative reform suggests that despite strong public opinion in favour of voluntary euthanasia and assisted suicide, there is not majority support from politicians as a

\begin{footnotesize}
\begin{enumerate}
\item Willmott, White and Then, n 10 at [13.70]-[13.80].
\item See generally White B and Willmott L, “The Doctrine of Double Effect” in White, McDonald and Willmott, n 7.
\item White B, Willmott L and Ashby M, “Palliative Care, Double Effect and the Law in Australia” (2011) 41 Internal Medicine Journal 485.
\item White, Willmott and Ashby, n 18.
\item See below at 419.
\end{enumerate}
\end{footnotesize}
group for changing the law. Understanding politicians’ perspectives and motivations for this position is important but there is only limited empirical evidence as to politicians’ role in this debate. One study examined how federal politicians voted in a conscience vote to overturn the Northern Territory euthanasia legislation (and two other sensitive conscience votes). Three key factors that were significant in how the politicians voted were party alliances, gender and religious affiliation. The most significant correlation was religious affiliation, with all Catholics voting in favour of overturning the Northern Territory legislation and all but one of the politicians from other Christian religions doing the same. Another study surveyed Queensland politicians as to their personal views on these issues and found that 55% of respondents favoured euthanasia reform. However, the study suggested that these personal views may not be followed in a public vote where concerns about party lines and re-election intrude.

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

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

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

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

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

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


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


25 See below at 431-432. Judicial reform also occurred in Colombia in 1997, although a recent media article has reported that a Bill has been passed in Colombia to regulate the practice of euthanasia in some circumstances: O’Gorman J, “Colombian Senate Approves Regulation of Euthanasia”, Colombia Reports (9 August 2012), http://www.colombiareports.com/colombia-news/news/25483-colombian-senate-approves-regulation-of-euthanasia.html viewed 17 August 2012.
TABLE 2 Voluntary euthanasia and assisted suicide legislation by jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands*</td>
<td>Termination of Life on Request and Assisted Suicide Act 2000</td>
</tr>
<tr>
<td>Belgium</td>
<td>Act on Euthanasia 2002</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Law of 16 March 2009 on Euthanasia and Assisted Suicide</td>
</tr>
<tr>
<td>Oregon**</td>
<td>Death with Dignity Act 1994</td>
</tr>
<tr>
<td>Washington***</td>
<td>Washington Death with Dignity Act</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Rights of the Terminally Ill Act 1995 (now repealed)</td>
</tr>
</tbody>
</table>

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

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

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

Secondly, there is significant divergence in terms of eligibility requirements, that is, what must be present before a person will qualify for voluntary euthanasia or assisted suicide under the particular regime. Such requirements relate to the person’s competence, age and medical condition as well as whether there are any residence requirements that must be satisfied. In Oregon and Washington (and the Northern Territory), the person must be competent at the time he or she is making the request to end her or his life, while in The Netherlands, Belgium and Luxembourg, a person’s advance statement requesting euthanasia can also be acted upon. In most jurisdictions (Luxembourg, Oregon, Washington and the Northern Territory), there is a requirement that the person be suffering from a terminal illness. Although there is no such requirement in The Netherlands or Belgium, in those jurisdictions, the person’s suffering must be “lasting and unbearable” (Netherlands) or the person must be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated (Belgium). In most jurisdictions, the person must be an adult, although the Belgian legislation extends to “emancipated minors” and in The Netherlands, such practices can occur for minors as young as 12.27 The legislation in Oregon and Washington contains residence requirements, but that is not the case in the other jurisdictions (and was not the case for the Northern Territory regime).

All statutes contain safeguards although there are significant variations between jurisdictions. These safeguards include ensuring that the consent of the person was given voluntarily, requiring information to be provided to the person, involving more than one doctor, and observing cooling-off periods between making the initial request for assistance and the person dying. Details of the safeguards in the various jurisdictions are contained in Table 7.

Finally, all statutes have provisions facilitating oversight of the practice of voluntary euthanasia and/or assisted suicide.

26 It should be noted that the Belgian legislation does not expressly permit assisted suicide. However, there appears to be general acceptance, including by the Federal Control and Evaluation Commission, the body established to oversee the implementation of the euthanasia law, that provided the safeguards of the euthanasia legislation are complied with, a doctor who assisted a suicide would also be protected by the legislation: Lewy G, Assisted Death in Europe and America, Four Regimes and Their Lessons (Oxford Scholarship Online, 2011) p 77, http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199746413.001.0001/acprof-9780199746413 viewed 20 August 2012.

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

Over recent years, Switzerland has become a destination for individuals who come from jurisdictions in which voluntary euthanasia and assisted suicide is unlawful, but who want assistance to end their lives. Ironically, Switzerland has not passed legislation to make either voluntary euthanasia or assisted suicide lawful. The law in Switzerland is governed by their *Criminal Code*, and under that Code, both voluntary euthanasia and assisted suicide are unlawful. The relevant provisions are set out below.28

Article 114 provides:
Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person’s own genuine and insistent request shall be liable to a custodial sentence not exceeding three years or to a monetary penalty.

Article 115 provides:
Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.

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

There are a number of consequences that flow from the fact that the permissive Swiss law arose from the interpretation given to an offence provision in its *Criminal Code* rather than a comprehensive statutory regime designed to regulate assisted suicide. Most significantly, there are no express eligibility criteria to be satisfied for the person seeking assistance to die, and few safeguards. Provided the person assisting another to die is not motivated by selfish motives, an offence has not been committed. It also means that assistance can be provided by friends and relatives, and is not limited to doctors as in the other jurisdictions. Further, again unlike the other jurisdictions, this also means there is less governmental oversight in terms of the practices which are occurring. The absence of a regulatory regime also means that there is not scope to impose a residence requirement as in Oregon and Washington. Because providing assistance is lawful if it is done with selfless motives, this test can be met both when assisting Swiss residents to die and those who visit Switzerland specifically seeking this assistance.29

ARGUMENTS FOR AND AGAINST REFORM

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

Finding a consensus of ethical values

Before rehearsing the arguments for and against voluntary euthanasia and assisted suicide, an attempt is made to identify some ethical or moral positions about which consensus as to their relevance to this debate may be possible. This exercise is undertaken in the hope that agreement about these positions

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

may provide a touchstone in discussions about whether or not the current regulatory environment
should remain or, if reform is proposed, the nature of such reform.

- The inherent value of human life: There is general, although not universal, consensus that special
status should be afforded to human beings over and above other species.
- The need to respect a person’s autonomy: The right of a competent person to self-determination is
a fundamental principle in a liberal democracy, and should be respected. 30
- The need to protect vulnerable members of society: As a society, we value all individuals and
want to protect those who are vulnerable and in need of protection.
- The need to alleviate pain and suffering from individuals who are unwell: As a compassionate
society, we seek to minimise or completely ameliorate pain or suffering endured by individuals
who are unwell.
- The need for the law to be coherent and transparent: For a liberal democracy to function
effectively, individuals should respect the prevailing legal framework. For this to occur, the law
must be coherent, and operate in a transparent fashion.
- The need for the law to be followed: For a liberal democracy to function effectively, individuals
need to follow the law.

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

Key arguments in favour of legalising voluntary euthanasia and assisted suicide

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

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

Illnesses and diseases have different medical trajectories. Some illnesses or diseases may mean
that a person is deprived of independence because he or she needs assistance from others for all
aspects of living. Some individuals may find it undignified to continue to live in circumstances where
they must rely on others to, eg, feed them, bathe them and assist them with toileting, and may prefer
to end their lives rather than continue to live in this fashion. 31 A competent person who forms that
view should have the right to end her or his life.

Voluntary euthanasia or assisted suicide is necessary for the relief of pain in some situations

Great improvements have been made in palliative care over the past decade. Nevertheless, not all pain
can be alleviated by medicine: both existential 32 and some physical pain cannot be alleviated and may

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

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

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

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

**Evidence that lives are ended unlawfully**

There is a clear body of evidence that demonstrates that voluntary euthanasia and assisted suicide occur despite being unlawful.\(^{34}\) This includes research that examines doctors’ intentions when administering pain-relieving medication and whether the provision of this treatment always complies with the law. As discussed above, an act done with an intention to relieve pain is lawful (even if death is foreseen), but the same act done with an intention to kill is not lawful.\(^{35}\) Despite this, some doctors who are treating terminally ill patients intend to kill when they administer pain-relieving medication, and so will be acting unlawfully.\(^{36}\) Further, the palliative practice of “terminal sedation”\(^{37}\) – where a patient is kept under deep continuous sedation to manage pain, while artificial nutrition and hydration is withdrawn or withheld ultimately leading to death – can give rise to legal ambiguity and has sometimes been equated to “slow euthanasia”.\(^{38}\)

**Consequences of unlawfulness**

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

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

**The current law is incoherent**

As considered earlier in the article, some decisions are lawful even though they result in a person’s death.\(^{39}\) Withholding and withdrawing life-sustaining treatment can be lawful, eg, when doing so is judged to be in a person’s best interests. Providing pain relief that causes the death of a person will be lawful if the doctor’s intention is to relieve pain rather than to kill the patient. This is the case even if the doctor foresees that the medication will end the patient’s life. The law is incoherent if some deliberate acts (or omissions) which occur in the knowledge that a person will die as a result are

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\(^{33}\) Campbell has described the ability to choose to die to avoid extreme pain and suffering which cannot be alleviated by medicine as a human right: Campbell T, “Euthanasia as a Human Right” in McLean S (ed), *First Do No Harm: Law, Ethics and Healthcare* (Ashgate, Aldershot, 2008) p 455.


\(^{35}\) See above at 414.


\(^{38}\) The lawfulness of this practice is likely to depend on the precise circumstances of the case, particularly the reasons for the provision of the sedation and the cessation or withholding of artificial nutrition and hydration.

\(^{39}\) See above at 413-414.
lawful, yet others (namely voluntary euthanasia and assisted suicide) are not.\textsuperscript{40} There is no moral distinction to warrant treating these situations differently.

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

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

There is a longstanding history of strong public support for the legalisation of voluntary euthanasia and assisted suicide in certain circumstances. A recent illustration is a survey conducted in November 2010 by the Australia Institute which found that 75\% of respondents thought a doctor should be allowed to assist a terminally ill person experiencing unrelievable suffering to die at their request.\textsuperscript{41}

**The current law is discriminatory**

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

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

**Key arguments against legalising voluntary euthanasia and assisted suicide**

**Sanctity of life**

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

For years the Catholic Church and most mainstream Protestant Churches have opposed any form of euthanasia on the grounds that decisions about life and death should be reserved for divine agency.\textsuperscript{42}

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

The importance of human life is also recognised by our common law. In the landmark English case of *Airedale NHS Trust v Bland* [1993] AC 789, the House of Lords recognised that it would be lawful to withdraw life-sustaining medical treatment from a man in a persistent vegetative state but

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

\textsuperscript{41} The Australia Institute, “Survey Results – Attitudes to Voluntary Euthanasia” (2011), https://www.tai.org.au/index.php?q=node%2F19&pubid=822&act=display viewed 19 August 2012. The question asked was: “This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?” Responses were: Yes, voluntary euthanasia should be legal (75\%); No, voluntary euthanasia should be against the law (13\%); Not sure (12\%). For a wider discussion of Australian attitudes in this area, see Sikora J and Lewins F, “Attitudes Concerning Euthanasia: Australia at the Turn of the 21st Century” (2007) 16 *Health Sociology Review* 68.


accepted that the “sanctity of life” formed part of the English legal system (at 859). The Australian
courts have also recognised the state’s interest in preserving human life.44

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

**If voluntary euthanasia or assisted suicide is legalised, it is impossible to construct safeguards that will ensure an individual who falls outside the regime is not killed**

As can be seen from Table 7 in the Appendix, all statutes that have provided for voluntary euthanasia or assisted suicide contain safeguards that are designed to ensure that the only people whose lives are ended or to whom assistance to die is provided are those who are (or were) competent and made their decision voluntarily, and who have particular medical conditions. In all of those jurisdictions, there is also oversight of the relevant legislation. However, it would be difficult, if not impossible, to ensure all of the legislative requirements relating to eligibility are satisfied in all cases. Of particular concern may be the ability to ensure that the request to die was given voluntarily. A person approaching the end of her or his life who relies heavily on others for all aspects of living may be pressured to end her or his life. Such pressure may not necessarily be overt, and may be exerted in subtle ways. Nevertheless, this may result in the fact that the request to die cannot be regarded as having been made voluntarily.

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

**If voluntary euthanasia or assisted suicide for competent adults is legalised, the regime will be broadened to include involuntary and non-voluntary euthanasia, and euthanasia for minors (the “slippery slope” argument)**

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

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

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

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

Medical and other health professionals are trained to save and protect human life, and improve the quality of the life of their patients. It would be contrary to their fundamental role in society for these professionals to be asked to kill their patients, or assist their patients to end their own lives.

A separate, but related, point is that doctors should not be forced to act in a way that is contrary to their conscience. Even if a legislative regime does not require them to provide assistance, such a regime may require a doctor to refer the patient to someone who may be able to assist to end her or his life. An obligation to make such a referral may also be contrary to their beliefs and they should not be required to act in a way that is contrary to their conscience.

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44 See eg *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88 at [5]-[16], and most recently a reference by the majority of the High Court in *Patel v The Queen* (2012) 86 ALJR 954; [2012] HCA 29 at [87] to “the value the law places on human life”. 
If voluntary euthanasia or assisted suicide were legalised, sick and other vulnerable people may feel coerced to end their lives

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

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

The role of human dignity in this debate

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

Because human dignity is a concept which is potentially relevant to both sides of this debate, it has not been included in the above outline of arguments for and against voluntary euthanasia and assisted suicide. Instead, in the arguments supporting reform, dignity is considered in the narrower context as part of the justification for allowing individual choice in decision-making at the end of life. On the other side, dignity is relevant in advancing the argument concerning the sanctity of life, and the need to protect human life.

WHAT HAPPENS IN PRACTICE?

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

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

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

**What happens in Australia?**

As the practice of voluntary euthanasia and assisted suicide is illegal, there are significant impediments to accurately quantifying the extent to which these practices occur in Australia. However, there have been a few studies that have sought to examine this issue empirically. One is a study by Kuhse et al which concluded that in 1995-1996, 1.8% of all deaths in Australia occurred due to voluntary euthanasia and 0.1% were due to physician-assisted suicide. As outlined in the next section, these statistics are broadly comparable with the position in permissive jurisdictions. A noteworthy difference existed, though, in relation to the rate of death due to “ending life without patient’s explicit request”: Kuhse et al noted it was significantly higher in Australia (3.5%) than in The Netherlands (0.7%, at the comparable time of 1995).

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

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

While there is not comprehensive evidence in relation to the extent to which voluntary euthanasia and assisted suicide occur in Australia, there is clear evidence that such practices do take place despite being unlawful, giving rise to potential for those involved to be prosecuted.

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

A vast body of literature exists about current practices in jurisdictions that permit voluntary euthanasia and/or assisted suicide. This literature includes official reports that are legislatively mandated as part of government oversight of these practices, as well as publications resulting from formal and

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47 See above at 421.
49 Kuhse et al, n 48 at 195-196.
50 Magnusson, n 34.
51 Douglas et al, n 36.
53 Syme, n 34.
54 See eg the prosecution of Daryl Stephens, a urologist in Western Australia. He was ultimately acquitted of murder (a charge which was pursued by the Director of Public Prosecutions despite a magistrate initially finding there was insufficient evidence to warrant taking the matter to trial): Weber D, “Doctor Releases Book on Woman’s Death”, *PM* (8 October 2002), http://www.abc.net.au/pm/stories/6096378.htm viewed 19 August 2012.
comprehensive reviews of law and practice that are conducted from time to time. However, the bulk of the literature is comprised of articles published in scholarly journals, frequently by commentators who have an entrenched view, one way or the other, about whether such practices should be lawful. Some of this literature reports on empirical research that has been conducted in permissive jurisdictions, providing data on the extent to which voluntary euthanasia and assisted suicide occur. Some commentators express concern in this writing that permissive jurisdictions, and most notably The Netherlands, have witnessed an expansion in voluntary euthanasia and assisted suicide practices which has led to the vulnerable in our society being placed at risk. The literature includes concerns about the difficulties of ensuring that the safeguards embodied in the legislation are observed, and that the practice of voluntary euthanasia and assisted suicide is limited to the circumstances contemplated by the legislation. Other commentators express concern that the assertions raised in such literature are either overstated, not supported by the available empirical evidence, or are in direct conflict with that evidence.

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

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

The Netherlands

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

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

55 Recently eg reviews of the law and medical practice at the end of life were undertaken in both the United Kingdom and Canada resulting in two comprehensive reports: see Report of the Commission on Assisted Dying, The Current Legal Status of Assisted Dying is Inadequate and Incoherent (2011), http://www.demos.co.uk/publications/thecommissiononassisteddyingviewed 20 August 2012; and Schüklenk et al, n 45, respectively. A review of “dying with dignity” and associated issues has also been considered by a select committee created by the National Assembly in Quebec, with their report being released in March 2012: Quebec, Select Committee, Dying with Dignity Report (2012), http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html viewed 10 September 2012.


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

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

59 Schüklenk et al, n 45 at 61-65.

60 This summary was based on information provided in Schüklenk et al, n 45 at 51-57.
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- 1984: There was further case law development and it was recognised that where a doctor was faced with a request from a patient to die, the doctor faced a conflict of duty. He or she was entitled to assist the patient to die under the doctrine of necessity.
- 1994-2002: Prosecutorial guidelines operated which indicated when a doctor would and would not be charged in relation to ending a patient’s life or assisting the patient to die.
- 2002: Legislation was passed and doctors could not be prosecuted if they acted with “due care” as defined in the legislation.

The collection of empirical data about end-of-life medical practice was sponsored by the Dutch government to obtain information about the kind of practice that was occurring and demographics of those people who are dying as a result of the relevant legal regime. Nationwide surveys were conducted in 1990, 1995, 2001, 2005 and 2010 and they resulted in the data in Table 3.

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

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

* The circumstances in which such acts occur are explained in Schüttken et al, n 45 at 62 as follows: "They typically involve patients who are very close to death and are presently incompetent but where there has been an earlier discussion about the hastening of death with them and/or their relatives, and where opioids were used to end life” and "about one third of these cases can also be described as terminal sedation: cases in which high dosages of sedatives were given without hydrating the patient”.

**Belgium**

The Belgian Act came into effect in 2002. A Federal Control and Evaluation Commission was established to oversee the operation of the legislation. The Commission has published reports on the instances of euthanasia since the commencement of the legislation. Between September 2002 and the end of 2003, the number of reported cases of euthanasia was 259; for the years 2004 and 2005, the number was 742; and for the years 2006 and 2007, the number was 924.64

The figures in Table 4 allow comparisons in practice between 1998 (when voluntary euthanasia was illegal) and 2007 (when voluntary euthanasia was legal).65 Of particular interest is the decrease in the percentage of deaths that occurred as a result of action taken by a doctor without the explicit request of the patient.

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


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

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

65 The information in this table was drawn from Schüttken et al, n 45 at 62.
TABLE 4 Deaths due to voluntary euthanasia and assisted suicide as a percentage of total deaths in Belgium

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

Switzerland

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

There are four major right-to-die organisations in Switzerland that have been established to assist individuals to end their lives: Exit – German Switzerland (Exit GS), Exit – French Switzerland, Dignitas and Exit International. One research project reviewed the assistance provided by Exit GS with that provided by Dignitas for the period 2001-2004. This review revealed that Exit GS was involved in 147 suicides, and Dignitas in 274. Dignitas has reported that it has assisted 15 Australians to die between the years of 2003 and 2011.

Oregon

The Oregon legislation, which survived a number of legal challenges since it was passed in 1994, had its first full year of operation in 1998. In 2008, the Department of Human Services published a summary report which reviewed how the legislation had functioned over the first decade of its operation. During this period, 341 people died after ingesting medication that had been prescribed under the Death with Dignity Act. Table 5 provides statistics of prescription history during this decade.

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

- those who sought medication were more likely to be better educated than those who died of natural causes;
- there was no evidence that women and older people (aged more than 84) were more likely to seek assistance;


Dignitas, n 29.

The Washington legislation has only been in operation since 2009, and therefore fewer statistics are available on how it is functioning in practice. As Oregon and Washington have the same assisted suicide legislative model, and the legislation in Oregon has operated since 1998, only the data from Oregon are considered in this article. Suffice it to say that in Washington in 2010, medication was dispensed to 87 individuals, and 51 deaths took place after ingesting the medication: Schielenk et al, n 45 at 63, drawing on official data.

In 2010, 97 prescriptions were written for medication, and 65 deaths took place (59 from prescriptions issued in 2010, and 6 from prescriptions written in previous years): Schielenk et al, n 45 at 63, drawing on official data.

These statistics were obtained from Lewy, n 26, p 134.

The points below were extracted from an analysis of the summary report in Lewy, n 26, pp 134-136.
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- minority groups (Blacks, Hispanics and Native Americans) were under-represented as those seeking assistance;
- divorced and never married individuals were more likely to seek assistance;
- fear of losing control and autonomy were the most frequently cited reasons for seeking assistance; and
- being a burden on family and friends was also cited as a concern for almost half of the individuals seeking assistance.

### TABLE 5 Prescriptions filled and used, and deaths under Oregon’s assisted suicide regime

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

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

The foregoing discussions reveal a range of views and considerations that inform decisions about the shape of the law in this area. This section proposes a framework for considering what position the law should take on voluntary euthanasia and assisted suicide. It starts by asking whether voluntary euthanasia and assisted suicide should be criminal acts. If this conduct should continue to be regulated by the criminal law in this way, decisions need to be made about whether the current approach should be retained or whether the criminal law should treat this conduct more strictly or leniently. On the other hand, if voluntary euthanasia and assisted suicide should be decriminalised, then issues arise as to how this conduct should be regulated. In both instances, appropriate vehicles for achieving any recommended policy outcomes need to be evaluated.

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

A threshold question is whether voluntary euthanasia and/or assisted suicide should be criminal acts. Commentators have identified a number of functions of criminal law. Two that have particular significance here are the punishment of an offender in order to formally and publicly denounce conduct as morally culpable, and the protection of the community from harm through deterrence. These functions inform assessments as to whether voluntary euthanasia and assisted suicide should

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attract criminal responsibility, along with consideration of the arguments for and against legalisation outlined above and the available evidence as to current practice in Australia and in the permissive jurisdictions.

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

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

Culpability of voluntary euthanasia and assisted suicide

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

In terms of the current position, as noted above, voluntary euthanasia and assisted suicide are unlawful in all Australian States and Territories, and police and prosecutors have pursued criminal proceedings where there is evidence to support that course of action. However, for those who are convicted, the sentences imposed tend to be at the very low end of what is possible for these offences, often not involving a period of imprisonment. One available policy choice is to retain this current position. It is important that this is acknowledged as a choice – leaving the status quo unchanged involves a decision not to act.

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

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

Legal options for change

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

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73 Otlowski M, “Mercy Killing Cases in the Australian Criminal Justice System” (1993) 17 Crim LJ 10; Bartels L and Otlowski M, “A Right to Die? Euthanasia and the Law in Australia” (2010) 17 JLM 532. Note the case of Daryl Stephens, a urologist in Western Australia, where the Director of Public Prosecutions pursued criminal charges despite a magistrate initially finding there was insufficient evidence to warrant taking the matter to trial: see Weber, n 54.

74 Bartels and Otlowski, n 73.

Sentencing reform

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

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

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

Context-specific offences

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

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

Prosecutorial guidelines

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

76 Bartels and Otlowski, n 73 at 534-535.
77 Bartels and Otlowski, n 73.
78 Crimes Act 1900 (NSW), ss 31B, 31C.
79 Criminal Law Consolidation Act 1935 (SA), s 13A; Crimes Act 1958 (Vic), s 6B.
in the public interest. In England and Wales, the Director of Public Prosecutions has developed a policy specifically dealing with assisted suicide and when it will and will not be in the public interest to prosecute such cases.  

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

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

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

The alternative position is now considered where voluntary euthanasia and assisted suicide should not be criminal acts but rather be regulated like other potentially lawful activity. This brings with it choices about the scope of conduct that should be permitted and regulated, and the legal reform options available to achieve that.

What conduct should be permitted and regulated?

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

• Competence: Most permissive regimes provide that voluntary euthanasia or assisted suicide may occur only in relation to a person who is competent to make their own decisions and, as outlined above, this article deals only with voluntary euthanasia and assisted suicide in this context.

• Voluntary and informed choice: Permissive regimes generally have processes to support decision-making that is voluntary and informed.

• A person’s condition: An issue is whether a regulatory system should require a person to have a particular type of illness or condition. For example, does a person have to have a terminal illness or be experiencing unacceptable suffering? Some argue against these limitations as representing an infringement of a person’s autonomy. Others consider them to be discriminatory, e.g., against an individual with disabilities who may not be able to satisfy a terminal illness requirement but who considers her or his life intolerable. On the other hand, these limitations can be seen as an appropriate safeguard to ensure that the system is limited to those who are suffering unbearably.

• Decision-making process: Legislative regulatory systems have traditionally established a decision-making framework for accessing voluntary euthanasia or assisted suicide. For example, there may be requirements as to the number and form (e.g., in writing) of requests for assistance, timing before assistance can be provided, and assessments by doctors. The role of doctors gives rise to other questions. Do they need to be involved? Are they the decision-makers as to when assistance may appropriately be provided or is their role more limited? Some argue that the involvement of doctors can harm the doctor-patient relationship and erode trust and the ethic of

81 United Kingdom, Director of Public Prosecutions, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (2010), http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf viewed 19 August 2012.

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

83 See above at 412.
How should Australia regulate voluntary euthanasia and assisted suicide?

care. Others argue that doctors must be involved to ensure access to information about treatment options, the safe and painless bringing about of death, and appropriate assessments of competence.

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

**Legal options for change**

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

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

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

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

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

**Defence to criminal law prosecution**

A second law reform option is to not make voluntary euthanasia or assisted suicide lawful, but to create a defence that doctors (or others) may rely upon to avoid criminal responsibility. This can occur

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84 Carter v Canada (Attorney-General) [2012] BCSC 886.
85 The Supreme Court decision is currently being appealed by Canada's federal government: Appeal Court Upholds BC Woman's Exemption from Doctor-assisted Suicide Ban (10 August 2012), [http://www.canada.com/health/Appell Court+upholds+women's+exemption+from+doctor-assisted+suicide/7071822/story.html](http://www.canada.com/health/Appell Court+upholds+women's+exemption+from+doctor-assisted+suicide/7071822/story.html) viewed 19 August 2012.
86 R (on the application of Nicklinson) v Ministry of Justice [2012] EWHC 2381.
87 R (on the application of Nicklinson) v Ministry of Justice [2012] EWHC 2381 at [86].

(2012) 20 JLM 410
through judicial decision. This happened in the State of Montana, in the United States, where the law recognises consent as a general defence to a criminal charge, provided doing so is not “against public policy”. The question before the Supreme Court of Montana was whether a doctor may rely on the consent defence if they provide assistance to die to a terminally ill, competent adult at her or his request. Without this defence, the doctors were potentially liable to be charged with homicide. The court concluded that allowing doctors to assist patients was not against public policy and that the consent defence would be available to a doctor if the state chose to prosecute the doctor.\textsuperscript{88}

The prospect of judicial reform of this type in Australia is again limited: the law in Australia in relation to consent is different from Montana and a recent attempt in England to rely on the common law “defence of necessity” was rejected.\textsuperscript{89} However, a defence governing voluntary euthanasia and assisted suicide can also be created by statute and this model was adopted by a South Australian Bill: the \textit{Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill 2011} (SA). Under the Bill, a defence to homicide\textsuperscript{90} was created for a treating doctor to administer drugs where he or she believed on reasonable grounds that the life of an adult of sound mind was intolerable to that person. Such action had to be at the request of the person and be regarded as a “reasonable response to the suffering”. Of note is that the Bill expressly provided that the onus of proof rested on the doctor on the balance of probabilities to demonstrate that he or she fell within the protection provided by the defence. This criminal defence model is also consistent with how assisted suicide is regulated in Switzerland with people being allowed to assist another to die, provided they are acting with unselfish motives.\textsuperscript{91}

As noted above, this model (whether it is achieved through judicial or legislative reform) does not make voluntary euthanasia and assisted suicide lawful, but rather creates a defence for such conduct. One of the implications of this is that usually at least some of the onus of demonstrating that criminal responsibility should not be imposed rests on the person who is alleged to have participated in voluntary euthanasia or assisted suicide. Some would regard this as a disadvantage as the conduct still remains in the criminal law realm. Others would consider this appropriate. The comments made earlier about the potential uncertainty of judge-made law would also apply here to a judicially created defence; the enactment of a legislative defence allows for greater precision.\textsuperscript{92}

\textbf{Statutory framework to regulate the practice}

A final reform option, and one favoured most by voluntary euthanasia and assisted suicide advocates, is the creation of a statutory framework to permit and regulate the practice. This is the most common approach taken in the permissive jurisdictions, and the various models in operation are discussed above.\textsuperscript{93}

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

\textbf{WHAT SHOULD HAPPEN NEXT?}

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

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

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

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

\textsuperscript{91} See above at 417.

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

\textsuperscript{93} See above at 415-416.
How should Australia regulate voluntary euthanasia and assisted suicide?

in those jurisdictions where voluntary euthanasia and/or assisted suicide are lawful. It also considered the practices at the end of life in Australia and overseas, the arguments that have been advanced in favour of and against legalisation, and possible reform options. It has attempted to approach this exercise in a balanced way that acknowledges the complexity of these issues and the diversity of views held.

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

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

### TABLE 6 Legislative reform attempts in Australia

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<td>Medical Treatment (Amendment) Bill 1995</td>
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<td>Michael Moore (Independent)</td>
<td>Legislative Assembly</td>
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<td></td>
<td>Euthanasia Referendum Bill 1997</td>
<td>18 June 1997</td>
<td>Michael Moore (Independent)</td>
<td>Legislative Assembly</td>
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<tr>
<td>New South Wales</td>
<td>Rights of the Terminally Ill Bill 2001</td>
<td>29 November 2001</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Trial (Referendum) Bill 2002</td>
<td>9 April 2002 (Notice of motion)</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Trial (Referendum) Bill 2003</td>
<td>17 September 2003</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2003</td>
<td>30 April 2003 (Notice of motion)</td>
<td>Ian Cohen (Australian Greens)</td>
<td>Legislative Council</td>
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<tr>
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<td>Rights of the Terminally Ill Bill 2010</td>
<td>22 September 2010 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2010</td>
<td>19 October 2010 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill Bill 2011</td>
<td>2 August 2011 (Notice of motion)</td>
<td>Cate Faehrmann (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>South Australia</td>
<td>Voluntary Euthanasia Bill 1995</td>
<td>9 March 1995</td>
<td>John Quirke (ALP)</td>
<td>House of Assembly</td>
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<tr>
<td></td>
<td>Voluntary Euthanasia Bill 1996</td>
<td>6 November 1996</td>
<td>Anne Levy (ALP)</td>
<td>Legislative Council</td>
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<td></td>
<td>Dignity in Dying Bill 2001</td>
<td>14 March 2001</td>
<td>Sandra Kanck (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2001</td>
<td>15 March 2001</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2003</td>
<td>24 September 2003</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Dignity in Dying Bill 2005</td>
<td>16 February 2005</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2006</td>
<td>14 March 2007</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2007</td>
<td>31 May 2007</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2008</td>
<td>16 October 2008</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008</td>
<td>12 November 2008</td>
<td>Mark Parnell (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2010</td>
<td>24 June 2010</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010</td>
<td>16 September 2010</td>
<td>Stephanie Key (ALP)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td></td>
<td>Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010</td>
<td>29 September 2010</td>
<td>Mark Parnell (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Name of Bill</td>
<td>Date introduced</td>
<td>Who introduced</td>
<td>Where introduced</td>
</tr>
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<td>-------------</td>
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</tr>
<tr>
<td>South Australia</td>
<td>Criminal Law Consolidation (Medical Defence - End of Life Arrangements) Amendement Bill 2011</td>
<td>10 March 2011</td>
<td>Stephanie Keay (ALP)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Voluntary Euthanasia Bill 2012</td>
<td>1 March 2012</td>
<td>Dr Bob Such (Independent)</td>
<td>House of Assembly</td>
</tr>
<tr>
<td>Victoria</td>
<td>Medical Treatment (Physician Assisted Dying) Bill 2008</td>
<td>26 May 2008</td>
<td>Nicholas McKim (Australian Greens)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Voluntary Euthanasia Bill 1997</td>
<td>20 August 1998</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Dying Bill 2002</td>
<td>20 October 2002</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2006</td>
<td>19 October 2006</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2009</td>
<td>13 August 2009</td>
<td>Norm Kelly (Australian Democrats)</td>
<td>Legislative Council</td>
</tr>
<tr>
<td></td>
<td>Voluntary Euthanasia Bill 2010 **</td>
<td>9 September 2010</td>
<td>Lyn Allison (Australian Greens)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill (Euthanasia Laws) Bill 2007</td>
<td>14 February 2007</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
<tr>
<td></td>
<td>Rights of the Terminally Ill (Euthanasia Legislation) Bill 2010</td>
<td>29 November 2010</td>
<td>Bob Brown (Australian Greens)</td>
<td>Senate</td>
</tr>
</tbody>
</table>

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

** This Bill was passed and overrode the Rights of the Terminally Ill Act 1995 (NT). There were subsequently a number of attempts made by Senators to overturn the effect of the Commonwealth Act (and these are listed above).
<table>
<thead>
<tr>
<th>Overview of the regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of legislation</strong></td>
</tr>
<tr>
<td>Rights of the Terminally Ill Act 1995</td>
</tr>
<tr>
<td>Termination of Life on Request and Assisted Suicide Act 2000</td>
</tr>
<tr>
<td>Act on Euthanasia 2002</td>
</tr>
<tr>
<td>Law of 16 March 2009 on Euthanasia and Assisted Suicide</td>
</tr>
<tr>
<td>Death with Dignity Act 1994</td>
</tr>
<tr>
<td>Washington Death with Dignity Act</td>
</tr>
<tr>
<td><strong>Year commenced operation</strong></td>
</tr>
<tr>
<td><strong>Nature of activity that is regulated</strong></td>
</tr>
<tr>
<td>Voluntary euthanasia and assisted suicide</td>
</tr>
<tr>
<td>Voluntary euthanasia and assisted suicide</td>
</tr>
<tr>
<td>Voluntary euthanasia*</td>
</tr>
<tr>
<td>Voluntary euthanasia and assisted suicide</td>
</tr>
<tr>
<td>Assisted suicide</td>
</tr>
<tr>
<td>Assisted suicide</td>
</tr>
<tr>
<td><strong>Eligibility requirements</strong></td>
</tr>
<tr>
<td><strong>Must be an adult?</strong></td>
</tr>
<tr>
<td>Yes                                        Yes                                        Yes                                        Yes</td>
</tr>
<tr>
<td>No Legislation extends to: (a) Minor between 16 and 18 who has a reasonable understanding of own interests (where parents or guardians involved in decision-making process) (b) Minor between 12 and 16 who has a reasonable understanding of own interests (where parents or guardians agree).</td>
</tr>
<tr>
<td>No Legislation extends to emancipated minors.</td>
</tr>
<tr>
<td>Yes                                        Yes                                        Yes                                        Yes</td>
</tr>
<tr>
<td><strong>Must be competent at time death occurs?</strong></td>
</tr>
<tr>
<td>Yes                                        No                                         Yes                                        Yes</td>
</tr>
<tr>
<td>No Legislation is not limited to competent individuals.</td>
</tr>
<tr>
<td>Legislation is not limited to competent individuals.</td>
</tr>
<tr>
<td>Legislation is not limited to competent individuals.</td>
</tr>
<tr>
<td>Legislation is not limited to competent individuals.</td>
</tr>
<tr>
<td>A person can also make &quot;end-of-life provisions in writing&quot; when competent to request euthanasia be performed if he or she becomes unconscious, has a &quot;severe and incurable accidental or pathological disorder&quot; and the situation is irreversible.</td>
</tr>
<tr>
<td>Yes                                        Yes                                        Yes                                        Yes</td>
</tr>
<tr>
<td><strong>Must person have a terminal illness?</strong></td>
</tr>
<tr>
<td>Yes                                        No                                         No                                         Yes                                        Yes                                        Yes</td>
</tr>
<tr>
<td>Is pain and/or suffering required?</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Yes (Illness is causing “severe pain or suffering“).</td>
</tr>
</tbody>
</table>

| Must person be a resident in the jurisdiction? | No | No** | No (However, doctor must be satisfied of the “durable” nature of the patient’s request. To this end, the doctor must have “several conversations with the patient spread out over a reasonable period of time”). | No (However, the doctor must have treated the patient for some time to ensure the “persistence” of the patient’s suffering, and to hold “several interviews with the patient, at reasonable intervals”). | Yes | Yes |

**Safeguards**

<table>
<thead>
<tr>
<th>Involvement of health professionals</th>
<th>2 doctors and a psychiatrist</th>
<th>2 doctors</th>
<th>2 doctors (unless not expected to die in near future and, if so, 3 doctors)</th>
<th>2 doctors</th>
<th>2 doctors</th>
<th>2 doctors</th>
</tr>
</thead>
</table>

| Legitimacy of request | 2 doctors must be satisfied that request made “freely, voluntarily and after due consideration”. | 2 doctors must be satisfied that the “request ... was voluntary and well-considered”. | Doctor to be satisfied that the “request is voluntary, well-considered and repeated, and is not the result of any external pressure”. | 2 doctors satisfied that request is made voluntarily. | 2 doctors satisfied that request is made voluntarily. | 2 doctors satisfied that request is made voluntarily. |

<p>| Patient must be professionally informed | Patient informed of the nature and likely course of illness and medical treatment and other support (including counselling and psychiatric support) available. | Patient informed of the situation he was in and about his prospects”. | Patient informed about health condition, life expectancy, the possible palliative and therapeutic courses of action and their consequences. | Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control). | Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control). | Patient informed of diagnosis and prognosis, risks and result of taking the medication, and alternative treatment (including comfort care, hospice care and pain control). |</p>
<table>
<thead>
<tr>
<th>Northern Territory</th>
<th>Netherlands</th>
<th>Belgium</th>
<th>Luxembourg</th>
<th>Oregon</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cooling-off period</strong></td>
<td>Yes At least 7 days between advising doctor of decision and signing of certificate; and 2 days from signing the certificate.</td>
<td>[Legislation is silent]</td>
<td>Doctor must be certain of the 'durable' nature of request. Doctor must have had 'several conversations with the patient spread out over a reasonable period of time' (and if patient is not expected to die in near future, there must be at least one month between the written request and the act of euthanasia).</td>
<td>Doctor to 'hold several interviews with the patient, at reasonable intervals having regard to the evolution of the patient's condition'.</td>
<td>Yes No less than 15 days between patient's initial oral request and writing prescription for medication; no less than 48 hours between the written request and writing a prescription for medication.</td>
</tr>
<tr>
<td><strong>Relevance of depression</strong></td>
<td>Patient is &quot;not suffering from treatable clinical depression in respect of the illness&quot;.</td>
<td>Legislation is silent regarding a patient who suffers from depression. However, the request must be &quot;well-considered&quot;. If depression affects the patient's judgment, this may have an impact on whether the doctor can regard the request as &quot;well-considered&quot;.</td>
<td>Legislation is silent regarding a patient who suffers from depression. However, the patient must be &quot;competent&quot; to make a request. If depression affects the patient's judgment, he or she may not be regarded as &quot;competent&quot;.</td>
<td>Legislation is silent regarding a patient who suffers from depression. However, patient must be &quot;capable&quot; to make a request. If depression affects the patient's judgment, he or she may not be regarded as &quot;capable&quot;.</td>
<td>Doctor to refer the patient for counselling if patient may be suffering from psychiatric or psychologi- cal disorder or depression causing impaired judgment and, if does, medication cannot be prescribed until counselor determines patient is not suffering in a way that impairs judgment.</td>
</tr>
<tr>
<td><strong>Oversight of the legislation</strong></td>
<td>Doctor to notify coroner; Crown advises the Attorney-General annually of number of deaths.</td>
<td>Doctor to notify municipal pathologist of action; Regional Review Committees have overall responsibility for reviewing notifications.</td>
<td>Doctor completes a Form for every death and registers it with the Federal Control and Evaluation Commission, and Form reviewed by Commission to ensure compliance.</td>
<td>Doctor to submit documentation for every death to National Commission for Control and Assessment, and documentation reviewed to ensure compliance.</td>
<td>Health care provider who dispenses medication to file a copy of dispensing record with the Department of Human Services; Department to review a sample of records annually; Department also to produce publicly available annual statistical report.</td>
</tr>
</tbody>
</table>

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

** Compare the Netherlands Ministry for Foreign Affairs which has stated that it would be "impossible" for a non-resident to receive voluntary euthanasia or assisted suicide on the basis that a close doctor-patient relationship is needed for the requirements of the legislation to be met: Netherlands Ministry of Foreign Affairs, *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in Practice, FAQ Euthanasia* (2010). It is not clear, however, on the face of the legislation as to why a person must be a resident for this to be so.
The right to choose an assisted death: Time for legislation?

Report following a Roundtable in Brisbane, January 2013
 "How should Australia regulate voluntary euthanasia and assisted suicide?"
Jessica Sparks is a law and journalism student. She has cystic fibrosis, and at 16 was diagnosed with end-stage lung disease, placed on a breathing machine and told death was imminent. Fortunately she received a double-lung transplant after surviving for a year.

The fact that a peaceful, assisted death is illegal, while much worse alternatives are legally available and much more easily accessible, is disgraceful.

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

It is important to note that for each person dying there are friends, relatives and carers who are also affected by such a painful and undignified death.
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<td>Recommendations</td>
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<td>Why change is needed</td>
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<td>There is no compelling reason to resist change</td>
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Australia21 is a non-profit body, committed to an analysis of complex issues, which bear on Australia’s future. During 2012, the Board was approached with the suggestion that the issues of voluntary euthanasia and assisted suicide would benefit from Australia21’s multidisciplinary approach to the exploration of complex policy issues.

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

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

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

The second part of the report describes what the authors, writing for Australia21, have concluded from this rich exchange of ideas and concerns, from the transcript of the discussion which included summative statements by all of the participants at the end of the day, and from published literature.

Australia21 hopes that by distributing this report, Australian legislators will be encouraged to engage in this debate with a clearer understanding of the concerns on both sides of the argument.

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

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

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

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

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

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

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

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

Accordingly, Australia21 recommends:

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

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

c) Until the above happens, each Member of Parliament should consider exercising his or her right to introduce a private member’s bill on voluntary euthanasia and assisted suicide.
Late last year, YourLastRight.com commissioned national public opinion research, conducted by Newspoll. The survey of more than 2,500 Australians confirmed ongoing very high public support for legal access to physician-assisted dying in the face of intolerable end-of-life suffering that cannot be relieved. Respondents were strongly in favour of this development across age groups, religious affiliation and political affiliation. (see over)

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

A politician whose stance is opposed to assisted dying law reform will lose considerably more votes at a general election (23%) than a politician who supports reform (6%). A majority of lost votes for “opposed” election candidates applies across all major political parties. The study also found that voluntary euthanasia law reform was more personally important to voters than other major national issues like the carbon tax, the national high-speed broadband network and gay marriage, and that the views of voluntary euthanasia law reform supporters are on average more deeply held than are views of opponents.

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

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

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**Age group**
(doctor can provide a lethal dose)

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**Religion**
(doctor can provide a lethal dose)

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

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

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

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

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

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

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

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

- **euthanasia**: for the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person.
- **voluntary euthanasia**: euthanasia is performed at the request of the person whose life is ended, and that person is competent.
- **non-voluntary euthanasia**: euthanasia is performed and the person is not competent.
- **involuntary euthanasia**: euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she not die.
- **withholding or withdrawing life-sustaining treatment**: treatment that is necessary to keep a person alive is not provided or is stopped.
- **assisted suicide**: a competent person dies after being provided by another with the means or knowledge to kill himself or herself.
- **physician-assisted suicide**: assisted suicide where a doctor acts as the assistant by providing the lethal treatment that the person self-administers.

Areas of broad agreement

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

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

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

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

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

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

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

5. Providing requested assistance to die should be part of how those doctors, who are willing to do so, can care compassionately for suffering patients.
Dr Rodney Syme

is a medical practitioner with a 38 year history of active participation in physician-assisted dying.

Dying may be associated with intolerable suffering and there may be a crescendo of suffering as death approaches. A doctor’s duty is to relieve suffering. Some suffering will only be relieved by death.

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

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

The current law is opaque, ambiguous, hypocritical and unenforceable.
Paul Collins
is an historian, broadcaster and writer.
He has taught history and theology in
Australia, the US and Pacific countries
and worked as a parish priest in
Sydney and Hobart.

The issue of voluntary euthanasia and
assisted suicide should be withdrawn
from the context of the criminal law
entirely, with interventions from
lawyers, courts, judges excluded
virtually completely. The law is a
blunt instrument at the best of times
but particularly when dealing with
sensitive issues such as life and death.

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

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

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

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

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

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

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

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

I draw your attention to a key conclusion from the 1994 House of Lords inquiry into medical ethics:③

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

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

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

There is a need for more discussion, debate and community-wide research to ensure that the complex issues relating to dementia are fully considered. It is clear that, even if voluntary euthanasia were to be legalised, it would be wrong to end the life of an individual who does not have the capacity to make the decision and who has not expressed previous wishes.
Dr Alex Markwell is an Emergency Physician at the Royal Brisbane and Women’s Hospital and Greenslopes Private Hospital. She is currently President of AMA Queensland and is a Senior Lecturer at the University of Queensland.

While the AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide, the organisation currently believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person’s life.

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

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

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

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

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

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

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

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

1. The Australian community wants change
Repeated polling has been carried out for 25 years by professional pollsters, and the public has consistently reported overwhelming support in favour of reform.\(^2,\)\(^6\) The question usually explores whether a person supports allowing a doctor to assist a person to end their lives if experiencing unrelievable and incurable suffering. In addition to the Newspoll survey reported on page 8, an opinion poll conducted by The Australia Institute in 2012 asked the following question:

**If a person is experiencing unrelievable and incurable suffering (physical and/or mental) should a doctor be allowed to help them end their life?**

Of the 1400 people surveyed, 71% agreed with the proposition, 12% of people disagreed and 17% were unsure.\(^6\)

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

a) Deaths are currently occurring contrary to the law
Research among Australian doctors caring for seriously ill patients has documented current practices in some detail.\(^12,\)\(^13\) According to that research, voluntary, involuntary and non-voluntary euthanasia all occur in Australia in defiance of the law. Some doctors have admitted publicly that they have acted with intent to end the patient’s life but, despite this admission, they have not been prosecuted.

Kuhse et al concluded that in 1995-1996, 1.8% of all deaths in Australia occurred as a result of voluntary euthanasia and 0.1% were due to physician-assisted suicide. Despite these actions being unlawful in Australia, the incidence was broadly comparable with that in permissive jurisdictions.\(^13\) Other research demonstrates that some doctors who treat terminally ill patients intend to shorten life (rather than only relieve pain) when they administer pain relieving medication, and so will be acting unlawfully.\(^12\)

b) The current law is incoherent or illogical
There are a number of aspects of the law in relation to the end of life care which are incoherent or illogical:

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

c) The law fails the principle of “equality before the law”
The Rule of Law requires that law must apply equally to all, but this is not the case in this field. Whereas some may be able to end their own life, another person’s disability may prevent them from doing so. Further, a person who is ill and relying on life-sustaining treatment to survive [such as a respirator] may lawfully ask for that equipment to be turned off. Another person who is equally ill, but suffering from a different condition which does not require such treatment, cannot be assisted to die.

At present, there are some who can access voluntary euthanasia and assisted suicide despite it being unlawful. Those people are generally able to do so because they possess some privilege. It may be privilege in terms of education or it may be in relation to contacts and connections one has within the medical or veterinary professions. The operation of the law cannot be justified if a privileged few are able to receive assistance to die, but others cannot.
d) Non-compliance with the law brings the law into disrepute

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

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

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

4. Palliative care cannot address all suffering

The palliative care movement has developed to assist patients with terminal illness when approaching the end of their life. It provides medical support for the relief of symptoms and also nursing, social and spiritual support for the relief of existential suffering. But palliative care, despite its accomplishments, is unable to meet the needs of all patients as they approach the end of their lives. While palliative care can assist with physical, psychological and existential pain, it cannot manage all suffering in all cases.
Emeritus Professor Ian Maddocks AM is Senior Australian of the Year 2013. He was the first President of the Australian Association for Hospice and Palliative Care (now known as Palliative Care Australia) and first President of the Australian and New Zealand Society for Palliative Medicine. Now aged 81, he continues daily care for the terminally ill.

Palliative care usually has adopted a confrontational position against voluntary euthanasia, recognising its work as supporting living before death rather than assisting death. Other factors are its historical association with Christian (Catholic) concern to preserve life; and a sense that support for euthanasia is a criticism of palliative care expertise.

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

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

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

It calls for the same full appreciation as palliative care physicians seek to bring to their work. Most of us want the right to have a say, but it is appropriate to ask that all death decisions be considered in the light of a full understanding of complex realities, and of close others whom it will affect.
Undoubtedly, euthanasia occurs now in various guises in Australia and is likely to continue to occur outside any regulatory guidelines if euthanasia or assisted suicide are decriminalised or legalised.

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

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

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

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

But if we do have legislative change, I think it will have a substantial effect on the national psyche and that the effect could be both positive and negative.
We have demonstrated why we think the law must change. Legislation to legalise assisted dying should be enacted unless there are compelling reasons not to do so. The two major arguments against reform are: 1) concerns that the vulnerable in our community will be placed at greater risk, and 2) the theological view that the divinely conferred sanctity of human life should prevent the intentional taking of life. Neither of these arguments is, in our view, sufficient to resist reform.

1. Safeguards to protect the vulnerable are working well internationally

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

Different legislative approaches to safeguards exist in the Netherlands, Belgium and Oregon and these regimes have been in place for long enough to assess their impact. Extensive evaluative data about their operation have been analysed and these, along with considerations such as the need to protect the vulnerable in society, have been considered in detail in many international publications and inquiries and, more recently, in a discussion paper in Tasmania.

The experience shows that guidelines to protect the vulnerable and ensure that assisted dying is reserved for the group in whose interest it is legislated, are generally operating effectively. Such data have sometimes been interpreted differently by those who support and oppose legalisation, but discussion at the roundtable supported (though not unanimously) the view that legislation in jurisdictions that have legalised voluntary euthanasia and/or assisted suicide is generally operating without evidence of the kinds of abuses that opponents and the 1994 report of the House of Lords had feared.

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

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

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

Australia is increasingly a secular society and it is difficult to defend law and policy that reflects divine understandings of the value of human life. There is now wide acceptance that human life is not an absolute good and that notions of compassion and autonomy can carry greater weight in some circumstances. Further, some religious groups are moving away from more traditional positions and agitating for a more humane approach to assisted dying. The polling data presented on page 8 of this report confirms that strong support for reform spans religious denominations.

Australia21 firmly asserts the right of people to hold and practise religious beliefs. An important concern raised at the roundtable was to ensure doctors, nurses and other health professionals are not required to participate in voluntary euthanasia or assisted suicide contrary to their conscience. However, respect for those beliefs should not bind others who have different beliefs and values, and religious teachings should certainly not be regarded, in our secular society, as a basis for developing law and policy.
Dr Roger Hunt
is currently Medical Head of
Palliative Care at The Queen
Elizabeth Hospital and a Senior
Lecturer, University of Adelaide.

I have cared for terminally ill patients
who have strongly expressed their
wish for help to die. Around 7% of
patients with advanced cancer make
persistent requests for help to die.
While I support patient-centred care
and patient autonomy, family and
broaden concerns can temper these.

There are situations in which a strong
consensus can be formed between
the terminally ill patient, their loved
ones, and their carers, that voluntary
euthanasia is reasonable and desired.

Compassionate clinicians can
experience enormous pressure
to grant a dying person’s wish
for a hastened death. In these
circumstances, I believe
clinicians should have protection
from prosecution for the most
serious crime of murder.

Voluntary euthanasia is ethically
distinct from murder, because
of respect for autonomy and
compassion (rather than sinister
motives), yet parliamentarians
have been reluctant to
distinguish them in law.
Dr Philip Nitschke
In 1996, Philip Nitschke became the first physician in the world to administer a legal lethal voluntary injection to four terminally ill patients under the Northern Territory’s Rights of the Terminally Ill Act.19 When the law was overturned nine months later, Philip founded Exit International, an international end of life choices group with a focus on practical strategies. Philip has written extensively on voluntary euthanasia and is the author of two books: Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill (Penguin, 2005) and The Peaceful Pill Handbook (Exit International USA, 2013).

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

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

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

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

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

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

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


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

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

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

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

Mr Paul Barratt AO
Chair, Australia21

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

Mr Jack Boyd
Law/Commerce Student

Dr Bob Brown
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Professor Colleen Cartwright
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Dr Paul Collins
Historian, Writer and Broadcaster

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Director, The Australia Institute

Emeritus Professor Bob Douglas AO
Retired Epidemiologist (Chair)

Dr Charles Douglas
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Mr Richard Eckersley
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Mr Neil Francis
Former Chair and CEO,
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Ethicist, Monash University

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Emeritus Professor Ian Maddocks AM
Senior Australian of the Year,
Palliative Care Physician
(Dotpoints only)

Dr Alex Markwell
President, AMA Queensland,
Emergency Physician

Mr Richard Mills
President, Dying with Dignity NSW

Dr Philip Nitschke
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Professor of Medical Ethics,
University of Queensland

Mr Marshall Perron
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Professor of Law, Health Law
Research Centre, QUT

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

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

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

Religious belief does play a role here.
People who want voluntary euthanasia are worse off (in regard to voluntary euthanasia) in hospital (or in a nursing home) than they are at home.
It is legal now to kill oneself but the legal methods are all messy.
Australia21 gratefully acknowledges financial support for this project from Mr Richard Eckersley, the estate of Ms Jan Lee Martin, Mrs Joan Douglas, the Health Law Research Centre at the Queensland University of Technology (QUT), Mr Robert Albert, Mr John Newsom, Dr and Mrs David Evans, Mrs Elizabeth Alpers, Dr Romaine Rutnam and Dr Tony Adams.

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

We are also particularly grateful for use of facilities at QUT, to the Vice Chancellor, Professor Peter Coaldrake AO, who hosted a reception for participants, and to Ms Amy Henderson and her staff at QUT for logistic support.
Mr Marshall Perron is a former Chief Minister of the Northern Territory. He was the architect and sponsor of the Northern Territory Rights of the Terminally Ill Act 1996 which was overturned by Federal Parliament in 1997.

If there are terminally and incurably ill patients who wish to end their suffering by accelerating inevitable death and if there are sympathetic doctors who are willing to help them to die with dignity, then the law should not forbid it.

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

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

“When you get really ill and near-death, go to the palliative care unit and they will do their best to help you but there is a chance they cannot.”

If you don’t want to go down that path then you can go and kill yourself and there is no law against suicide. We don’t want you to but no one can stop you. You can go and hang yourself or shoot yourself. That is okay.

But if you want to have the family around for the hugs and tears and say goodbye, it is very hard to do that when you’re going to hang yourself from the ceiling fan.”

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

Ben White* and Jocelyn Downie†

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

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I Introduction

Euthanasia and assisted suicide remain the subject of ongoing debate in Australia. Public interest has been sparked by a series of recent prosecutions, most notably those of Shirley Justin and Caren Jenning in connection with the death of Graeme Wylie.1 Other recent prosecutions that have attracted attention include those of Ann Leith2 and Victor Rijn3 in Victoria, Merin Nielsen in Queensland,4 and David Mathers in New South Wales.5 A promi-

1 The cases associated with Graeme Wylie's death are discussed further below at Part VIIIA.
2 See Adrian Lowe and Steve Butcher, 'No Conviction for Euthanasia Drug', The Age (Melbourne), 16 April 2010, 3.
nent part of the debate in this area has been directed to the need for reform and those efforts to date have focused on legislative change. For example, there have been a number of Bills recently introduced or considered in South Australia, Western Australia and New South Wales seeking to liberalise the law. There have also been reports of a forthcoming Bill being prepared in Tasmania, which has the support of the Premier of that state, and there have been attempts at the Commonwealth level to repeal the laws that preclude territory governments from legislating in relation to euthanasia.

One issue that has not yet received sufficient attention in the Australian context, however, is the use of discretion as to when cases of euthanasia and assisted suicide should be prosecuted. Examination of the role that prosecutorial discretion might play in such cases is timely given recent developments in England and Wales and Canada. In 2010, after a period of public consulta-


6 Criminal Law Consolidation (Medical Defences — End of Life Arrangements) Amendment Bill 2011 (SA); Voluntary Euthanasia Bill 2010 (SA).

7 Voluntary Euthanasia Bill 2010 (WA).

8 Rights of the Terminally Ill Bill 2011 (NSW).


11 See Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010 (Cth).

12 A notable exception to this is Otlowski’s study, published in 1993, which looked at how 19 cases of ‘mercy killings’ were treated by the criminal justice system (including the exercise of prosecutorial discretion) over a period of almost 30 years: Margaret Otlowski, ‘Mercy Killing Cases in the Australian Criminal Justice System’ (1993) 17 Criminal Law Journal 10. There have also been some more recent discussions of this issue that are relevant but do not cover the same terrain as our article: see, eg, Thomas Faunce and Ruth Townsend, ‘Justins v The Queen: Assisted Suicide, Juries and the Discretion to Prosecute’ (2011) 18 Journal of Law and Medicine 706; Margaret Otlowski, ‘House of Lords Directs DPP to Clarify Assisted Suicide Law’ (2010) 18(1) Australian Health Law Bulletin 6; Brendan Murphy, ‘Human Rights, Human Dignity and the Right to Die: Lessons from Europe on Assisted Suicide’ (2009) 33 Criminal Law Journal 341; Jeremy W Rapke, ‘R (Purdy) v DPP — Its Implications for Prosecuting Authorities’ (Paper presented at the Conference of Australian and Pacific Prosecutors, Brisbane, October 2009).
tion, the Director of Public Prosecutions ("DPP") in England and Wales released its Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, which provides offence-specific guidance for how prosecutors will approach their decision of whether or not to prosecute.\textsuperscript{13} In Canada, both the reports of the Royal Society of Canada Expert Panel on End-of-Life Decision-Making and the all-party Select Committee of the Quebec National Assembly included the adoption of prosecutorial guidelines as part of their recommendations for reform in this area.\textsuperscript{14}

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

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


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

II PROSECUTORIAL GUIDELINES IN AUSTRALIA

The criminal offences that principally arise in the context of euthanasia and assisted suicide are murder, manslaughter, and aiding, abetting or counselling suicide.\textsuperscript{15} It is no defence that the accused's conduct was motivated by compassion,\textsuperscript{16} nor is a person excused from criminal responsibility because a victim consented to his or her own death.\textsuperscript{17} However, the commission of one of the above offences is not of itself sufficient to lead to prosecution. All of the

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

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

\textsuperscript{17} In relation to the common law, see \textit{R v Cato} [1976] 1 WLR 110, 117 (Lord Widgery CJ); Oltowski, \textit{Voluntary Euthanasia and the Common Law}, above n 16, 20–1. In relation to the Code states, see \textit{Criminal Code Act 1983} (NT) s 26(3); \textit{Criminal Code Act 1899} (Qld) sch 1 s 28(4); \textit{Criminal Code Act 1924} (Tas) sch 1 s 53(a); \textit{Criminal Code Act Compilation Act 1913} (WA) sch s 261. On this point, we anticipate a possible argument that our proposed guidelines could be subject to an administrative law challenge on the basis that they are based on an autonomous choice by the deceased for his or her life to end and this is inconsistent with the prohibition on consenting to one's own death. However, we consider that our proposed guidelines would withstand such a challenge because the guidelines do not infringe on the criteria for when criminal responsibility as a matter of law is established. Instead, the proposed voluntary euthanasia and assisted suicide guidelines are relevant only to assessments as to whether it is in the public interest for that conduct to be prosecuted and a discretion to be exercised accordingly. We also note that the public interest factor of autonomous choice in the proposed guidelines would not be the sole criterion for the exercise of prosecutorial discretion as DPPs would also have to apply the other public interest considerations as set out in the general prosecution guidelines.
state and territory DPPs have issued guidelines that govern the exercise of prosecutorial discretion generally and made them publicly available.¹⁸ In all but one jurisdiction (Tasmania), the production of these guidelines is expressly authorised by the statute that creates the office of the DPP.¹⁹ These guidelines set out the test that the DPP will apply in considering whether to prosecute an accused. Although the approach is formulated in different ways in the various jurisdictions,²⁰ there are broadly two considerations:


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

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

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

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

Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 8, which outlines a three-stage approach).

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

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

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

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

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

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

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

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

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

See, eg, ibid 5 [2.1.10(t)].

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

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

Note, however, that the Attorney-General of the ACT has issued a direction entitled Director of Public Prosecutions Direction 2006 (No 2) (ACT), which clarifies that health professionals will not be prosecuted for withholding or withdrawing life-sustaining treatment that has been
III THE ASSISTED SUICIDE POLICY IN ENGLAND AND WALES

The position is different in England and Wales, as they have recently produced a prosecutorial policy dealing with assisted suicide (the policy does not cover voluntary euthanasia).\textsuperscript{34} This occurred after the final judicial decision of the House of Lords in July 2009: \textit{R (Purdy) v Director of Public Prosecutions ('Purdy')}.\textsuperscript{35} Ms Purdy suffered from primary progressive multiple sclerosis and wished to obtain assistance from her husband to travel to a jurisdiction where assisted suicide was lawful so that she might die. She was, however, concerned that her husband might be prosecuted and so requested information from the DPP as to the factors he would consider when deciding whether to consent to the initiation of a prosecution for assisted suicide. This consent is specifically required by s 2(4) of the \textit{Suicide Act 1961}.\textsuperscript{36} The DPP declined to provide that information and Ms Purdy challenged that decision. The House of Lords concluded that Ms Purdy was entitled to know what factors the DPP would consider when deciding whether to prosecute and directed him to promulgate an offence-specific policy to this effect.\textsuperscript{37}

In reaching this conclusion, the House of Lords considered that Ms Purdy's right to respect for her private life under art 8(1) of the European \textit{Convention for the Protection of Human Rights and Fundamental Freedoms ('Convention')}\textsuperscript{38} was engaged.\textsuperscript{39} A failure to provide an offence-specific policy setting out the factors that will be used to determine whether a prosecution is in the public interest interfered with that right in a manner that was not 'in accordance with law' as required by art 8(2) of the \textit{Convention}.\textsuperscript{40} Matters of

\textsuperscript{34} See Crown Prosecution Service (England and Wales), \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, above n 13.

\textsuperscript{35} [2010] 1 AC 345.

\textsuperscript{36} 9 \& 10 Eliz 2, c 60.


\textsuperscript{38} Opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by Protocol No 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, Amending the Control System of the Convention, opened for signature 13 May 2004, CETS No 194 (entered into force 1 June 2010).

\textsuperscript{39} Purdy [2010] 1 AC 345, 386–90 [29]–[39] (Lord Hope), 399 [67] (Baroness Hale), 401 [75] (Lord Brown), 406 [95] (Lord Neuberger).

\textsuperscript{40} Ibid 395–6 [54]–[55] (Lord Hope), 398 [64] (Baroness Hale), 405 [85] (Lord Brown), 407–8 [100]–[101] (Lord Neuberger); see also at 390–91 [40]–[43] (Lord Hope) (discussing art 8(2)), 391 [44]–[53] (Lord Hope) (discussing the Director's discretion).
significance in reaching this conclusion included the recognised inadequacy of the general Code for Crown Prosecutors\(^{41}\) in providing guidance for prosecution decisions in cases of this type\(^{42}\) and the disparity between the prohibition on assisted suicide and the general practice in terms of prosecutions actually brought.\(^{43}\) Greater clarity was needed as to how this discretion was to be exercised for Ms Purdy to be able to make decisions about how she lived her life.\(^{44}\)

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

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

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

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


\(^{47}\) Crown Prosecution Service (England and Wales), *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide*, above n 13. Note also that the Isle of Man has recently followed suit and issued guidelines in similar terms: see ‘Suicide Policy Same as UK’, *Isle of Man News: Isle of Man Examiner* (online), 28 September 2011 <http://www.iomtoday.co.im/news/isle-of-man-news/suicide_policy_same_as_uk_1_3814031>.
Public Interest Factors Tending in Favour of Prosecution under the England and Wales Assisted Suicide Policy\textsuperscript{48}

1. The victim was under 18 years of age.
2. The victim did not have the capacity (as defined by the \textit{Mental Capacity Act 2005}) to reach an informed decision to commit suicide.
3. The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
4. The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
5. The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
6. The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim.\textsuperscript{49}
7. The suspect pressured the victim to commit suicide.
8. The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
9. The suspect had a history of violence or abuse against the victim.
10. The victim was physically able to undertake the act that constituted the assistance him or herself.
11. The suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.
12. The suspect gave encouragement or assistance to more than one victim who were not known to each other.
13. The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.

\textsuperscript{48} Crown Prosecution Service (England and Wales), \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, above n 13, 5–6 [43].

\textsuperscript{49} The policy later clarifies that a ‘common sense approach’ should be taken in relation to this factor. Some benefit may accrue to the suspect from the victim’s death but the critical element is the suspect’s motive: ibid 6 [44].
14 The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.

15 The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.

16 The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

Public Interest Factors Tending against Prosecution under the England and Wales Assisted Suicide Policy

1 The victim had reached a voluntary, clear, settled and informed decision to commit suicide.

2 The suspect was wholly motivated by compassion.

3 The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.

4 The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.

5 The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.

6 The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

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50 Ibid 7 [45].
There is a growing body of academic work that examines the England and Wales policy.\textsuperscript{51} There is not scope in this paper to rehearse that literature, nor is it our goal to undertake a detailed critique of the policy. However, to contextualise our own attempt at drafting guidelines, we feel compelled to make four brief observations about them. These observations inform our alternative approach and lead to points of disagreement and thereafter divergence of our guidelines from the England and Wales policy.

The first observation is that the policy does not appear to be founded on a set of coherent guiding principles. This seemed to be confirmed by evidence given by the DPP responsible for developing the policy, Keir Starmer QC, to the privately established Commission on Assisted Dying.\textsuperscript{52} In response to a question about what the ‘underlying principle’ was for the policy, he noted that a ‘schematic approach’ had been avoided on the basis that such an approach would risk, ‘unless it’s very carefully constructed, undermining


\textsuperscript{52} More information is available at: Commission on Assisted Dying, About the Commission on Assisted Dying (17 August 2010) <http://www.commissiononassisteddying.co.uk/about-the-commission-for-assisted-dying>. 

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Parliament's intention that this should be an offence.\textsuperscript{53} The role of the DPP was instead, he explained, to exercise discretion on a case-by-case basis.\textsuperscript{54} The risk of that approach, however, is that the policy may not be conceptually sound and may lead to undesirable outcomes in practice. Consider, for example, the factor in favour of prosecution that the suspect was aware that the deceased intended to commit suicide in a public place where people may be present. It is clear that this factor is different in character to the others in the policy and seems to be aimed at different considerations. We ultimately omitted this factor from our guidelines because it did not flow from the guiding principles we established as relevant to our approach. We were also concerned that it may inadvertently capture places where we would argue it could be appropriate for voluntary euthanasia or assisted suicide to occur, such as a hospital room which, at least sometimes, is a 'public place'. Nevertheless, depending on one's starting point, such a factor could be regarded as appropriate. However, without a clear articulation of relevant guiding principles, it is unclear whether this is so and what purpose this factor is serving.\textsuperscript{55}

The second observation is linked to the first and concerns how the authors of the policy failed to articulate the significance of, and the relationships between, the various factors in the policy.\textsuperscript{56} For example, as we outline below when constructing our approach, some factors are considerations in their own right. An illustration from the policy is that 'the victim had not reached a


\textsuperscript{54} Ibid.

\textsuperscript{55} It could reflect an attempt to prevent harm to third parties who witness the assisted suicide or voluntary euthanasia. However, for such an objective, the language would be both under- and over-inclusive. That is, it could capture individuals in a public place, such as a hospital room, where no innocent third parties will be harmed, and it could also fail to capture individuals in a private place, where third parties will be harmed by discovering the body. Location seems to be a poor proxy for some consequences one might legitimately seek to prevent.

\textsuperscript{56} A similar critique is made in relation to the various elements of the 'public interest' test contained in the general Code for Crown Prosecutors; see John Rogers, 'Restructuring the Exercise of Prosecutorial Discretion in England' (2006) 26 Oxford Journal of Legal Studies 775, 793–4. The latest incarnation of this test is contained in Crown Prosecution Service (England and Wales), Code for Crown Prosecutors, above n 41, 10–15 [4.10]–[4.20]. The interim policy did suggest some factors be given greater weighting than others: Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide, above n 45, 4 [20], 5 [22]. This was ultimately removed to make the policy 'clearer and more accessible': Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide: Summary of Responses, above n 46, 18 [4.7], 21 [5.6], 32 [8.5], 34 [9.5].
voluntary, clear, settled and informed decision to commit suicide.\textsuperscript{57} By contrast, other factors might best be described as 'evidential,' that is, they are evidence as to when other factors in the policy will be substantiated or not. A relevant example is that 'the suspect pressured the victim to commit suicide\textsuperscript{58} as this is evidence that goes to the factor mentioned earlier, namely the voluntary nature of the decision. This distinction matters as consistent and considered decision-making requires an understanding of the role and significance of the relevant factors in a process of deliberation. We acknowledge that the policy does not note that assessing the public interest is not a numerical exercise and that prosecutors 'must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment.'\textsuperscript{59} However, we consider this sort of guidance to still fall short of articulating in a meaningful way how the factors are to be used in the decision-making process.

The third observation is that the policy applies only to assisted suicide and does not deal with voluntary euthanasia.\textsuperscript{60} Although this arose because of the way in which the policy was produced in response to the Purdy decision, we consider that differentiating between voluntary euthanasia and assisted suicide is not justifiable for four reasons. First, to differentiate discriminates on the basis of disability. If the policy does not include voluntary euthanasia, a person whose disability or illness means that he or she is not capable of ending life on his or her own (and so requires another to do the final act that ends life) may be deprived of that assistance because of concerns about prosecution.\textsuperscript{61} Second, given that we argue for guidelines grounded in respect for autonomy, both assisted suicide and voluntary euthanasia are justified (even though the final agent of death is different as between assisted suicide and voluntary euthanasia). Third, an assumption that sometimes underpins treating assisted suicide differently from voluntary euthanasia is that the

\textsuperscript{57} Crown Prosecution Service (England and Wales), \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, above n 13, 5 [43(3)].

\textsuperscript{58} Ibid 6 [43(7)].

\textsuperscript{59} Ibid 5 [39].

\textsuperscript{60} Voluntary euthanasia is where a person performs an act that intentionally ends the life of another person. This is done in response to a competent request by that second person who considers his or her life is no longer worth living. Assisted suicide is where a competent person dies after being provided by another with the means or knowledge to kill him or herself. For a discussion of various terminology in this area, see Ben White and Lindy Willmott, \textit{Background Paper: How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?} (Australia 21, 2012) 7–8.

\textsuperscript{61} Otlowski, \textit{Voluntary Euthanasia and the Common Law}, above n 16, 194–5.
former is *always* less serious than the latter. But this is not always the case, and including both in the guidelines allows prosecutors to assess whether a prosecution is appropriate in the circumstances of each case. And, as noted below, this assessment would occur not only having regard to the offence-specific guidelines but also the general prosecutorial guidelines which take into account factors such as the level of culpability of the accused. Finally, we accept that some people may say that they would experience an emotional difference between assisting another person to commit suicide and participating in voluntary euthanasia. However, different emotional reactions do not provide a foundation for a claim of there being a morally significant distinction — particularly a distinction to be used as the basis for public policy. Otherwise, of course, the fact that some people experience *withholding* treatment differently from *withdrawing* treatment could justify permitting one and not the other. In the context of public policy grounded in respect for autonomy, in most circumstances, the emotional difference *could* justify a person, such as a medical or other health professional, not being forced to provide both assisted suicide and voluntary euthanasia (autonomy is often constrained where its exercise would result in harm to others) but it *could not* justify a difference in public policy with respect to the permissibility of one and not the other.

The final observation is concerned with the emphasis the England and Wales policy places on the conduct of the suspect being characterised as non-professional, ‘compassionately-motivated, one-off assistance’. Related to this, the policy specifically discourages the involvement of medical and other health professionals as well as individuals belonging to organisations that facilitate assisted suicide. Such an approach gives rise to concerns that

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63 For example, we would argue that a case of coerced assisted suicide where the will of a person was overborn should be treated more seriously than a case involving a competent request for voluntary euthanasia.
65 See Olsowski, *Voluntary Euthanasia and the Common Law*, above n 16, 195 (‘doctors should not be required to abdicate their autonomy in favour of that of the patient’).
66 See, eg, Dan W Brock, 'Voluntary Active Euthanasia' (1992) 22(2) Hastings Center Report 10, 10.
67 Crown Prosecution Service (England and Wales), *Interim Policy on Assisted Suicide: Summary of Responses*, above n 46, 10 [2.7]. See also Commission on Assisted Dying, *Transcript of Evidence from Keir Starmer QC*, above n 53, 8–9, 11; Williams, above n 51, 192–3; Mullock, above n 51, 453–60, who note the significant weight given to this consideration.
assessments of the deceased’s competence, without the relevant expertise and experience, may be incorrect.\textsuperscript{68} Also of concern is the fact that amateur attempts to assist the deceased to die may lead to him or her dying in pain or discomfort, or experiencing the indignity in death that the deceased was seeking to avoid.\textsuperscript{69} Further, precluding the involvement of medical and other health professionals may also reduce opportunities for the deceased to make a decision about whether to die in light of complete and accurate information about his or her prognosis and treatment options.\textsuperscript{70} For these reasons, our proposed guidelines do not treat acting in a professional capacity in and of itself as a factor in favour of prosecution. We note finally that this aspect of the England and Wales policy is currently the subject of a legal challenge by a man who wishes to end his life but whose family will not assist him. ‘Martin’ is challenging the policy seeking that it be amended to permit professionals to assist him to die.\textsuperscript{71}

\textbf{IV Proposed Voluntary Euthanasia and Assisted Suicide Guidelines: Introduction}

Turning from the experience in England and Wales, and informed by our above critique of its policy, we now set out our proposed guidelines for when prosecutions should or should not occur in relation to voluntary euthanasia and assisted suicide. Although we are not able to undertake a detailed review of the England and Wales policy in this paper, we consider there are sufficient concerns about that model to warrant starting anew and designing a set of guidelines for the Australian context, albeit informed by the experience in England and Wales. As part of that process, we start from first principles and

\textsuperscript{68} Lewis, above n 51, 129. Although there are aspects of assessing whether decision-making is competent and voluntary that do not require medical expertise (for example, the impact of family dynamics), medical involvement in capacity assessments is likely to reduce error: Ost, above n 51, 534–7.

\textsuperscript{69} Lewis, above n 51, 129–30; Seale, above n 51; Ost, above n 51, 533–4; Mullock, above n 51, 452–3; Commission on Assisted Dying, 'The Current Legal Status of Assisted Dying is Inadequate and Incoherent...'; above n 51, 98–9.

\textsuperscript{70} Ost, above n 51, 537.

\textsuperscript{71} Clare Dyer, 'Nickinson's Widow Is Refused Right to Appeal to Higher Court' (2012) 345 British Medical Journal e6690. 'Martin' received leave to appeal against the English High Court’s conclusion in R (on the application of Nickinson) v Ministry of Justice [2012] EWHC 2381 (16 August 2012) that the DPP was not required to clarify his policy as requested. 'Martin’s' case was heard along with the related case of Tony Nickinson (who challenged the law rather than the DPP policy). Nickinson was unsuccessful before the High Court and his widow (Nickinson had subsequently died) was denied leave to appeal.
identify three guiding principles for constructing these guidelines: respecting autonomous choice; promoting high quality decision-making by prosecutors; and ensuring public confidence in the decisions of prosecutors. Each of these principles is discussed in more detail below.

Having identified those principles, we are then in a position to determine the content of the guidelines, which we have organised into six components. The first component states that a public interest factor that tends in favour of, or against, prosecution is whether the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end. The second and third components of the guidelines deal with how the nature of the deceased's choice (if any) is to be established: what are the elements of an autonomous choice in the context of voluntary euthanasia and assisted suicide; and what is the evidence that is directly relevant to determining whether those elements are present or not. For example, one element of an autonomous choice is that it was made voluntarily, and direct evidence of whether that is the case or not might include whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect.

The fourth component is comprised of factors that do not constitute direct evidence of whether the elements of an autonomous choice are present or not, but that nevertheless give confidence or raise doubts as to the nature of the choice. An example of this is where the suspect has a financial interest in the death of the deceased. While in such cases, as a matter of fact, it is still possible to show that an autonomous choice has been made, the presence of this factor creates a real risk that this may not be the case. Recognition of such 'confidence factors' in the guidelines is important in individual cases but also in the longer term for ensuring the public has confidence in these decisions and that these guidelines do not foster situations where non-autonomous choices are acted upon.

These four components comprise the decision-making content of the offence-specific guidelines, and explain how a DPP should use each component in his or her decision-making. Although this is explained further below when each component is considered in more detail, we have briefly indicated here the role played by each of the components and how they relate to each other. This is important in light of the objection expressed earlier in relation to the England and Wales policy that it fails to articulate the significance of, and the relationships between, the various factors in that policy. We anticipate the suggestion that in practice, such decision-making may not be as nuanced and orderly as the approach we have proposed here. Nevertheless, deficits in practice do not detract from the importance of conceptual clarity in decision-
making and there is merit in attempting to articulate how decisions should be
made in a principled way.

The final two components relate more to process issues of decision-making
than the content of those decisions. The fifth component requires that
decisions whether or not to prosecute under the guidelines must be made by
the DPP himself or herself. The sixth component establishes a reporting
structure for decisions whether or not to prosecute. Reporting should occur
in relation to individual decisions but systematic data should also be kept and
published to ensure the system is working.

Turning finally to the scope and operation of the proposed guidelines, they
are intended to supplement, and not to exclude, the operation of the general
prosecutorial guidelines. Directors of public prosecutions would be required
to apply the broader public interest considerations in the general guidelines as
well as the additional public interest factor identified as significant for these
specific offences set out below. Our guidelines also apply only where the
deceased was capable of making an autonomous choice for his or her life to
end. This includes competent adults and competent minors as discussed
below. Given the centrality of autonomy in these guidelines, it is not
appropriate that they govern those who are incompetent. Finally, for the
reasons outlined above, the guidelines apply to both voluntary euthanasia
and assisted suicide. We note though that the operation of the general
prosecutorial guidelines may be significant in terms of how these two situa-
tions are treated. As noted above, some of the factors in the general guide-
lines to be considered in assessing whether prosecution is in the public
interest include the seriousness of the alleged offence and the degree of
culpability of the accused. It may be that in particular cases of voluntary
euthanasia the greater level of participation by the accused in the deceased’s
death points more towards prosecution than if he or she had only assisted the
deceased’s suicide, but that will not always be the case and allowing the
guidelines to deal with both situations allows this discretion to be exercised in
light of the facts of each case.

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72 This is also the approach taken in England and Wales: Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, 4–5 [38].

73 See below Part VIIA.

74 See above Part III.

75 See above Part II.
V Three Guiding Principles

In drafting the proposed prosecutorial guidelines, we were guided by three principles:

1. the critical factor that tends against prosecution is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end;

2. the decision-making pursuant to the prosecutorial discretion in this area needs to be of high quality; and

3. the decision-making pursuant to that discretion needs to attract public confidence.

A An Autonomous Choice

Support for autonomy as an appropriate value underpinning these guidelines can be found in law and public opinion. First, the principle of respect for autonomy is a fundamental tenet of Australian law. The High Court has consistently recognised the significance of autonomy in the common law and this is most notably seen in the recent case of Stuart v Kirkland-Veenstra. In that case, where the High Court declined to recognise a duty of care owed by police officers to prevent a person from committing suicide, Gummow, Hayne

76 Support can, of course, also be found in ethics. We do not, however, rely upon an ethical argument for respect for autonomy here. This is in part because we believe that the argument grounded in law and public opinion is sufficient and it can be made without introducing the complexity and controversy associated with competing ethical theories about autonomy. Contrast, for example, Immanuel Kant, Fundamental Principles of the Metaphysic of Morals (T K A Abbott trans, Prometheus Books, 1987) [trans of: Grundlegung zur Metaphysik der Sitten (first published 1785)]; John Stuart Mill, On Liberty (David Bromwich and George Kateb eds, Yale University Press, first published 1859, 2003 ed); Susan Sherwin, 'Relational Autonomy and Global Threats' in Jocelyn Downie and Jennifer L Llewellyn (eds), Being Relational: Reflections on Relational Theory and Health Law (UBC Press, 2012) 13. While we believe that the case can be made for autonomy as a core value and respect for autonomy as a core principle within an ethical foundation for the law, we leave that discussion for other venues. We believe that it is necessary and sufficient to ground the guidelines proposed in this article in the conventional understanding of autonomy that underpins the law more generally. The guidelines can and should evolve inasmuch as the law evolves in relation to changing conceptions of autonomy within moral philosophy. But we do not see the project in this article as contributing to or driving such change.

and Heydon JJ concluded that such a duty would ‘mark a significant departure from an underlying value of the common law which gives primacy to personal autonomy’.78 These judges considered that personal autonomy is ‘a value that informs much of the common law’79 and permits the individual to decide whether to engage in conduct that may cause harm to himself or herself.80 Other support in law for the principle of respect for autonomy comes from the cases that deal with a closely related field: refusals of medical treatment. For example, in *Brightwater Care Group (Inc) v Rossiter*, Martin CJ referred to the ‘common law principle of autonomy and self-determination’81 and also noted that the principle is ‘well established at common law’.82

Public opinion provides another basis for adopting respect for autonomy as a guiding principle for the prosecution guidelines. While there have been a number of surveys that found that public opinion favours legalising voluntary euthanasia and assisted suicide (at least in certain circumstances),83 these surveys have not explored *why* those views are held. There is some evidence, however, that much of the high level of public support for reform in this area is motivated by the commitment to the value of autonomy. Sikora and Lewins examined 12 large representative surveys conducted between 1993 and 2002 on the issue of assisted suicide and analysed views on its acceptability in four different factual situations.84 By examining the responses of participants in these different situations, the authors were able to discern the weight given by participants to the various dominant ethical perspectives as identified in the euthanasia literature.85 They concluded that ‘a large proportion of the population accepts all forms of voluntary euthanasia, which points to the strong

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79 Ibid 248 [88].
80 Ibid 248 [89], citing *Agar v Hyde* (2000) 201 CLR 552, 583–4 [88]–[90] (Gaudron, McHugh, Gummow and Hayne JJ). The judges also endorsed the view of Lord Hope in *Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360, 379–80: ‘[o]n the whole people are entitled to act as they please, even if this will inevitably lead to their own death or injury’.
81 (2009) 40 WAR 84, 95 [48].
85 The three dominant themes considered were utilitarianism, individualism-commitment to autonomy and a commitment to Christian doctrine: ibid 69–71.
commitment to individual autonomy as the underpinning motivation\textsuperscript{86} and that the 'pattern of responses indicates that the commitment to individual autonomy may lead many Australians, close to 50% in these surveys, to approve of active voluntary euthanasia in any circumstance.'\textsuperscript{87}

In light of its recognition by Australian law and its role in public opinion, we consider that respect for autonomy is an appropriate guiding principle to inform our approach to drafting guidelines that outline when prosecution may or may not be in the public interest. Therefore, as argued below, we consider that the critical factor that tends against prosecution in such cases is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

B. High Quality Decision-Making

A decision whether or not to prosecute cases potentially involving voluntary euthanasia and assisted suicide is significant. Most obviously, whether a prosecution occurs in relation to a death is significant for the deceased. For example, a choice not to prosecute on public interest grounds means the taking of the deceased's life does not, in all of the circumstances, warrant criminal sanctions. While in some instances such an outcome would be as the deceased had hoped, in other circumstances such a decision could be regarded as a failure to acknowledge the wrongful nature of the death. A decision whether to prosecute is also significant for the deceased's family and friends who, for example, may be seeking public acknowledgement of the loss and harm they have suffered.\textsuperscript{88} The decision is also significant for the suspect (who may also be a member of the deceased's family or a friend). A decision to prosecute imposes the 'harms of prosecution'\textsuperscript{89} on the suspect and he or she also faces the prospect of conviction for a serious criminal offence, potentially murder, which in some Australian states carries a mandatory life sentence.\textsuperscript{90} Finally, it is significant for society as a whole: the ending of another person's

\textsuperscript{86} Ibid 77.
\textsuperscript{87} Ibid.
\textsuperscript{88} For a discussion of some of the harm caused by the unlawful killing of a family member, see Tracey Booth, 'Voices after the Killing: Hearing the Stories of Family Victims in New South Wales' (2001) 10 Griffith Law Review 25.
\textsuperscript{89} Rogers, 'Restructuring the Exercise of Prosecutorial Discretion in England', above n 56, 787–91.
\textsuperscript{90} See, eg, Criminal Law Consolidation Act 1935 (SA) s 11; Criminal Code Act 1899 (Qld) sch 1 s 305.
life matters for the community and so determining the appropriate criminal law response is important. It is therefore critical that decisions whether or not to prosecute in such cases be of high quality. For the purposes of this article, we consider that high quality decision-making requires a process that is rigorous, transparent and accountable, and which results in outcomes that accurately reflect conceptually sound criteria (which we put forward in our proposed guidelines). The importance of high quality decision-making is particularly significant given that such decisions are not susceptible to judicial review in Australia.

The production of clear guidelines dealing with the exercise of prosecutorial discretion in relation to cases of voluntary euthanasia and assisted suicide is one way to promote high quality decision-making. As was discussed in Purdy, clear guidelines provide a basis for ensuring decisions whether to prosecute are made predictably and consistently. This is a function of prosecution guidelines generally and this claim can also be made in relation to those designed for specific offences. Making the guidelines publicly available also helps promote high quality decision-making as prosecutorial decisions (even in the absence of reasons for those decisions as discussed below) can then attract some level of scrutiny that can be referenced against those criteria.

The terms of the guidelines themselves can also establish ways in which high quality decision-making in this area can be promoted. One is by ensuring there is rigour in the decision-making process, and the requirement to

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92 Maxwell v The Queen (1996) 184 CLR 501, 512–14 (Dawson and McHugh JJ), 534–5 (Gaudron and Gummow JJ). Note, however, that the courts do retain power to intervene to prevent an abuse of process or ensure a fair trial: at 512–14 (Dawson and McHugh JJ), 555 (Gaudron and Gummow JJ). See also Barton v The Queen (1980) 147 CLR 75, 90–1, 96 (Gibbs AC and Mason J); Likiardopoulos v The Queen [2012] HCA 37 (14 September 2012) 1[1]–[5] (French CJ), [37] (Gummow, Hayne, Crennan, Kiefel and Bell JJ).


94 See, eg, Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, iii; Office of the Director of Public Prosecutions (Qld), Director's Guidelines, above n 18, 1.

95 See below Part XA.

produce reasons for decisions can help to achieve that.\textsuperscript{97} Another is by advocating an open approach to the exercise of the prosecutorial discretion and making those reasons for decisions publicly available so that decision-making is transparent and accountable to the community.\textsuperscript{98} Developing monitoring systems of longer-term trends to ensure the efficacy of the guidelines and decision-making pursuant to them can also ensure that the discretion is being exercised to a high standard.\textsuperscript{99} The terms of the guidelines can also support high quality decision-making by requiring that the DPP himself or herself decide whether a prosecution should occur or not.

\textbf{C. Public Confidence in the Exercise of Prosecutorial Discretion}

The third guiding principle that informs our proposed guidelines is that they, and the decisions made pursuant to them by DPPs, need to retain public confidence. As noted above, these are significant decisions in a difficult area and so it is important that the public has confidence in how they are made.\textsuperscript{100} Although this guiding principle is related to the previous one, for example in that high quality decision-making can attract public confidence, these principles are distinct and so warrant separate consideration. Public confidence could be had in decision-making that is not of a high standard, and high quality decision-making will not always attract public confidence.

One way in which public confidence in prosecutorial decision-making can be earned is through openness. As noted above, the public availability of the


\textsuperscript{98} Ashworth, above n 96, 605–6. This is why the current DPP in England and Wales, Keir Starmer QC, states that he makes publicly available reasons for decisions not to prosecute in cases that are already in the public domain: Commission on Assisted Dying, \textit{Transcript of Evidence from Keir Starmer QC}, above n 53, 5. See also ibid.

\textsuperscript{99} While not gathered in relation to prosecutorial guidelines of the sort advocated for in this article, the systemic data collected in the Netherlands have, for example, highlighted issues of concern that have then been able to be addressed through changes to law and practice. See, eg, the discussion of changing reporting requirements and rates in Judith A C Rietjens et al, "Two Decades of Research on Euthanasia from the Netherlands: What Have We Learnt and What Questions Remain?" (2009) 6 Bioethical Inquiry 271, 279.

\textsuperscript{100} Daw and Solomon, above n 51, 742, 750–1; Some of the Australian state and territory prosecutorial guidelines explicitly recognise that wrongly exercising prosecutorial discretion undermines public confidence in the criminal justice system: South Australian Office of the Director of Public Prosecutions, \textit{Prosecution Policy}, above n 18, 3; Office of the Director of Public Prosecutions (Tas), \textit{The Role of an Independent Prosecutor and Guidelines for the Exercise of the Discretion to Prosecute}, above n 18, 2; Director of Public Prosecutions Victoria, \textit{Director’s Policy: The Prosecutorial Discretion}, above n 18, 1 [2.1.1].
guidelines can make decision-making more transparent which can engender
certainty in the exercise of prosecutorial discretion. There is also
scope for the guidelines to impose requirements designed to promote public
certainty. Openness in decision-making by making the reasons for deci-
sions publicly available enables the public to scrutinise the exercise of the
discretion which, if being exercised appropriately, will attract public cer-
tainty. A similar argument applies to making systemic data about how the
guidelines are being used publicly available. Requiring the DPP to be the
ultimate decision-maker in these cases can also promote public certainty in the
guidelines.

Of course, one could argue that all decisions should be made well and
should attract public certainty and that the guiding principles of high
quality decision-making and public certainty in the exercise of this discer-
sion should apply not only in relation to the offences being discussed in this
article, but to all offences. Indeed, many of the factors identified above could
be applied or adapted to other offences, particularly those of a serious nature.
However, because of the nature of the conduct at issue and the novelty of the
approach (effectively allowing that some instances of assisted suicide and
voluntary euthanasia do not warrant prosecution), decisions as to whether or
not prosecuting a case involving voluntary euthanasia or assisted suicide is in
the public interest can give rise to a particularly high level of community

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101 Ashworth, above n 96, 605–6; Commission on Assisted Dying, Transcript of Evidence from
Keir Starmer QC, above n 53, 5.

102 Louis Blom-Cooper, 'Reasons for Not Prosecuting' [2000] Public Law 560; Ashworth, above
n 96, 605–6; Commission on Assisted Dying, Transcript of Evidence from Keir Starmer QC,
above n 53, 5. See also Flick, above n 97, 118–19.

103 For example, the public availability of data about the Netherlands, Belgium, Oregon and
Washington State as to the practice of voluntary euthanasia and assisted suicide has made it
possible for the public to see that claims about slippery slopes and risks to vulnerable groups
(such as the poor, the elderly, people from ethnic backgrounds and people with disabilities)
demonstrably false. See, eg, Rietjens et al, above n 99; Kenneth Chambaere et al, 'Trends in
Medical Decision Making 500. See also Oregon Health Authority, Death with Dignity Act,
Oregon.gov <http://publichealth.oregon.gov/ProviderPartnerResources/EvaluationResearch/
DeathwithDignityAct/Pages/index.aspx>; Washington State Department of Health, Death
with Dignity Act <http://www.doh.wa.gov/dwda/>. Of course there are authors who argue
that there is empirical evidence of slippery slopes and risks to vulnerable groups. See, eg, John
Keown, Euthanasia, Ethics and Public Policy: An Argument against Legalization (Cambridge
University Press, 2002) pt 3; Emily Jackson and John Keown, Debating Euthanasia (Hart
interest and sometimes concern. We therefore believe it to be especially important to explicitly articulate these guiding principles here.

VI AUTONOMOUS CHOICE

As outlined above, respect for autonomy is one of the guiding principles we used when constructing the proposed prosecutorial guidelines. And whereas high quality decision-making and public confidence are directed at least in part to procedural matters, respect for autonomy makes a greater contribution to determining the content of the guidelines. Accordingly, we place autonomy at the centre of our approach and include whether the deceased’s death occurred as a result of an autonomous choice by him or her as the first component of our guidelines and the sole additional public interest factor they contribute. As noted above, this does not preclude consideration of the broader public interest factors contained in the general prosecutorial guidelines. Rather, these proposed guidelines add a further factor for DPPs to consider that is specifically tailored for this context.

1 Autonomous Choice: An Additional Public Interest Factor
Specific to these Offences

1.1 An additional public interest factor that tends in favour of prosecution is that the deceased’s death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

1.2 An additional public interest factor that tends against prosecution is that the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

VII ELEMENTS AND DIRECT EVIDENCE OF AN AUTONOMOUS CHOICE

This section considers the second and third components of the proposed guidelines. The second component identifies the elements of an autonomous choice while the third component sets out an inclusive list of the direct evidence that may be relevant to assessing whether those elements have been satisfied or not.

104 For evidence of this high level of community interest and concern in England and Wales, see Crown Prosecution Service (England and Wales), Interim Policy on Assisted Suicide: Summary of Responses, above n 46, 6 [1.14].
The three elements that need to be satisfied for the deceased's death to have occurred as a result of his or her autonomous choice are:

1. the deceased was competent to make the decision to end his or her life;
2. the decision was made voluntarily by the deceased; and
3. the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

These elements are derived from the law that applies to when medical treatment is refused. Although not entirely apposite to cases of voluntary euthanasia and assisted suicide, this is a useful departure point and this was the approach taken by the England and Wales policy.105

A. Competence

Applying the law that governs refusal of treatment, a person will be judged competent if he or she has the necessary capacity to make a decision and is then able to communicate that decision.106 McDougall J in Hunter and New England Area Health Service v A ('Hunter') described the test at common law for when an adult will be found to lack capacity as where he or she:

1. is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or
2. is unable to use and weigh the information as part of the process of making the decision.107

Adults are presumed to be capable of making their own decisions.108 The competence required to make a decision is said to be commensurate with its significance so that a decision with grave consequences, such as one which

105 Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, 5 [43(2)–(3)], 7 [45(1)]. See also the discussion of the relevant Australian (and some foreign) cases in this area in Justins v The Queen (2010) 79 NSWLR 544, 601–4 [350]–[362] (Johnson J).
106 R (Burke) v General Medical Council [2005] QB 424, 440 [41] (Munby J); this aspect of the judgment was confirmed on appeal: R (Burke) v General Medical Council [2006] QB 273, 290 [10] (Lord Phillips MR, Waller and Wall LJ)).
107 (2009) 74 NSWLR 88, 93 [25]. McDougall J was paraphrasing the Court of Appeal of England and Wales in Re MB (Medical Treatment) [1997] 2 FLR 426, 436–7 (Dame Butler Sloss LJ).
results in death, requires a higher level of capacity than other decisions.\footnote{Re B (Adult: Refusal of Medical Treatment) [2002] 2 All ER 449, 458 [31] (Dame Butler-Sloss P), quoting Re T (Adult: Refusal of Treatment) [1993] Fam 95, 113 (Lord Donaldson MR).} Children are not presumed to have capacity but are capable of making decisions if they possess 'a sufficient understanding and intelligence to enable him or her to understand fully what is proposed' ('Gillick competence').\footnote{Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 AC 112, 188–9 (Lord Scarman), adopted in Australia in Secretary, Department of Health and Community Services (NT) v JW (1992) 175 CLR 218, 238–9 (Mason CJ, Dawson, Toohey and Gaudron JJ), 311 (McHugh J) ('Marion’s Case'). Note, however, that the courts retain the power to override a decision of a Gillick-competent child to refuse medical treatment; see Ben Mathews, 'Children and Consent to Medical Treatment' in Ben White, Fiona McDonald and Lindy Willmott (eds), Health Law in Australia (Lawbook, 2010) 114, 133–5 [5.160], 139–40 [5.210].}

Evidence that is relevant to determining whether a deceased was competent or not includes whether he or she had a recent capacity assessment undertaken by an appropriately qualified medical or other health professional. Also relevant is whether the deceased was in need of assistance to make decisions about other aspects of his or her life. Although capacity is specific to the particular decision to be made, findings of incompetence in other realms can sometimes shed light on whether the deceased had capacity to choose for his or her life to end.

Before leaving this issue, we note the attempt by the trial judge in \textit{R v Justins} (considered on appeal in \textit{Justins v The Queen})\footnote{R v Justins [2008] NSWSC 1194 (12 November 2008), revd \textit{Justins v The Queen} (2010) 79 NSWLR 544. For further discussion of this case, see Faunce and Townsend, above n 12.} to set out a test for capacity to commit suicide. In this case, the accused, Justins, placed a bottle of Nembutal and a glass on a table in front of her de facto partner, Wylie, because she believed he wanted to die. She gave evidence that she said: ‘This will relieve your pain, Graeme. If you drink this you will die.’\footnote{Justins v The Queen (2010) 79 NSWLR 544, 546 [7] (Spigelman CJ), 571 [172] (Simpson J).} He poured himself a glass from the bottle and drank it knowing he would die. Wylie had previously attempted suicide and had expressed interest in ending his own life and sought assistance to do so. There were doubts, however, as to whether Wylie had capacity to make this decision. He had been diagnosed with Alzheimer’s disease three years earlier and there was a range of evidence that his mental capacity had diminished. A critical issue for the jury was whether Wylie had capacity at the time of his death. A lack of capacity would suggest that Justins caused the death whereas the presence of capacity would suggest that drinking the Nembutal was instead truly Wylie’s act. The trial judge
directed the jury that to have ‘capacity to commit suicide’, a person must be able to do all of the following:

1. know the extent of his illness and its prognosis;
2. understand the nature of the act of suicide and its consequences;
3. comprehend the benefits and disadvantages of the alternatives (life and death);
4. be able to weigh the benefits and advantages and decide between them; and
5. be able to communicate that decision.\textsuperscript{113}

The jury acquitted Justins of murder but found her guilty of manslaughter by gross criminal negligence. The New South Wales Court of Criminal Appeal quashed the conviction and ordered a new trial.\textsuperscript{114} One ground of appeal on which Justins was successful was that the trial judge misdirected himself in relation to the issue of capacity and erred by stating these five elements as requirements of law.\textsuperscript{115} Instead, these elements (which emerged from the expert evidence) were only factual matters for the jury to consider when determining whether Wylie had capacity. As a result, this case does not establish or endorse a legal test for when an adult has capacity to commit suicide.\textsuperscript{116} We do note, however, that the approach suggested by the trial judge is broadly consistent with the law that governs when a person may refuse treatment as set out above.

B Voluntariness

Again building on the law that governs refusal of medical treatment, a decision to commit suicide must also be free of undue influence.\textsuperscript{117} It is worth

\textsuperscript{113} Ibid 549–50 [25] (Spigelman CJ). Note also that the direction stated: ‘It must be his independent decision, even though taken with the advice of others’: at 549 [25], which reflects the voluntariness element discussed below.

\textsuperscript{114} That second trial did not go ahead as the Crown instead accepted a guilty plea to aiding and abetting suicide (which it had refused to accept at Justins' trial). Justins received no further punishment having already served her sentence for the more serious charge of manslaughter: \textit{R v Justins} [2011] NSWSC 568 (26 May 2011).

\textsuperscript{115} \textit{Justins v The Queen} (2010) 79 NSWLR 544, 557–60 [74]–[101] (Spigelman CJ), 585 [268] (Simpson J), 600–1 [345]–[349] (Johnson J).

\textsuperscript{116} Indeed Simpson J specifically stated that it would be inappropriate in the context of this appeal to define what constitutes capacity to commit suicide: ibid 585 [269] (Simpson J).

\textsuperscript{117} \textit{Re T (Adult: Refusal of Treatment)} [1993] Fam 95, 121 (Staughton LJ); \textit{Hunter} (2009) 74 NSWLR 88, 94 [26] (McDougall J).
noting though that not all influence will be undue. So, provided that the
decision remains that of the person in question, it is legitimate for others,
such as family, friends and doctors, to provide advice and even seek to
persuade the person to change her or his mind.\textsuperscript{118} Evidence relevant to the
voluntary nature of the decision includes whether there was any pressure
placed on the deceased in his or her decision-making, whether the suggestion
for taking such steps originally came from the deceased, and whether there
was a clear and unequivocal request from the deceased for assisted suicide or
voluntary euthanasia.

\textbf{C Received or Offered Sufficient Information}

Our proposed guidelines require that the deceased had received or was
offered sufficient information about the decision to end his or her life includ-
ing, where appropriate, information from qualified medical or other health
professionals. This would include information about the diagnosis, prognosis
and treatment options for a person’s illness or disability (if any); other care
options including palliative care; the nature of possible methods of voluntary
euthanasia or assisted suicide and associated risks; and the consequences of
alternative courses of action. Since \textit{Rogers v Whitaker},\textsuperscript{119} Australian law has
recognised that medical and other \textbf{health} professionals have a duty to offer all
information that would be considered significant in the circumstances by
either a reasonable person or the particular individual concerned. The High
Court’s reasoning was based on autonomy: a person can only make a mean-
ingful choice to undertake treatment or not with relevant information about
what that treatment involves and its potential risks.\textsuperscript{120} So recognition of the
need for an autonomous decision requires that either the deceased has
received such information or been offered it.

While it is clear how a decision by a person who has received the relevant
information supports respect for autonomy, further explanation is needed in

\textsuperscript{118} See \textit{Re T (Adult: Refusal of Treatment)} [1993] Fam 95, 121, in which the English Court of
Appeal found that a woman’s refusal of treatment was not binding on the treating team,
Staughton J considered that influence will be undue only if there is ‘such a degree of external
influence as to persuade the patient to depart from her own wishes, to an extent that the law
regards it as undue.’

\textsuperscript{119} (1992) 175 CLR 479.

\textsuperscript{120} Ibid 487, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). The civil liability
legislation in Queensland, Tasmania and Victoria includes provisions dealing with this duty
to warn in terms that reflect the common law position: \textit{Civil Liability Act 2003} (Qld) s 21;
\textit{Civil Liability Act 2002} (Tas) s 21; \textit{Wrong Act 1958} (Vic) s 50.
relation to why the guidelines also recognise as sufficient the offering of relevant information. This issue has received some attention in Australia in a series of cases dealing with refusals of life-sustaining treatment. McDougall J in Hunter considered that a refusal of treatment did not need to be informed to be effective,\(^{121}\) whereas Martin CJ in Brightwater Care Group (Inc) v Rossiter disagreed.\(^{122}\) Kourakis J in H Ltd v J preferred the approach taken in Hunter but qualified this by saying that another specific legal duty could require that a refusal of treatment be informed.\(^{123}\) There is no scope in this paper to engage properly in this debate or to resolve these conflicting judicial authorities. For our purposes, it is sufficient to note our preference for the Hunter position and to adopt the view that a person is able to refuse life-sustaining treatment without having received information about that decision.\(^{124}\) To require that a person must have received information to be able to refuse treatment is inconsistent with the widely endorsed position that treatment may be refused for irrational reasons or no reason at all.\(^{125}\) We consider a similar approach should be taken here and note this is supported by comments in Justins v The Queen to the effect that a person may be regarded as having capacity to commit suicide even if doing so on a basis that is ill-informed or not supported by a reason.\(^{126}\) So while it is desirable that a decision by a deceased to end his or her life is an informed one from a policy perspective, compelling receipt of (as opposed to offering) information is inconsistent both with that broad legal framework and with permitting a person to make autonomous decisions to refuse information.

Evidence as to whether the deceased had received or been offered sufficient information will include the steps taken to ensure this occurred including, where appropriate, whether qualified medical or other health professionals were involved. Also relevant would be the nature of the information received by, or offered to, the deceased such as whether it included relevant information about the diagnosis, prognosis and treatment options for a person’s illness or disability (if any), other care options including palliative

\(^{121}\) (2009) 74 NSWLR 88, 98 [40].
\(^{122}\) (2009) 40 WAR 84, 92 [30].
\(^{123}\) (2010) 107 SASR 352, 367–8 [41]–[43].
\(^{124}\) This point is discussed further in Lindy Willmott, Ben White and Shih-Ning Then, ‘Withholding and Withdrawing Life-Sustaining Medical Treatment’ in Ben White, Fiona McDonnell and Lindy Willmott (eds), Health Law in Australia (Lawbook, 2010) 449, 455–7 [13.40].
\(^{125}\) See, eg, Re T (Adult: Refusal of Treatment) [1993] Fam 95, 102, 113 (Lord Donaldson MR).
\(^{126}\) Justins v The Queen (2010) 79 NSWLR 544, 604 [363]–[365] (Johnson J); see also at 585 [269] (Simpson J).
care, the nature of possible methods of voluntary euthanasia or assisted suicide and associated risks, and the consequences of alternative courses of action. Further evidence that is relevant to the sufficiency of information offered to the deceased or received by him or her is whether any of that information was misleading or inaccurate, and whether it was in a form that the deceased could understand.

D Guidelines

Accordingly, the prosecutorial guidelines should outline the elements of an autonomous choice and an inclusive discussion of the direct evidence that may be relevant to determining whether those elements are satisfied.

2 Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

2.1 the deceased was competent to make the decision to end his or her life;
2.2 the decision was made voluntarily by the deceased; and
2.3 the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

3 Direct Evidence in relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased’s death occurred as a result of an autonomous choice by him or her include whether:

3.1 the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (competence);
3.2 the deceased needed assistance to make decisions about other aspects of his or her life (competence);
3.3 there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntariness);
3.4 the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntariness);
3.5 the suspect or others took steps to ensure that the deceased’s decision was not brought about by pressure or coercion (voluntariness);
3.6 the suspect or others took steps to ensure that the deceased had received, or was offered, sufficient and accurate information about the decision including, where appropriate, information from qualified medical or other health professionals (sufficient information).

VIII Confidence regarding whether Death Occurred as a Result of Autonomous Choice

The proposed guidelines also include factors that are relevant to a prosecutor’s confidence about whether the death that occurred was as a result of an autonomous choice by the deceased (confidence factors). The role of these factors is different from those mentioned in the previous section where the goal was to identify matters that could be used as direct evidence in relation to whether the three elements of an autonomous choice discussed above were satisfied. The factors in this section do not have that same direct probative value and so cannot be used in that way.

Two examples of confidence factors are where the suspect has an interest of his or her own that conflicts with the interest of the deceased in making an autonomous choice about death (conflict of interest), and where there is a history of violence or abuse towards the deceased by the suspect. These factors are not direct evidence of an absence of autonomy and it is possible that decisions that occur in the presence of such factors could still be autonomous and therefore not appropriate for prosecution. To illustrate, a DPP who was firmly satisfied that a deceased had made an autonomous choice to die, in spite of the existence of potentially negative confidence factors, would be justified under our guidelines in not prosecuting. Nevertheless, the presence of these circumstances can give rise to real doubts that such a choice has been made. This risk is sufficient to justify addressing them in the guidelines. One of the guiding principles for constructing these guidelines is the importance of public confidence in prosecutorial decision-making. If circumstances that cause us to doubt there was an autonomous choice are specifically addressed, confidence can be had by the public that prosecutorial discretion is only being exercised to decline to prosecute in clear cases of autonomous decision-making.

Also included in this section are confidence factors that are indirectly about autonomy. An example is whether a suspect reported the deceased’s death to the police and cooperated with its investigation. Such action is not directly about whether the death occurred as a result of an autonomous choice. However, reporting and cooperation by a suspect can suggest that his or her behaviour is more likely to be consistent with the non-prosecution
factors in the guidelines than if the suspect concealed his or her involvement. Given that those non-prosecution factors are based on the deceased making an autonomous choice, these factors can still, albeit indirectly, give rise to confidence or doubts as to the nature of any choice made by the deceased.

These confidence factors have two functions in the guidelines. The first is that factors which give rise to doubts about whether the deceased made an autonomous choice for his or her life to end act as triggers for further investigation or scrutiny of the circumstances in which the death occurred. The presence of these confidence factors is a warning that should prompt a DPP to review even more closely the direct evidence in relation to the elements of an autonomous choice in the case at hand. We note that confidence factors can also provide reassurance that the deceased chose to die but we are not proposing that this should lead to a reduced level of scrutiny. The second function for confidence factors is that they must be used by DPPs in their deliberations when weighing the direct evidence of the elements of an autonomous choice set out above. To illustrate, the existence of a troubling conflict of interest is an important part of the context in which DPPs would assess the available direct evidence about whether the deceased was making a competent and voluntary decision. We now consider the four confidence factors we include in our proposed guidelines.

A History of Violence or Abuse

A history of violence or abuse by the suspect towards the deceased gives rise to real concerns about whether the deceased made an autonomous choice for his or her life to end. Such abuse need not be physical in nature and can include emotional or psychological abuse. While it is possible for a decision to end one’s life to be made autonomously despite that history, the existence of this type of relationship between the suspect and deceased casts doubt over this and poses a risk that the decision was not autonomous. Accordingly, the guidelines identify this factor as one that should trigger very close scrutiny of the circumstances in which the death occurred. A DPP should weigh any available evidence as to whether the deceased made an autonomous choice in

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127 For a discussion of some of the evidence as to the impact that a history of violence and/or coercion can have on decision-making autonomy, albeit in the context of domestic violence, see Tamara L. Kuenen, 'Analyzing the Impact of Coercion on Domestic Violence Victims: How Much Is 'Too Much?" (2007) 22 Berkeley Journal of Gender, Law & Justice 2. See also Cheryl Hanna, 'The Paradox of Progress: Translating Evan Stark’s Coercive Control into Legal Doctrine for Abused Women' (2009) 15 Violence against Women 1458.
light of this history. Part of this may include accessing information or advice about the dynamics of such relationships and the impact that any violence or abuse may have had on the deceased's ability to make his or her own choices.

B Settled Decision

A confidence factor that may point the other way is that the deceased's decision appeared to be a settled one. One way this could be demonstrated is through repeated requests by the deceased for his or her life to end. We note that the settled nature of a decision is not an element of an autonomous choice: it is not part of the law that governs the refusal of medical treatment discussed above. Nevertheless, if a decision appears to be a settled one, then a prosecutor, and indeed the public, could have greater confidence that the choice was autonomous. However, as noted above, we are not suggesting this should lead to a lower level of scrutiny than that which generally occurs in these cases.

C Conflict of Interest

One factor that tends to undermine confidence that the deceased's death occurred as a result of an autonomous choice by him or her is that there is an interest on the part of the suspect that conflicts with the interest of the deceased in making that autonomous choice. Sometimes the nature of the conflict is such that it creates a challenge to the deceased making an autonomous choice in that the suspect is tempted to coerce the deceased or otherwise undermine his or her free choice. Other times the conflict might not be in direct opposition to a deceased's autonomy, but rather lead to or encourage the suspect to be careless or disinterested in ensuring that death was genuinely the deceased's choice. In both instances, however, the existence of a conflict creates the risk that the deceased is not making an autonomous choice and this is what warrants inclusion of conflict of interest as a confidence factor in the guidelines.

There are a range of interests that can give rise to conflict. One is where a suspect has a financial interest in the deceased's death. The obvious example is where the suspect or a person close to him or her will benefit financially through an inheritance. A financial conflict of interest can also arise not because of the deceased's death but because a suspect is financially remunerated for providing assistance of some kind. This could arise in relation to an organisation that facilitates voluntary euthanasia or assisted suicide for a fee. Another example is where a medical or other health professional participates
in the deceased’s death and is remunerated for that. Other conflicts of interest may be non-financial. A suspect may have reputational interests he or she is interested in advancing that may be in conflict with the deceased making an autonomous choice. A suspect may also wish to be relieved of the burden of caring for the deceased.

The presence of a conflict of interest will trigger a DPP to scrutinise closely the circumstances of the deceased’s death and to weigh the evidence in relation to the nature of any choice made by the deceased in light of that conflict. The level of this additional scrutiny and deliberation will depend, however, on the nature of the conflict and the extent to which the suspect’s own interests were significant in the decision to end the deceased’s life or provide assistance to do so.\(^{128}\) This approach is consistent with how the law in relation to fiduciary relationships, from which the conflict rule comes, has developed in Australia. Not all conflicts of interest by fiduciaries will be regarded as breaching the conflict rule:

> if the doctrine be inexorably applied and without regard to the particular circumstances of the situation, every transaction will be condemned once it be shown that the fiduciary had such a hope or expectation, however unlikely to be realized it may be, and however trifling an inducement it will be if it is realized ... We have found no decisions that have applied this rule inflexibly to every occasion in which the fiduciary has been shown to have had a personal interest that might in fact have conflicted with his loyalty. On the contrary in a number of situations courts have held that the rule does not apply, not only when the putative interest, though in itself strong enough to be an inducement, was too remote, but also when, though not too remote, it was too feeble an inducement to be a determining motive.\(^{129}\)

Applying this approach, while a possible conflict of interest will be a trigger for DPPs to take care, the nature of that conflict will determine the extent of that additional scrutiny and deliberation. The issue is whether the potential for the suspect to benefit is either, first, so remote so that it is of no consequence, or secondly, if it is not too remote, it is insufficient to be a relevant

\(^{128}\) This approach has similarities to the ‘common sense’ one outlined in the England and Wales policy, where a suspect may obtain a benefit from the deceased’s death but that this need not be a factor in favour of prosecution if ‘compassion was the only driving force’ for his or her actions: Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, [44].

factor in the decision to end the deceased’s life or to assist with that decision. It is this second issue that will be most significant in this context and will ultimately be a matter for the DPP to determine, on the facts of the case, how troubled he or she is by the conflict of interest. To illustrate, an inheritance for a suspect will automatically trigger additional scrutiny and deliberation but a DPP will need to determine the extent to which it could be regarded as a relevant factor in the suspect’s decision-making process. We consider that very close scrutiny would be called for where the suspect’s financial circumstances had recently changed for the worse and this seemed to prompt a renewed interest in assisting the deceased. By contrast, a medical or other health professional who received payment for providing a medical or other health service as part of their usual care for a patient is unlikely to consider that remuneration a relevant factor in their decision to be involved in the death. But more scrutiny will be required, however, if that professional had established a practice devoted exclusively or primarily to assisting people to die and so depended for his or her livelihood on voluntary euthanasia or assisted suicide. Finally, people volunteering in a not-for-profit organisation might obtain some reputational or other benefit from being involved in a death. Although perhaps less likely than where financial incentives are involved, such interests are capable of giving rise to a conflict of interest and additional scrutiny and deliberation is needed commensurate with the nature and extent of the conflict.

D Reporting the Death

The guidelines include as a confidence factor that either the suspect reported the death to the police and cooperated fully with its investigation, or did not take such action. How a suspect behaves in this regard can inform a prosecutor’s confidence as to whether a deceased’s death occurred in conformity with the non-prosecution factors in the guidelines which, as noted above, goes indirectly to the confidence a DPP can have in relation to whether there was

130 We note that earlier in this paper we have argued against treating ‘acting in a professional capacity in and of itself’ as a factor tending in favour of prosecution; see Crown Prosecution Service (England and Wales), Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide, above n 13, 6 [43(14)], which states that acting in a professional capacity is a public interest factor tending in favour of prosecution. Therefore the fact that a medical or other health professional is involved in voluntary euthanasia or assisted suicide in a professional capacity does not of itself point towards prosecution. However, if that involvement gives rise to a conflict of interest then that must be considered by a DPP as a confidence factor.
an autonomous choice by the deceased. While there can be other motivations, one reason why a suspect may feel able to report the death to police is that they will not be prosecuted based on the criteria in the guidelines. By contrast, it could be argued that a suspect whose involvement in a death points towards the factors in favour of prosecution would be more likely to conceal the death or his or her involvement in it, or refuse to participate in a police investigation, for fear of the adverse consequences.\textsuperscript{131}

If these arguments are correct, then reporting and cooperation is an appropriate confidence factor for the guidelines. As with other confidence factors, a troubling response warrants additional scrutiny and deliberation, whereas a comforting response would not reduce the rigour of a prosecutor's approach but is relevant to deliberations as to how any evidence in relation to an autonomous choice is weighed.

We also note that including this particular factor has additional systemic benefits for how the guidelines operate above and beyond deliberations in particular cases. Incentivising disclosure of cases involving voluntary euthanasia and assisted suicide so they may be investigated adds to the public confidence that potential suspects are acting, and will in future act, in accordance with the guidelines. It also bolsters the public reporting of cases involving the guidelines (proposed below) which again promotes public confidence that the guidelines are functioning appropriately.

\textbf{E. Guidelines}

The guidelines should include the following confidence factors, namely those factors which either give confidence or raise doubts as to whether a deceased’s death occurred as a result of an autonomous choice.

\textsuperscript{131} Of course, there could also be other motivations for not reporting the death to police and cooperating with its investigation. For example, a person whose conduct is otherwise unlikely to attract prosecution may not be aware of the guidelines and so conceal his or her involvement in the death for fear of prosecution.
4 Confidence whether Death Occurred as the Result of Autonomous Choice

The presence of factors that give confidence that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.1 the deceased's decision for his or her life to end appeared to be a settled one;

4.2 the suspect reported the death to the police within a reasonable time and cooperated fully with the investigation.

The presence of factors that raise doubts that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.3 a history of violence or abuse by the suspect towards the deceased;

4.4 an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision-making;

4.5 the suspect did not report the death to the police within a reasonable time or did not cooperate fully with the investigation.

IX Decision to Be Made by the Director of Public Prosecutions

It was noted above that two of the principles that inform how the guidelines are constructed are:

1 the decision-making pursuant to the prosecutorial discretion in this area needs to be of high quality; and

2 the decision-making pursuant to that discretion needs to attract public confidence.

One way in which these goals can be promoted is by requiring that decisions whether or not to prosecute under the guidelines be made by the DPP himself or herself. We note that this is consistent with some Australian jurisdictions
that already have provisions in their general prosecutorial guidelines dealing with when the DPP’s consent is specifically required either to bring or discontinue a prosecution for certain types of offences. Such an approach is also consistent with the position in England and Wales although the DPP’s role in that jurisdiction is given legislative force. Section 2(4) of the Suicide Act 1961 provides that proceedings under that Act may be instituted only with the consent of the DPP. There are also other key differences between the position in England and Wales and what is being proposed in these guidelines. One is that our proposed guidelines are broader than the position in England and Wales in that the DPP’s consent in that jurisdiction is only required if a prosecution is instituted. The DPP is not required by the Act to make decisions where it is proposed that a person not be prosecuted; his or her role is only mandated where there is a decision to prosecute. We understand, however, that the practice to date is for the DPP to be involved in all decisions (including those not to prosecute), which is consistent with our proposed approach.

Another key difference relates to the wider function of the consent provision in England and Wales. The House of Lords in Purdy identified the ‘basic reason’ for the relevant sub-section as being to prevent the risk of prosecutions in ‘inappropriate circumstances’. A significant motivation for imposing a legislative requirement for DPP consent to prosecutions is to avoid vexatious or inappropriate private prosecutions. Our proposed guidelines do not directly address this concern as they only purport to guide the exercise of prosecutorial discretion by the state and cannot of themselves (unlike a legislative requirement for consent) prevent inappropriate private prosecutions.

Nevertheless, despite these differences, some of the rationales for s 2(4) of the Suicide Act 1961 are relevant to the proposed fifth component of our

132 See, eg, Office of the Director of Public Prosecutions (Qld), Director’s Guidelines, above n 18, 21; Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, 9–10, 12.
133 9 & 10 Eliz 2, c 60.
134 Commission on Assisted Dying, Transcript of Evidence from Keir Starmer QC, above n 53, 6.
135 [2010] 1 AC 345, 392 [45].
136 For a wider discussion of the importance of the right to bring a private prosecution, and the corresponding justifications advanced for requiring DPP or other consents to prosecution, see Law Commission, England and Wales, Consents to Prosecution (Report No 255, 1998) 12–14 [2.12]–[2.21] (private prosecutions), 22–6 [3.27]–[3.35] (justifications for a requirement of consent). See also ibid.
137 9 & 10 Eliz 2, c 60.
guidelines. In particular, we note that Lord Hope in *Purdy* pointed to reasons underpinning the consent requirement as including

to secure consistency of practice ... [and] to enable account to be taken of mitigating factors and to provide some central control of the use of the criminal law
where it has to intrude into areas which are particularly sensitive or controversial.\(^{138}\)

We agree and consider that requiring the DPP to make all decisions whether to prosecute or not under these guidelines will lead to greater consistency and predictability in decision-making. This is partly because all such decisions will be made by a single person in each jurisdiction (at least for the duration that they hold office).\(^{139}\) We also point to the likely calibre of the individual in the role of the DPP as the person making this decision; as the highest-ranked prosecutor in the jurisdiction, they would possess a high level of competence and a breadth of experience to ensure high quality decision-making. These factors would also promote public confidence in decisions made pursuant to the guidelines.

5 Decision to Be Made by the Director of Public Prosecutions

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be made by the Director of Public Prosecutions.

X Public Reporting of Decision-Making

Another way in which high quality decision-making that attracts public confidence can be promoted is through giving reasons for decisions and making them publicly available. We propose this be done where possible in relation to individual decisions not to prosecute but also that information about how the guidelines are operating at a systemic level be collected and published.

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139 We note that the relevant legislation establishing the DPPs generally permits for the delegation of his or her functions but we consider that it should not occur for these decisions. In relation to specific delegation powers in these Acts, see *Director of Public Prosecutions Act 1990* (ACT) s 17; *Director of Public Prosecutions Act 1986* (NSW) s 33; *Director of Public Prosecutions Act 1990* (NT) s 32; *Director of Public Prosecutions Act 1991* (SA) s 6A; *Public Prosecutions Act 1994* (Vic) s 30 (although note the limitations in this provision as to when delegation may occur); *Director of Public Prosecutions Act 1991* (WA) s 31.
A Reasons for Decisions

Subject to any contrary legal obligations prohibiting such a course, DPPs are able to give reasons for their prosecutorial decisions\(^{140}\) and make them publicly available. Five of the Australian state and territory prosecution guidelines contain discrete policies specifically addressing the giving of reasons.\(^{141}\) Six of them also contain specific policies dealing with media interaction, generally in the context of using the media as a vehicle to engage with the public, and sometimes with reference to publishing reasons for decisions.\(^{142}\) To advance the guiding principles of high quality decision-making and public confidence, we consider that the guidelines should require that, where possible, reasons for decisions be given in these cases and made publicly available. We do note, however, that this aspect of the guidelines applies only to decisions not to prosecute and not to decisions for a prosecution to go ahead. Aside from concerns about prejudicing either the Crown's ability to prosecute or the accused's right to a fair trial, a decision to prosecute means the Crown's case is subjected to the public rigour of the criminal justice system, and this is sufficient to address the guiding principles of high quality decision-making and public confidence identified above.

There are a number of benefits of publishing reasons for decisions. One is that the discipline of producing written reasons assists a decision-maker in his

\(^{140}\) Although note that administrative decision-makers are under no general duty at common law to provide reasons for their decisions: Public Service Board of New South Wales v Osmond (1986) 159 CLR 656.

\(^{141}\) Office of the Director of Public Prosecutions (ACT), Prosecution Policy, above n 18, [6]; Office of the Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 19 [12]; Office of the Director of Public Prosecutions (Qld), Director's Guidelines, above n 18, 28 [22]; Director of Public Prosecutions Victoria, Director's Policy: The Giving of Reasons for Discretionary Decisions (3 March 2010) <http://www.opp.vic.gov.au/getattachment/25f56122-017f-4896-8dac-8559e999eb65/24-The-Giving-of-Reasons-for-Discretionary-Decisio.aspx>; Director of Public Prosecutions for Western Australia, Statement of Prosecution Policy and Guidelines, above n 18, 16 [72]; see also specific consideration of the issue as part of the media policy: at 28 [164], app 6. There is no separate policy in the Northern Territory but the guidelines do mention this issue in various places: see, eg. Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, 9 [7.2], 11 [7.11], 12 [7.18].

\(^{142}\) Office of the Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 57–61 [32]; Office of the Director of Public Prosecutions (NT), Guidelines, above n 18, 49–50 [26]; Office of the Director of Public Prosecutions (Qld), Director's Guidelines, above n 18, 65–6 [56]; South Australian Office of the Director of Public Prosecutions, Prosecution Policy, above n 18, 15; Director of Public Prosecutions Victoria, Director's Policy: Media, 3–4 [3]–[9] <http://www.opp.vic.gov.au/getattachment/494f51f-18f3-48ef-a0a-d13e990c05c/12-Media-Policy.aspx>; Director of Public Prosecutions for Western Australia, Statement of Prosecution Policy and Guidelines, above n 18, app 6.
or her deliberations and ensures the reasoning is subjected to the rigour of justification, thereby promoting high quality decision-making.\textsuperscript{143} Another benefit is that it ensures accountability and transparency in decision-making by requiring justification of a conclusion to the public, and this also supports public confidence.\textsuperscript{144} A third benefit is that awareness of the basis of how these decisions are made promotes predictability and consistency in decision-making.\textsuperscript{145} This is of advantage for successive DPPs seeking to exercise their discretion consistently and there would also be scope to consider and benefit from decisions made in other Australian jurisdictions. It also assists members of the public who will know not only the general criteria for prosecution decisions, but also how those criteria are being applied in practice. This means they will be in a position to regulate their own conduct so as to ensure, if possible, that it is not in the public interest for them to be prosecuted.

While these benefits are applicable generally to the exercise of prosecutorial discretion, we consider the case for published reasons for decisions is particularly compelling in relation to voluntary euthanasia and assisted suicide. As the experience in England and Wales has demonstrated, prosecutorial discretion in this area can give rise to a high level of public interest and concern about how it may be exercised.\textsuperscript{146} It is therefore appropriate that the public can scrutinise these decisions, and be reassured if they are being made in accordance with the guidelines. These concerns have prompted the DPP in England and Wales to make publicly available reasons for his decisions in relation to the assisted suicide policy where the information about the case is already in the public domain.\textsuperscript{147} Accordingly, although the majority of guidelines already address in a generic way the issue of reasons for decisions,


\textsuperscript{144} Pittard, above n 143, 174; Flick, above n 97, 118–19. See also above n 102 as to these arguments specifically applied in the context of prosecutorial decision-making.

\textsuperscript{145} Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Palme (2003) 216 CLR 212, 242 [105] (Kirby J); Pittard, above n 143, 174.

\textsuperscript{146} See, eg, Crown Prosecution Service (England and Wales), \textit{Interim Policy on Assisted Suicide: Summary of Responses}, above n 46, 6 [1.14].

we consider it should be specifically dealt with in these guidelines and that reasons for decisions should be provided and made public wherever possible.

We do recognise, however, that the context of prosecutorial decision-making means there are constraints that may limit or preclude the giving of full reasons or making them publicly available. For example, DPPs are subject to various legislative privacy obligations which, absent a relevant exception, prohibit publication of certain information.148 Some or all of these obligations may not apply, however, in relation to information that is already in the public domain, for example, if it is discussed in open court at a committal hearing and the prosecution is later discontinued. Another relevant consideration is whether the production and publication of reasons would prejudice the prosecution of a co-offender, or an ongoing investigation.149 Other public interest considerations which may weigh against giving reasons are if doing so would significantly prejudice the administration of justice or cause serious harm to witnesses or the suspect.150 Accordingly, while it is desirable as outlined above, it will not always be possible to produce and publish reasons for decisions. Nevertheless, we consider the publication of reasons should be the presumption, and where that is not possible, consideration should also be given to whether it is possible to publish reasons of some kind that do not prejudice meeting those other obligations. For example, it might be possible to make reasons for a decision available in a de-identified form or for the reasons not to refer to particular information that should not be disclosed.


149 Director of Public Prosecutions Victoria, Director’s Policy: The Giving of Reasons for Discretionary Decisions, above n 141, 3 [24.3(e)].

150 Office of the Director of Public Prosecutions (ACT), Prosecution Policy, above n 18, [6]; Office of the Director of Public Prosecutions (NSW), Prosecution Guidelines, above n 18, 19 [12]; Office of the Director of Public Prosecutions (Qld), Director’s Guidelines, above n 18, 28 [22(v)]; Director of Public Prosecutions for Western Australia, Statement of Prosecution Policy and Guidelines, above n 18, 16 [72].
B Systemic Data Reporting in Annual Report

Another way in which high quality decision-making that attracts public confidence can be promoted is to monitor how the guidelines are working at a systemic level. This permits a level of scrutiny of global trends to ensure that the guidelines are leading to appropriate outcomes. Such an approach is generally a feature of voluntary euthanasia and assisted suicide legislation that establishes or empowers a commission or other body to oversee the administration of the legislation.\(^{151}\) Again, this information should be made available for public scrutiny.

The reporting of systemic data (which can be done in a de-identified form) will be valuable for determining whether the terms of the guidelines themselves are appropriate or not. It will also permit scrutiny of how the guidelines are being applied in practice over a period of time. This sort of scrutiny ensures that decision-making is of a high quality and enables problems to be identified and addressed.\(^{152}\) It can also provide a measure of public confidence in that the community knows how the guidelines are being used and what the outcomes are. These data can include decisions to prosecute as concerns about prejudicing the prosecution identified in relation to reasons for decisions need not arise at this systemic de-identified level of reporting, or if they do, the data can be included at a later stage once all proceedings have concluded.

The nature of the systemic data we consider should be captured includes:

- demographic data for the deceased such as gender, age, ethnic background, health status, disabilities (if any), income level and educational level;
- the deceased’s underlying illness (if any);
- whether the deceased had access to palliative care;
- whether the deceased had private health insurance;
- the relationship between the suspect and the deceased;
- whether the case involved voluntary euthanasia or assisted suicide;

\(^{151}\) See, eg, the summary description of the various oversight mechanisms in the Netherlands, Belgium, Luxembourg, Oregon and Washington State in Schüklken et al, above n 14, 55–9. The collection and publication of data to improve the administration of criminal law processes has also been suggested in relation to death penalty cases in the United States: James S Liebman, ’The Overproduction of Death’ (2000) 100 Columbia Law Review 2030, 2150 n 288.

\(^{152}\) See, eg, experiences with respect to ‘life ending acts without explicit request of the patient’ and reporting rates in the Netherlands as discussed in Rietjens et al, above n 99. See also Chambare et al, above n 103, for a discussion of trends in end-of-life decision-making in Belgium.
• the number of decisions reached to prosecute or not prosecute; and
• the number of convictions that occurred in those cases where the decision was to prosecute.

To achieve an understanding of the trends that might be emerging from the use of the guidelines, the data collected in the first six bullet points needs to be correlated with those collected in the last two bullet points.

6 Public Reporting of Decision-Making

6.1 Subject to any contrary legal obligation, the Director of Public Prosecutions will produce and publish reasons for a decision not to prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

6.2 The Director of Public Prosecutions will publish in his or her Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

XI Conclusion

The purpose of this article was to construct offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. In undertaking this task, we were guided by the principles of respect for autonomy, the need for high quality prosecutorial decision-making and the importance of public confidence in that decision-making. We also drew on the existing England and Wales policy.

We propose that in light of the Purdy decision, and given the recent Canadian developments noted above, it is timely for the various state and territory DPPs around Australia to consider guidelines of this type. As Murphy notes:

The Purdy case should send a signal to the various prosecution authorities that the need to incorporate offence-specific policy is on the horizon, especially where the jurisdiction contains or anticipates the introduction of express

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153 See above n 14.
human rights enactments. The Purdy case is highly significant for any jurisdiction that has, or is planning to introduce, human rights Acts or Charters.\textsuperscript{154}

Others have reached a similar view.\textsuperscript{155} Australia presently does not have a human rights statute at federal level. There is, however, human rights legislation in Victoria and the Australian Capital Territory, and both jurisdictions have provisions dealing with privacy in broadly similar terms to art 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which was considered in Purdy.\textsuperscript{156} One commentator has noted the view that if the Purdy decision is applied in Victoria, aspects of current criminal law may be inconsistent with its Charter of Human Rights and Responsibilities Act 2006 (Vic).\textsuperscript{157}

We do observe, however, that the case for such guidelines may be less urgent in Australia as the situation here is different from that in England and Wales. One difference which may be of significance is the lack of history in Australia of a publicly compassionate approach to non-prosecution of these offences. This can be contrasted with the DPP in England and Wales, who had declined to prosecute in a number of cases of assisted suicide involving travel to permissive jurisdictions, including the very public Daniel James case in which reasons for the decision were published.\textsuperscript{158} The DPP’s approach to these cases was considered significant by the House of Lords in Purdy in concluding that greater clarity and certainty was needed as to when a prosecution will occur and when it will not. Other points of possible contrast that were relevant to the House of Lords’ deliberations were the obligation on the DPP to produce prosecution guidelines (whereas in Australia, DPPs are empowered but not required to do so) and that in England and Wales assisted suicide can only be prosecuted with consent of the DPP.\textsuperscript{159}

\textsuperscript{154} Murphy, above n 12, 356.
\textsuperscript{155} See, eg Rapke, above n 12, 11–17; Faunce and Townsend, above n 12, 714–15.
\textsuperscript{157} Rapke, above n 12, 11.
\textsuperscript{159} See Suicide Act 1961, 9 & 10 Eliz 2, c 60, s 2(4).
Nevertheless, despite these differences, we consider that the *Purdy* decision squarely raises questions about the need for specific prosecutorial guidelines dealing with voluntary euthanasia and assisted suicide. This is particularly so in jurisdictions with a human rights statute but we also consider there is merit in considering this approach in the absence of such legislation. For those jurisdictions contemplating such a step, we offer these guidelines as a principled approach to decisions whether or not to prosecute cases of voluntary euthanasia and assisted suicide.
XII Appendix: Proposed Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide

1 Autonomous Choice: An Additional Public Interest Factor Specific to these Offences

1.1 An additional public interest factor that tends in favour of prosecution is that the deceased’s death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

1.2 An additional public interest factor that tends against prosecution is that the deceased’s death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

2 Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

2.1 the deceased was competent to make the decision to end his or her life;

2.2 the decision was made voluntarily by the deceased; and

2.3 the deceased had received, or was offered, sufficient information in relation to the decision to end his or her life.

3 Direct Evidence in relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased’s death occurred as a result of an autonomous choice by him or her include whether:

3.1 the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (competence);

3.2 the deceased needed assistance to make decisions about other aspects of his or her life (competence);

3.3 there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntariness);

3.4 the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntariness);
3.5 the suspect or others took steps to ensure that the deceased’s decision was not brought about by pressure or coercion (voluntariness);

3.6 the suspect or others took steps to ensure that the deceased had received, or was offered, sufficient and accurate information about the decision including, where appropriate, information from qualified medical or other health professionals (sufficient information).

4 Confidence whether Death Occurred as the Result of Autonomous Choice

The presence of factors that give confidence that the deceased’s death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.1 the deceased’s decision for his or her life to end appeared to be a settled one;

4.2 the suspect reported the death to the police within a reasonable time and cooperated fully with the investigation.

The presence of factors that raise doubts that the deceased’s death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

4.3 a history of violence or abuse by the suspect towards the deceased;

4.4 an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect’s decision-making;

4.5 the suspect did not report the death to the police within a reasonable time or did not cooperate fully with the investigation.

5 Decision to Be Made by the Director of Public Prosecutions

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be made by the Director of Public Prosecutions.
6 Public Reporting of Decision-Making

6.1 Subject to any contrary legal obligation, the Director of Public Prosecutions will produce and publish reasons for a decision not to prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

6.2 The Director of Public Prosecutions will publish in his or her Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

ETHICS IN MEDICINE

Palliative care, double effect and the law in Australia

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Key words
palliative care, doctrine of double effect, intention, homicide, criminal law.

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Abstract
Care and decision-making at the end of life that promotes comfort and dignity is widely endorsed by public policy and the law. In ethical analysis of palliative care interventions that are argued potentially to hasten death, these may be deemed to be ethically permissible by the application of the doctrine of double effect, if the doctor’s intention is to relieve pain and not cause death. In part because of the significance of ethics in the development of law in the medical sphere, this doctrine is also likely to be recognized as part of Australia’s common law, although hitherto there have been no cases concerning palliative care brought before a court in Australia to test this. Three Australian States have, nonetheless, created legislative defences that are different from the common law with the intent of clarifying the law, promoting palliative care, and distinguishing it from euthanasia. However, these defences have the potential to provide less protection for doctors administering palliative care. In addition to requiring a doctor to have an appropriate intent, the defences insist on adherence to particular medical practice standards and perhaps require patient consent. Doctors providing end-of-life care in these States need to be aware of these legislative changes. Acting in accordance with the common law doctrine of double effect may not provide legal protection. Similar changes are likely to occur in other States and Territories as there is a trend towards enacting legislative defences that deal with the provision of palliative care.

Introduction
The application of the doctrine of double effect to the provision of palliative care has been the subject of consideration from ethical and clinical perspectives. However, very little has been written about the extent to
which the doctrine actually provides legal protection for doctors in Australia. This is significant because the scope of the legal defence is not settled. Further, ongoing legislative intervention in this area, enacted with the public policy intent of improving care at the end of life by clarifying the law and protecting practitioners who deliver appropriate palliative care, has changed the nature of the defence in some Australian States and this new statutory model may be adopted in other parts of the country. Although the only prosecutions in this area of practice hitherto have been where causation of death and the healthcare worker’s intention were both clearly in question, this article considers the extent to which doctors can rely on the doctrine of double effect when providing palliative care, the nature of current and likely future legislative reform and the implications these developments have for clinical practice.

Discussion

In an examination of the medical, legislative, judicial and parliamentary scrutiny of end-of-life issues in Australia between 1983 and 1998, and in four comparable OECD countries: the UK, Canada, the USA and New Zealand, it can be shown that all the reports, legislation, judgments and parliamentary committee proceedings studied assume that palliative care interventions and treatment abatement decisions may indeed constitute a cause of death. However, this is allowed in law due to the public policy imperative to relieve pain and suffering and avoid prolongation of the dying process.8

Ethics, public policy and the law have all given strong support to the need to control pain, retain dignity and avoid futile and burdensome treatment for people who are dying, provided that death is not intentionally caused in the process. The so-called principle, rule or doctrine of double effect, derived from the tradition of Catholic moral theology, offers a bioethical technique that can be used to make a distinction between lawful palliative care interventions and euthanasia (in jurisdictions, such as presently all those in Australia, where this is illegal).

The doctrine of double effect

The essence of the doctrine of double effect is that an act performed with good intent can still be moral despite negative side-effects. In the context of palliative care, this can arise when four conditions are met:1,3

1 Administering palliative medication is not, in itself, immoral.
2 The intention is to relieve pain, not to hasten the patient’s death.
3 The relief of pain is not achieved through causing the patient’s death.
4 Proportionally, the need to relieve pain is such that it warrants accepting the risk of hastening death.

The doctrine, applied to palliative care, is generally accepted in the medical profession and its peak bodies,5,9,10 although some dispute its relevance on the basis that properly administered palliative care does not hasten death.3 It has, however, been subjected to trenchant criticism in this role by philosophers,11–13 lawyers14 and clinicians.15,16

There is no tradition of double effect being used in legal reasoning until it was adopted by the common law in end-of-life treatment decisions. It first appears as the basis of the 1957 instruction to the jury by Devlin J (as he then was) in R v Adams,17,18 in the specific situation of the use of opioid drugs, for pain relief in end-of-life care:

But that does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect on the patient’s life of the medicines that he administers or else be in peril of a charge of murder. 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 is not because there is a special defence for medical men but because no act is murder which does not cause death. We are not dealing here with the philosophical or technical cause, but with the commonsense cause. The cause of death is the illness or injury, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term. But . . . no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life.

The judgment is based on the medical evidence submitted to the court that reflected the medical view of the time that because morphine can cause respiratory depression, its use in pain and symptom relief can lead to coma and death. In particular, the notion that there is agreement about a ‘high’ dose of an opioid drug such as morphine beyond which timing and possibly causation might be in question has permeated medicine, and hence, every legal deliberation on this issue since.

However, the experience of the hospice and palliative care movement over the past three decades has shown that the safe and effective use of morphine, other opioids,
and sedatives in pain and symptom control need not bring cause of death into question.\textsuperscript{19}

There is no clinical scientific evidence that morphine causes death, if used with appropriate skill to treat symptoms. In particular, the respiratory depressant effects have been shown to be minimal, and it seems that the presence of pain acts as antagonist to respiratory depression and sedative effects of opioids.\textsuperscript{20} However, like any class of drugs, opioids are dangerous if used inappropriately.

The Ontario coroner (Dr James Young) laid down four conditions that need to be satisfied for palliative care interventions to be legal in his jurisdiction. These conditions describe well the clinical and ethical basis of palliative medicine practice internationally, and would have wide support in the specialty for differentiating it from euthanasia:

(1) The care must be intended solely to relieve suffering; (2) it must be administered in response to suffering or signs of suffering; (3) it must [be] commensurate with that suffering; and (4) it cannot be a deliberate infliction of death. Documentation is required, and the doses must increase progressively.\textsuperscript{21,22}

The intention is to relieve symptoms and suffering, not bring forward the time of death. Whilst this position is sustainable in the palliative phase, it is susceptible to challenge in the terminal phase, when death is imminent (hours or days away).\textsuperscript{23} It should be acknowledged by practitioners that, as death approaches, abatement of life-sustaining treatment and terminal sedation may indeed alter the time of death, although this matter cannot be verified scientifically, one way or the other, in a particular case, or in general. There are serious limitations to the use of clinical studies in this area, and the causal question itself cannot be directly asked in any interventional study for obvious reasons. We cannot know when a particular patient would have died in the absence of palliative interventions or treatment abatement, particularly during the final dying process, and it would be unethical to design randomized controlled trials to find out. However, two clinical observational studies show no evidence of shortened survival resulting from opioid or sedative use in the last days of life.\textsuperscript{24,25}

**Potential criminal responsibility for palliative care**

The law seeks to avoid criminalizing appropriate medical practice. When considering such matters, the law usually appears to take a common sense and multifactorial view of causation, and will often not even apply a causal analysis, focusing more on legality of actions and presence or absence of duties instead.\textsuperscript{26}

However, causing or hastening a person’s death can give rise to criminal responsibility. The offence that is most likely to arise is murder. This is proven where a person’s death has been caused (or accelerated) by another and where there is an intention to kill.\textsuperscript{27} Although there is some variation in different Australian jurisdictions, of significance is that the criminal law generally regards foreseeing death as a probable consequence of acting as sufficient to constitute intent. It is in the context of this potential criminal liability when providing palliative care that the doctrine of double effect has received some limited consideration by the courts.

**Recognition of the doctrine at law**

The elements of the common law defence are outlined in more detail below. However, in brief, the doctrine of double effect provides a defence to a criminal charge where it is alleged that a doctor has caused the death of a patient as a result of the provision of medication if the intention of the doctor in providing that medication was to relieve pain rather than to hasten the patient’s death. There has not been a case that has considered whether the doctrine of double effect is part of Australia’s common law. But the doctrine has received some judicial endorsement in similar legal systems, such as the UK,\textsuperscript{17,28–30} the USA,\textsuperscript{31,32} Canada\textsuperscript{33} and New Zealand,\textsuperscript{34,35} and is likely to be accepted as part of the common law of Australia.\textsuperscript{36} The status of the common law doctrine of double effect is less clear in the Northern Territory, Queensland, Tasmania and Western Australia, where the criminal law has been codified so that criminal responsibility is determined on the basis of the various Criminal Codes.

There are competing arguments as to the basis for legal recognition of double effect,\textsuperscript{37,38} but the most widely accepted formulation of the doctrine at law is based on a doctor’s intention. If the primary intention of the person administering palliative care is to relieve pain, and not cause death, and then that person will not be criminally responsible for a death that might follow, even if it is foreseen. The legal operation of the doctrine of double effect is illustrated by two famous cases: Adams and Cox (see Box 1).

In three States, legislation has created different defences which are generally more limited than the doctrine of double effect. Queensland and Western Australia have sections 282A and 259, respectively, in their Criminal Codes. South Australia has stand alone legislation, the Consent to Medical Treatment and Palliative Care Act 1995 (SA), of which section 17 creates a defence for palliative care in certain circumstances. These provisions are set out in Box 2. The need for legislative action was more pressing in Queensland and Western Australia given that their
Box 1  Key cases on double effect at common law

*R v Adams* (1957, UK)\(^{17}\)

Dr Adams was a general practitioner charged with the murder of an 81-year-old patient, Mrs Morrell. It is unclear from the case report the precise medication administered in the period leading up to Morrell’s death but it included morphine and heroin as well as two ‘large’ injections of para-chloro on the night before she died. Prosecutors argued that Morrell was in a coma in the last days of her life and called two medical experts who concluded that there was no medical justification for this level of palliation. The quantities and combination of the drugs demonstrated an intention to kill. The defence’s medical expert disagreed and did not consider the medication of Morrell to be excessive in the circumstances. Doubt was also cast on the evidence that Morrell was in a coma and so it was argued that pain relief was needed. The jury acquitted Adams. Although the basis of the verdict is not known, it has been subsequently argued that the jury must not have been satisfied beyond reasonable doubt that Adams intended to kill Morrell rather than relieve her pain.

*R v Cox* (1992, UK)\(^{18}\)

Dr Cox was a rheumatologist charged with the attempted murder of Mrs Boyes, an elderly patient suffering from rheumatoid arthritis. Cox was not charged with murder because it was not possible to exclude that Boyes’ other conditions caused her death. The evidence revealed that the doctor and patient relationship over 13 years had led to an unusually strong bond of affection and mutual respect between them. As Boyes deteriorated, Cox became unable to manage her pain. He then administered 26 mmol of undiluted potassium chloride, which was described as having no curative or analgesic properties and was estimated to be twice the lethal dose. Boyes died within minutes. The jury was instructed to convict Cox if satisfied that his primary intention in administering the potassium chloride was to cause Boyes’ death. The judge noted that although the administration of medication with the purpose of relieving pain and suffering can be lawful, this relief cannot be achieved through intentionally causing another’s death. Cox was found guilty by the jury but received only a 1-year suspended sentence.

**Scope of legal protection**

There are four major issues that determine the scope of legal protection provided by the doctrine of double effect or the legislative defences: a doctor’s intention, the standard of medical care required, whether consent is needed, and the relevance of a patient’s condition.

**A doctor’s intention**

Under the common law and statutory defences, a doctor cannot have an intention to cause death. In all States except Western Australia, the law also expressly requires that the intention instead be to relieve pain and suffering.

**Medical practice standards required**

Under the common law, there is no requirement to comply with particular medical standards. However, departures from reasonable medical practice may suggest an intention to kill rather than to relieve pain. It is also unlikely that the common law doctrine would protect a doctor who gave palliative medication at such high doses as to be grossly negligent.

The position appears stricter in Queensland and Western Australia. In Queensland, the palliative care must be reasonable in the context of good medical practice taking into account the patient’s state and all circumstances. ‘Good medical practice’ is defined to mean good medical practice nationally having regard to recognized medical standards, practices and procedures and ethical standards of the medical profession in Australia. The
Box 2 Legislative defences

Sections 17 and 18 of the Consent to Medical Treatment and Palliative Care Act 1995 (SA)

17. The care of people who are dying
(1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner’s supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress:
   (a) with the consent of the patient or the patient’s representative; and
   (b) in good faith and without negligence; and
   (c) in accordance with proper professional standards of palliative care,
even though an incidental effect of the treatment is to hasten the death of the patient.

(3) For the purposes of the law of the State:
   (a) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause of death;

Note:
‡ A novus actus interveniens i.e. a cause that breaks a pre-existing chain of causation.

18. Saving provision
(1) This Act does not authorise the administration of medical treatment for the purpose of causing the death of the person to whom the treatment is administered.
(2) This Act does not authorise a person to assist the suicide of another.

Section 259(1) of the Criminal Code (WA)

259. Surgical and medical treatment
(1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care):
   (a) to another person for that other person’s benefit; or
   (b) to an unborn child for the preservation of the mother’s life,
if the administration of the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.

Section 282A of the Criminal Code (Qld)

282A Palliative care
(1) A person is not criminally responsible for providing palliative care to another person if:
   (a) the person provides the palliative care in good faith and with reasonable care and skill; and
   (b) the provision of the palliative care is reasonable, having regard to the other person’s state at the time and all the circumstances of the case; and
   (c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing.
(2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person’s death.
(3) However, nothing in this section authorises, justifies or excuses:
   (a) an act done or omission made with intent to kill another person; or
   (b) aiding another person to kill himself or herself.
(4) To remove any doubt, it is declared that the provision of the palliative care is reasonable only if it is reasonable in the context of good medical practice.
(5) In this section:
good medical practice means good medical practice for the medical profession in Australia having regard to:
   (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
   (b) the recognised ethical standards of the medical profession in Australia.
palliative care means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.

It is also noted that the Australian Capital Territory has a reference to pain relief in section 17 of its Medical Treatment (Health Directions) Act 2006 (ACT). This provision is not considered separately in this article because we do not consider it alters the common law position. There is no reference to removing criminal liability; the section simply states that a patient has a ‘right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances’. The provision also has a very limited scope, operating only where there is a health direction (advance directive) made under the Act that refuses medical treatment.
Western Australian defence does not make reference to medical standards but does require that the treatment be ‘reasonable, having regard to the patient’s state at the time and to all the circumstances of the case’. Under the South Australian legislative defence, the medical treatment must be provided ‘in accordance with proper professional standards of palliative care’.

**Consent**

Consent from the patient or a person authorized to consent on their behalf is not required by the doctrine of double effect at common law. Consent is also not mandated in Queensland or Western Australia but may be relevant to assessing whether the treatment is ‘reasonable’. This is particularly so in Queensland where reasonableness is judged in the context of good medical practice. Because treating without consent is generally unlawful, it may be difficult to argue that good medical practice accepts unlawful conduct, particularly if it hastens death. The South Australian legislative defence expressly requires consent from the patient or from a person empowered by law to consent of their behalf.

**Relevance of a patient’s condition**

It is likely that the common law doctrine will only apply to a patient who is near death. This has been the state of the patients in the cases that have come before the courts to date (although in one case later investigations revealed that the doctor’s belief as to the patient’s condition was mistaken). Although the courts have not expressly limited the doctrine’s operation in this way, the better the patient’s prognosis, the less likely the doctrine is to protect doctors if death is hastened.

Queensland and Western Australia also do not expressly require a patient to be near death. However, as with the issue of consent above, the need for treatment to be regarded as reasonable may preclude protection in cases where a patient’s prognosis is not poor. Western Australia also requires that the treatment be for the benefit of a patient, which again will be difficult to demonstrate in circumstances where death is not approaching. The cause of that approaching death need not, however, be a terminal illness or even a medical condition. It was recently accepted that the Western Australian provision will apply in circumstances where the need for palliation arises due to a refusal of life-sustaining treatment.

The legislative defence in South Australia only applies where a patient is in the ‘terminal phase’ of a ‘terminal illness’. This occurs when a patient is suffering an illness or condition that is likely to result in death and there is no real prospect of recovery or remission of symptoms, either temporarily or permanently.

**Conclusion**

While the common law is largely consistent with the doctrine of double effect as an ethical principle, this is not the situation for the legislative excuses. These defences are of a different nature, particularly in relation to the required standard of medical care and consent.

The most significant change is the legislative requirement to adhere to a particular standard of medical practice. Generally, criminal responsibility for careless medical practice is imposed only where the conduct of the doctor is so grossly negligent that it should be regarded as a crime against the State and therefore worthy of punishment. By contrast, the legislative defences to criminal charges in Queensland and South Australia are available only if a higher standard is met: doctors must comply with good medical practice or proper professional standards of palliative care respectively.

This is significant not only because a higher standard of practice is required but also because legal exposure for doctors is increased by making criminal acts less challenging to prove. At common law, the focus is on a doctor’s subjective intention. This is notoriously difficult to establish, particularly beyond reasonable doubt as is required in the criminal law setting. Fewer difficulties arise in proving a failure to comply with an objective and measurable standard of practice. The probable outcome is that the State, when prosecuting a doctor, is likely to focus on demonstrating that the standard of care was inadequate, as that is easier to prove than criminal intent.

In relation to consent, the legislative defences again offer less protection than at common law. Whereas consent from a patient or someone authorized to consent on his or her behalf is not required under the common law defence, it is if relying on the South Australian legislation and possibly also in Queensland and Western Australia. The effect is that a doctor could potentially be subject to criminal liability for unlawfully causing death due to a failure to obtain consent for otherwise appropriate palliative care. While this may be less problematic in South Australia if the defence at common law is also available, this is of concern in Queensland and Western Australia where the legislative provisions provide the sole defence.

The nature of medical decision-making at the end of life gives rise to legal risk. Although criminal prosecutions are rare, interaction with the legal system can have significant consequences for those involved, even if their actions are vindicated. It is therefore vital that doctors are aware of these local legislative changes,
particularly in Queensland and Western Australia where the defence is the only one available. Legal obligations in these jurisdictions will not be satisfied simply by acting in accordance with what the doctrine dictates as an ethical principle. Recent Western Australian case law makes clear that, at least in that State, protection depends on the terms of the legislative defence and not double effect.40

Further, we anticipate these issues will, in due course, become significant nationally. A modified version of the doctrine of double effect has been given legislative force in three of the eight Australian jurisdictions and this trend to legislate is likely to continue. Despite the likelihood that the doctrine forms part of the common law in Australia, it does not sit comfortably with fundamental criminal law principles relating to intention and causation of death.37,38 For example, in relation to intention, the criminal law usually imposes liability not only where a person acts intending to achieve an outcome but also where that outcome is foreseen as probable.37 Such an approach is problematic for double effect as it depends on foreseeing, but not intending, an outcome but also where that outcome is foreseen as probable.37 Regardless of future legislative changes that may legalize euthanasia, it will still be necessary to differentiate it from palliative care, and be transparent with regard to intention and goals of care.

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Scalp vein thrombosis mimicking giant cell arteritis relapse

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Key words
Giant cell arteritis, scalp vein thrombosis.

Abstract
Scalp vein thrombosis is an unusual complication during giant cell arteritis. Revealed by headache, it can be misdiagnosed as a disease relapse. An ultrasound scan should rapidly be performed to make the diagnosis, avoiding inappropriate treatment escalation.

Giant cell arteritis (GCA) is the most frequent vasculitis in people older than 60 years. It involves large and medium size arteries and particularly cranial arteries.1 Scalp tenderness and jaw claudication are the classical manifestations. Headache is a cardinal symptom leading to diagnosis. During follow up, recurrence is often related to relapse, but a careful examination is important to eliminate differential diagnoses and to avoid unnecessary treatment escalation.

Venous scalp thrombosis is a rare disease, generally observed during catheter-related infection in children.2 To our knowledge, spontaneous scalp vein thrombosis has never been reported in adults. We report a unique case of scalp vein thrombosis mimicking GCA relapse.

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Voluntary palliated starvation: A lawful and ethical way to die?

Ben White, Lindy Willmott and Julian Savulescu*

Increasingly, individuals want control over their own destiny. This includes the way in which they die and the timing of their death. The desire for self-determination at the end of life is one of the drivers for the ever-increasing number of jurisdictions overseas that are legalising voluntary euthanasia and/or assisted suicide, and for the continuous attempts to reform State and Territory law in Australia. Despite public support for law reform in this field, legislative change in Australia is unlikely in the near future given the current political landscape. This article argues that there may be another solution which provides competent adults with control over their death and to have any pain and symptoms managed by doctors, but which is currently lawful and consistent with prevailing ethical principles. “Voluntary palliated starvation” refers to the process which occurs when a competent individual chooses to stop eating and drinking, and receives palliative care to address pain, suffering and symptoms that may be experienced by the individual as he or she approaches death. The article argues that, at least in some circumstances, such a death would be lawful for the individual and doctors involved, and consistent with principles of medical ethics.

INTRODUCTION

Voluntary euthanasia and assisted suicide are a source of ongoing discussion at both federal¹ and State level in Australia.² Despite this agitation for change, apart from a brief period in the Northern Territory, efforts to legalise assisted dying have failed. But is there a means to achieve this same outcome, a comfortable death desired by a competent adult at a time of their choosing, which is justifiable according to current medical ethics and within the law? The concept of “voluntary palliated starvation”

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² For example, before the 2013 federal election, the Voluntary Euthanasia Party was formed and had seven candidates, with two Senate candidates standing in each of the Australian Capital Territory, New South Wales and South Australia seats, and one candidate standing for a lower house seat in the Northern Territory: “Euthanasia Party Launches Candidates”, news.com.au (online) (19 August 2013), http://www.news.com.au/national/breaking-news/euthanasia-party-launches-candidates/story-e6ff52e9-122669930838/from=public rss. More recently, on 10 November 2014, the Senate Standing Committee on Legal and Constitutional Affairs tabled its final report on the Medical Services (Dying with Dignity) Exposure Draft Bill 2014 which was released in June 2014 by Greens Senator, Richard Di Natale. Since the Northern Territory euthanasia legislation, Rights of the Terminally Ill Act 1995 (NT), was overturned by the Euthanasia Laws Act 1997 (Cth), there have also been ongoing attempts to repeal the relevant Commonwealth legislation, particularly by the Australian Greens party.

³ Over the past five years, for example, New South Wales has introduced the Rights of the Terminally Ill Bill in 2010 (lapsed on prorogation) and 2013 (defeated 23:13); South Australia has introduced nine separate euthanasia Bills, the last two of which lapsed on prorogation; Tasmania has introduced the Dying with Dignity Bill 2009 (defeated 15:7) and the more recent Voluntary Assisted Dying Bill 2013 that was narrowly defeated 13:11; Victoria has introduced the Medical Treatment (Physician Assisted Dying) Bill 2008 (defeated 25:13); and finally Western Australia has introduced the Voluntary Euthanasia Bill 2010 (defeated 24:11). The various legislative attempts in Australia are also discussed in White B and Willmott L, “How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?” (2012) 20 JLM 410. See also the Australia21 report following a euthanasia and assisted dying roundtable in Brisbane in January 2013: Douglas B, Willmott L and White B, The Right to Choose an Assisted Death: Time for Legislation? (Australia21, 2013), http://eprints.qut.edu.au/59240.
starvation” (VPS), advanced elsewhere,\(^3\) refers to when a competent adult refuses to eat or drink and then receives palliative care to relieve any suffering he or she experiences from dying due to a lack of food and water. Of note is that this provides a means for people, whether or not they are terminally ill or dependent on medical treatment to survive, to die comfortably.

Death resulting from a competent patient’s decision to cease eating and drinking is not a new concept, and has been discussed as an option for hastening death for more than two decades.\(^7\) As early as 1993, Bernat and his colleagues urged consideration of patient refusal of hydration and nutrition as an alternative to physician-assisted suicide and voluntary active euthanasia.\(^8\) At the same time, Bernat called for more scientific research into the physiological effects of starvation and dehydration so that patients would be confident that death in this way would not be accompanied by suffering. There is now a body of research which provides evidence that death as a result of starvation and dehydration for patients who are dying may not be uncomfortable if appropriately managed.\(^9\) So while there has been some consideration of the situation for individuals who are dying, there has been less focus on this kind of death for those who are not terminally ill.

At this point, it is useful to recount the situation of Tony Nicklinson, a man who was not terminally ill, but wished to die. Tony was the applicant in Nicklinson v Ministry of Justice\(^\footnote{Nicklinson v Ministry of Justice [2012] EWHC 304.}\) and his wife, as testatrix of his estate, was a party to the appeal to the English Court of Appeal in Nicklinson v A Primary Care Trust.\(^\footnote{Nicklinson v A Primary Care Trust [2013] EWCA Civ 961. Tony’s wife was unsuccessful in the appeal to the English Court of Appeal. Tony’s wife and “Martin” (another person who had “locked-in” syndrome and wished to die) appealed to the Supreme Court of the United Kingdom in December 2013. The appeal was heard over four days by a nine-judge panel rather than the traditional five. The decision was reserved: see R (On the Application of Nicklinson) (AP) (Appellants) v Ministry of Justice (Respondent), Case ID UKSC 20130235, \url{http://supremecourt.uk/current-cases/case_2013_0235.html}. See also Bindmans LLP, “Jane Nicklinson and Paul Lamb’s Case to Die with Dignity” (21 November 2013), \url{http://www.bindmans.com/news-and-events/news-article/jane-nicklinson-and-paul-lamb-s-case-to-die-with-dignity}.) Tony died before the appeal was heard. This litigation was commenced because Tony sought assistance to die as he was not in a position to kill himself and he wished to challenge the current law that prohibited him receiving the desired assistance. Tony found himself in this situation after suffering a stroke and becoming “locked-in” so that he was almost completely paralysed. He relied on others for all his care needs and, while able to eat, needed to be “fed like a baby”.\(^\footnote{See, for example, Wagner B, Ersek M and Riddell S, “HPNA Position Statement: Artificial Nutrition and Hydration in End of Life Care” (Hospice and Palliative Nurses Association, 2013), \url{http://www.hpna.org/pdf/Artificial_Nutrition_and_Hydration_PDF.pdf}.}\) However, he was not dying nor was he terminally ill.\(^\footnote{Bernat JL, Gert B and Mogielnicki RP, “Patient Refusal of Hydration and Nutrition” (1993) 153(24) Arch Intern Med 273.}\) Tony was competent and his decision to want to die was described as “rational” by the court. After being unsuccessful in the English High

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\(^4\) Ivanovic N, Buche D and Fringer A, “Voluntary Stopping of Eating and Drinking at the End of Life – A ‘Systematic Search and Review’ Giving Insight into an Option of Hastening Death in Capacitated Adults at the End of Life” (2014) 13(1) BMC Palliat Care 1. For an overview and history of the very limited legal engagement on this issue, see Pope T and West A, “Legal Briefing: Voluntarily Stopping Eating and Drinking” (2014) 25 J Clin Ethics 68. While there is only limited empirical evidence about the frequency with which deaths occur as a result of voluntarily ceasing to eat and drink, research in the Netherlands estimates that between 600 and 2,800 people die each year in that country as a result of their decision to stop eating and drinking: Chabot BE, Auto-euthanasie: Verborgen Stervenswegen in Gesprek met Naasten (Uitgeverij Bert Bakker, Amsterdam, 2007). Van der Heide A et al, Euthanasie en Andere Medische Beslissingen Rond het Levenseinde (ZonMW, 11 July 2012) as reported in Sheldon T, “Doctors Should Care for People who Choose to Die by Starvation, Says Dutch Medical Association” (2014) 348 BMJ 331. See also the findings of empirical research into the experience of nurses employed by hospice programs in Oregon where 33% reported that in the previous four years they had cared for a patient who hastened their own death by the refusal of food and fluids: Ganzini et al, “Nurses’ Experiences with Hospice Patients who Refuse Food and Fluids to Hasten Death” (2003) 349(4) N Engl J Med 359.  
\(^6\) See, for example, Wagner B, Ersek M and Riddell S, “HPNA Position Statement: Artificial Nutrition and Hydration in End of Life Care” (Hospice and Palliative Nurses Association, 2013), \url{http://www.hpna.org/pdf/Artificial_Nutrition_and_Hydration_PDF.pdf}.  
\(^7\) Nicklinson v Ministry of Justice [2012] EWHC 304.  
\(^8\) Nicklinson v A Primary Care Trust [2013] EWCA Civ 961. Tony’s wife was unsuccessful in the appeal to the English Court of Appeal. Tony’s wife and “Martin” (another person who had “locked-in” syndrome and wished to die) appealed to the Supreme Court of the United Kingdom in December 2013. The appeal was heard over four days by a nine-judge panel rather than the traditional five. The decision was reserved: see R (On the Application of Nicklinson) (AP) (Appellants) v Ministry of Justice (Respondent), Case ID UKSC 20130235, \url{http://supremecourt.uk/current-cases/case_2013_0235.html}. See also Bindmans LLP, “Jane Nicklinson and Paul Lamb’s Case to Die with Dignity” (21 November 2013), \url{http://www.bindmans.com/news-and-events/news-article/jane-nicklinson-and-paul-lamb-s-case-to-die-with-dignity}.)  
\(^{10}\) Nicklinson was not “terminally ill” in the sense that he was not dying and was capable of living for some time. In another sense, however, he may be regarded as terminally ill in that he was dependent on ongoing care and artificial nutrition and hydration to continue living.
Court, Tony refused nutrition, fluids and medical treatment with the intention of dying, and he subsequently died of pneumonia. 

Tony’s plight illustrates some of the issues that arise in this article but to elucidate them more clearly, let us consider a revised scenario (or at least add facts to remove possible uncertainty). Let us assume that Tony is not suffering from pneumonia or any other illness: his cause of death will be starvation and/or dehydration. And as he starves and dehydrates, he slowly starts to feel discomfort, then some pain and suffering. Let us also assume that Tony is then provided with palliative care to manage that pain and those symptoms as they arise.

The key issue is the implications of making palliative care available in this situation. As discussed, a competent refusal to eat and drink, even when that results in death, is not particularly controversial from an ethical or legal perspective. But does the provision of palliative care to manage the pain and/or symptoms associated with this decision alter the legal or ethical implications of this conduct? It is argued that it need not do so and that there are cases (such as the revised Tony scenario) where VPS would be both lawful and ethical.

VOLUNTARY STARVATION BY A COMPETENT ADULT

Every competent adult has the right to refuse to eat and drink, and not to be force-fed contrary to their wishes. This is a recognised ethical right and also has entrenched support in law.

Legal perspective

The most frequently cited authority for this principle is the landmark case of Schloendorff v New York Hospital in which Cardozo J observed that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body”. 

This is also a part of the common law of Australia and is reflected in the civil and criminal law of trespass (battery) in each State and Territory. 

This protection of the person remains even if the course of action adopted, such as refusing life-sustaining treatment, will lead to death.

It is now well accepted in Australia (and elsewhere) that artificial nutrition and hydration are capable of being lawfully refused. This has been approached often on the basis of it being a refusal of medical treatment, and the cases are generally in the context of incompetent adults. At times, the decisions arise due to the relevant legislative framework that operated, but the principles at play are consistent with the common law. The same principles also apply to a decision by a competent adult to refuse to eat and drink. The right to bodily integrity embedded in law protects all bodily integrity, not just in relation to medical treatment and so protects a refusal to eat and drink and prevents force-feeding. This principle was recently applied by the English Court of Protection, commenting that “[p]eople with capacity are entitled to make decisions for themselves, including about what they will

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11 Nicklinson v A Primary Care Trust [2013] EWCA Civ 961 at [12].
13 Schloendorff v New York Hospital 211 NY 125 at 129 (1914).
14 Secretary, Department of Health and Community Services (NT) v JWB (Marion’s Case) (1991) 175 CLR 218.
15 Richards B, “General Principles of Consent to Medical Treatment” in White B, McDonald F and Willmott L (eds), Health Law in Australia (Thomson Reuters, Sydney, 2010) at [4.20].
17 Re BWV; Ex parte Gardner (2003) 7 VR 487.
and will not eat, even if their decision brings about their death”, 18 and by the Supreme Court of South Australia in a case where the competent refusal of food and water was held to be lawful. 19

In recognising the common law right to refuse to eat and drink, courts have also been called upon to consider the corresponding liability of those who respect this refusal such as residential aged care facilities 20 and residential disability care facilities. 21 Generally this has involved considering statutory provisions in the relevant State and whether they alter this common law right. Although the legislative framework will differ between jurisdictions, the general principles from these cases show, as one might expect, that respecting a competent refusal will not give rise to liability.

One area of possible legal risk that has been suggested is whether respecting this competent refusal might be treated as assisting a suicide (the concept of suicide, although no longer a crime in Australia, has been judicially described as “the intentional taking of one’s own life”). 22 The case of H Ltd v J has rejected this concern concluding, by analogy, that as refusing life-sustaining medical treatment is not suicide, 23 nor should refusing to eat and drink be considered suicide:

I acknowledge that there is a difference between food and medicine. There is also a difference between the taking of food by natural means and the medical administration of nutrition. However, those differences do not appear to me to be sufficient to sustain a distinction between suicide and the exercise of a right to self-determination … I find that refusal of sustenance and medication is not suicide within the common law meaning of that term. 24

So because a refusal to eat and drink is not suicide, one cannot be guilty of assisting a suicide by respecting that refusal. 25 In H Ltd v J, Kourakis J (now Chief Justice) also concluded that, even if he was wrong and refusing to eat and drink was capable of being suicide, merely respecting a competent refusal would not constitute the necessary aiding, abetting or counselling of the suicide required under the law of that State. Courts are likely to require at least some assistance or encouragement before imposing liability in this setting. 26

Indeed, a person who is respecting a competent refusal of food and fluids may, at the same time, be attempting to discourage, challenge or otherwise dissuade a person wishing to die. However, when ultimately a person is not persuaded to take food and fluid, the law requires that the person’s own wish over what is introduced into his or her own body be respected.

Another possible area of legal concern is the duty on those who have charge of another to provide the necessaries of life, where a failure to do so would give rise to criminal responsibility for the

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18 Re E (Medical Treatment: Anorexia) [2012] EWHC 1639 at [7].
19 H Ltd v J (2010) 107 SASR 352 at [64].
21 Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84.
23 See also, for example, two recent Australian cases that have concluded that refusing life-sustaining treatment is not suicide: X v Sydney Children’s Hospitals Network [2013] NSWCA 320; Re JS [2014] NSWSC 302.
24 H Ltd v J (2010) 107 SASR 352 at [64]-[65].
25 This view, and the reasoning in H Ltd v J (2010) 107 SASR 352, can be critiqued as inconsistent both as a matter of logic and legal principle. One example of such critique (although it preceded H Ltd v J) is Oltowski, n 22, Ch 2. However, these critiques of themselves do not have force of law and so do not alter the legal position described in this article. The task here is to state the law as it is likely to be, drawing upon the most applicable and relevant primary legal sources.
26 In Attorney-General v Able [1984] QB 795, Wool J outlined the elements of the offence of aiding and abetting suicide under the relevant legislation at the time, and determined that a conviction required both intent to assist and that the deceased was assisted or encouraged to suicide. See also, for example, the Australian cases (sentencing remarks) of R v Maxwell [2003] VSC 278; R v Hood [2002] VSC 123; R v Nielsen [2012] QSC 29.
person’s death. Here, again, the courts have concluded that where there is a lawful refusal in place, this duty will not arise. While there is some variation in the framing of this duty nationally (for example, some jurisdictions rely on the common law while others have it in statute), this is likely to be the position under Australian law. There was also an alternative argument advanced in Brightwater Care Group (Inc) v Rossiter that a competent adult should not be regarded as being in the “charge of another” and so a care facility would not be subject to this duty, although this argument has been criticised elsewhere.

**Ethical considerations**

From an ethical perspective, the right of a competent adult to refuse to eat and drink could be seen as a basic right or derivative from the right not to have one’s body invaded or violated without consent. One of our most basic interests is control over our own bodies. Thus, our body should not be subjected to the will of another without our consent. This is so on either Kantian or consequentialist grounds (though Kant himself and some modern Kantians think suicide in many cases is morally wrong). There is a basic moral principle of inviolability of the person:

It is impermissible for one person, A, or several people, B-D, to insert any part of their body, object or substance into the body of another competent person, X, without X’s consent.

(A more formal version is:

It is impermissible for one person, A, or several people, B-D, to perform an act which involves foreseeably and avoidably inserting any part of their body, object or substance into the body of another competent person, X, without X’s valid consent.)

While it follows from this that every person has the ethical right to refuse to eat and drink, does it remain ethical if that refusal results in death through starvation?

Historically, there was no property in the body. Indeed, at times, our bodies belonged to the sovereign. Thus there used to exist the ancient crime of *maim*, which is rendering the body unfit for fighting (whether or not that injury is consented to). Others believed that our body belonged to God and so it was to usurp His will to prematurely take one’s own life. However, if anyone owns the body, it is the person who resides in it. So we have a right to end our life as we choose. The central ethical concept relevant to assisted dying in general is that of autonomy. Autonomy comes from the Greek words “autos” and “nomos” which together mean “self-governing”. Respect for autonomy is the principle that we should respect each individual’s own conception of what is a good life for him or her, unless he or she presents a direct threat of harm to other people. Each of us has a right to determine how our lives should go, even when those decisions appear irrational or extraordinary.

It is respect for autonomy which grounds the justification for allowing Jehovah’s Witnesses to die by refusal of life-saving blood transfusion. Witnesses believe, contrary to all other Christian denominations, that the Bible forbids literally the taking of blood. If they do not refuse, they believe they will not enjoy eternal paradise. This interpretation is unlikely to be correct given the weight of scholarship, even within the Christian tradition, against it. Yet nonetheless the wishes of autonomous Witnesses are respected. So to be allowed to die does not require that our values be maximally rational or universally shared.

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27 In terms of the legal duty of doctors to provide “necessaries of life” and how that operates in the contexts of decisions to withhold or withdraw medical treatment, see Willmott L, White B and Then S, “Withholding and Withdrawing Life-Sustaining Medical Treatment” in White B, McDonald F and Willmott L (eds), Health Law in Australia (Thomson Reuters, Sydney, 2010) at [13.20].

28 Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84 at [43]-[49]; H Ltd v J (2010) 107 SASR 352 at [73]-[74].

29 Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84 at [33]-[42].


31 Savulescu, n 3 at 111.

32 See R v Brown [1993] 2 WLR 556 at 589 (Lord Mustill). See also Arthur v Arthur [1964] ALR 1021; R v Woodward [1970] QWN 30. The obsolete common law crime of “maim” has been subsumed into what is now known as grievous bodily harm and other similar non-fatal offences to the person.
However, some choices do not reflect our deeply held values. Some are frivolous, influenced by social or peer pressure, or solely the result of addictions or depression. From an ethical perspective, it may not be acceptable to respect a person’s choice to die in such circumstances. Yet unusual choices are not necessarily non-autonomous. Perhaps the most unusual is the desire by the philosopher Michael Bayles to commit suicide, as evidenced in his obituary:

Michael Bayles committed suicide August 6, 1990. He was born in Charleston, Illinois January 21, 1941, and so died in his fiftieth year. His suicide was carefully planned and is as much an expression of Myke as his varied writings in ethical theory and applied ethics, philosophy of law, and political theory. Myke’s argument for the moral acceptability of suicide is that, as he put it, “only humans can choose when they will die” and that “to fail to exercise that choice is to deprive oneself of a distinctive freedom”. A person’s life is a story, he suggests, and a person ought to consider how the story ought to end, with suicide an option under appropriate circumstances. “If”, he says, “what makes life a good story is happiness or the pursuit of projects, then a long, drawn out ending without either is a bad end of what may have been a good story”.

Bayles had been very productive in the years leading up to his death though he progressively took on fewer and fewer projects. He wanted to die without unmet obligations.

He had, in the three years before his death, seen to publication his Principles of Law and what Joel Feinberg has called “a groundbreaking theory of procedural justice with applications not only to legal practices but to social institutions generally”. And the day he committed suicide he received word that his book on HLA Hart had been accepted for publication.

Some wrote Bayles was depressed. This may have been the case. But if that depression were unchangeable and his valuing suicide had persisted for some time and was the result of rational reflection, then it may still have been an expression of his autonomy. What matters according to the principle of respect for autonomy is not that a person makes the right decision, but that they make their own decision, according to their values.

Lisette Nigot, aged 79 and apparently healthy, also made an unusual choice. This retired academic, who was living in Perth, took an overdose and died shortly before her 80th birthday. The note that she left behind her bed when she died explained: “After 80 years of a good life, I have [had] enough of it. I want to stop it before it gets bad.” It was important to Nigot to end her life while she was well and before her health deteriorated and this represented her autonomous choice.

While autonomy is key in ethical terms, what is critical in clinical terms is whether the person is competent. For clinical practice, independent, competent determinations of competence are central. A patient refusing nutrition and hydration in order to end her life runs the risk of being deemed incompetent just because she wants to end her life. A patient who is terminally ill, or suffering from a condition like motor neurone disease, or even just tired of life is unlikely to be deemed incompetent and so forcibly prevented from acting on that strategy.

Importantly, doctors can respect autonomy by providing information and argument to patients in an attempt to engage and perhaps even change a person’s values. Yet when argument and facts have been presented, respect for persons requires that their decisions for their own lives be respected, including the decision of when to end their life.

Now if doctors, courts and family members can make a decision that a person’s life is no longer worth living and feeding should be stopped (as can occur legally when the patient is incompetent and cessation of feeding is assessed as being in the patient’s best interests), why cannot the person, like

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34 Robinson, n 33 at 2.
Tony Nicklinson, make that decision, and it be acted upon? Surely the person who has the most right to decide whether life is tolerable is the person who must live that life.

**PALLIATION IN THE COURSE OF VOLUNTARY STARVATION BY A COMPETENT ADULT**

The discussion so far has made the reasonably uncontroversial claim that a person has both a legal and ethical right to refuse to eat and drink, even if this will lead to his or her death. And if there is a lawful refusal, respecting it will not attract legal liability. In the revised scenario above, Tony may refuse to eat and drink and his carers would need to abide by his decision. But dying in this way – through dehydration and/or starvation – can lead to suffering, particularly if the person is not already dying. In the recent English Court of Appeal decision of *Nicklinson v A Primary Care Trust*, an attempt to die by refusal to eat and drink was described as constituting the “most distressing circumstances”.

The dilemma that is grappled with now is whether a person refusing to eat and drink (self-induced starvation) should be able to receive palliative care to manage the pain and symptoms associated with this choice to make their dying comfortable. Does the addition of palliative care, so called “voluntary palliated starvation” or VPS, alter the legal and ethical analysis above? It is argued that the provision of palliative care, at least in the situations contemplated as illustrated by the revised Tony scenario above, can be legally and ethically justifiable.

**Legal perspective**

The argument is that first, there is no legally relevant distinction between providing palliative care to manage the symptoms of a refusal to eat and drink and other situations where palliative care can be lawfully provided. Secondly, the addition of palliative care need not alter the position relating to criminal responsibility discussed above that respecting a competent refusal to eat and drink is lawful.

**Palliative care is lawful for refusals to eat and drink**

Palliative care may be lawfully provided to a patient as they approach death to manage their pain and symptoms. *Brightwater Care Group (Inc) v Rossiter* makes clear that this position does not change just because the death is occurring due to a refusal of treatment:

There are a number of general principles which can be confidently stated in relation to this issue. The first is that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter’s withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. Put another way, Dr Benstead’s rights and obligations with respect to the provision of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration are no different to the obligations which attend the treatment of any other patient who may be approaching death.

Similarly, it would be lawful (as well as good and acceptable medical practice) to relieve the suffering of a person dying from a valid refusal of blood transfusion, such as a Jehovah’s Witness. It is the fact of the suffering that is relevant, not its origin.

Mr Rossiter, therefore, was entitled to the same palliative care to ease his dying process even though the symptoms and the need for that care arose due to his refusal of artificial nutrition and hydration. Indeed, it was clear from the judgment and the declaration made by the judge that he expected (and hoped) Mr Rossiter would be provided with palliative care. As a matter of logic, this position must also hold for the refusal of food and water (not just nutrition and hydration provided artificially) as the decision to refuse to eat and drink is protected in the same way and for the same reasons by the law. And the failure to receive either could be expected to cause equal suffering.

Further support for this proposition can be gleaned from three other cases where the issue of palliative care to deal with the symptoms of treatment refusal was raised during the course of

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37 It is noted that there is evidence to suggest that when not eating or drinking is part of the normal dying process, the absence of food and drink may not result in suffering to the patient. See further n 6.

38 *Nicklinson v A Primary Care Trust* [2013] EWCA Civ 961 at [9].

39 *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84 at [52].
proceedings but not seen as unlawful. In *H Ltd v J*, a case which involved a refusal of food and water (and insulin) and not artificial nutrition and hydration, the judge contemplated that palliative care would be given to manage pain and symptoms and this was not flagged as being problematic.\(^{40}\) If such conduct were to be unlawful, one would expect a judge to have grappled with such a concern before granting declarations that respecting refusals of food and water (and insulin) would be lawful. Likewise in the case of *Australian Capital Territory v JT*, the declaration sought was that it would be lawful to act on an adult’s refusal of food and water and provide only palliative care. Although the declaration was not granted on the facts of the case, the Supreme Court made no adverse comment about the general lawfulness of such an approach.\(^{41}\) Finally, in *Re JS*, where a competent adult was refusing mechanical ventilation that was keeping him alive, the New South Wales Supreme Court also made no adverse comment about the lawfulness of palliative care to manage symptoms associated with the cessation of treatment. The court did decline to grant a declaration that the provision of such care would be lawful but this was because it would not be appropriate to prescribe the limits of JS’s future care rather than concerns about lawfulness.\(^{42}\)

This consistent approach to palliative care for patients refusing to eat and drink would mean that it would be lawful for that palliative care to hasten death provided the intention was to relieve pain. While there is some variation around Australia (some States being governed by the common law and others by statute), the provision of appropriate palliative care that intends to relieve pain and not cause death is lawful\(^{43}\) and this would also be the case for VPS.

**Addition of palliative care does not give rise to other criminal responsibility**

Even if the administration of palliative care to manage the symptoms of a refusal to eat and drink is lawful as if it had been provided to deal with symptoms of refusing medical treatment, it might still be argued that the addition of palliative care alters the general principles of criminal responsibility that were discussed above. In other words, while refusing to eat and drink is lawful and that refusal must be respected, does the provision of palliative care in this situation change the nature of that interaction between patient and care providers such that criminal responsibility might arise?

The revised scenario of Tony Nicklinson helps to crystallise this type of case. Tony is dying from starvation and/or dehydration and starts to feel discomfort, then pain and suffering. He is then provided with palliative care to manage that pain and those symptoms as they arise until he dies.

In terms of the law related to assisted suicide, the same main hurdle for prosecutors mentioned above would arise. If refusing food and water is not suicide, those providing palliative care, with the intention of providing symptom relief rather than hastening death, in “assistance” of that aim, cannot be assisting a suicide. This is made clear in the quote from *H Ltd v J* above. As noted earlier though, that there was an alternative or “back-up” ground advanced in that case. The judge stated that even if he was wrong and it was suicide, merely respecting a competent refusal falls short of the required encouragement to constitute aiding and abetting and so no criminal offence is committed. This reasoning might not apply where palliative care is being provided. There is an argument that offering palliation could constitute some kind of encouragement in the sense that the patient might not be prepared to refuse to eat and drink without the availability of palliative care. That said, the judge in *H Ltd v J* made clear that this second line of reasoning was advanced as a back-up to the main proposition that refusing to eat and drink is not suicide in legal terms. If that first argument is accepted, and this article submits it should be, then the addition of palliative care does not alter the criminal responsibility discussed above.

The other area of potential liability identified earlier was in relation to causing death through the failure to provide the necessaries of life. The addition of palliative care does not change the above analysis. It is the competent refusal to eat and drink that relieves carers of this duty and the addition of

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\(^{40}\) *H Ltd v J* (2010) 107 SASR 352 at [98].

\(^{41}\) *Australian Capital Territory v JT* (2009) 4 ACTLR 68.

\(^{42}\) *Re JS* [2014] NSWSC 302 at [30], [35].

further care does not alter any responsibilities in this regard. And questions of causing the death in the scenario proposed would also not arise. As noted above, appropriate palliative care intended to relieve pain – as it clearly is in the revised Tony scenario – does not give rise to criminal responsibility even if an unintended consequence is to hasten death.

This is not to say, however, that a refusal to eat and drink coupled with palliative care could never give rise to liability. The criminal law is inevitably interacting with a particular situation and set of facts and it is possible to consider other scenarios where the combination of palliative care with a decision to refuse to eat and drink could change the nature of the parties’ conduct and corresponding responsibility. One such instance might be where the clear intention of the palliative care is to cause death immediately and not merely to relieve pain and suffering. That said, the types of cases discussed in this article, as illustrated by the revised Tony scenario, remain within the law and palliative care can be provided to ameliorate the suffering that refusing to eat and drink can give rise to. VPS can be lawful and therefore is a legal option available to those wishing to die comfortably who are not terminally ill or dependent on life-sustaining medical treatment.

**Ethical considerations**

There are two connected but separate issues associated with the ethics of providing palliative care to a competent patient who has chosen to die through cessation of eating and drinking. The first is whether it is ethical for doctors to provide clinical support to a patient who is seeking to die in this way. The second issue arises only if it is concluded that it is ethical to provide that support, and it is whether an individual doctor should be required to provide such support. Each issue is considered in turn.

As to the first, it is argued that it is ethical for doctors to provide palliative care. To recap on the earlier argument, it is claimed that it is ethical for a competent person to refuse to eat and drink even if that decision results in death, because a person has a fundamental right not to have their body violated or invaded without their consent. It follows, as explained, that doctors are morally required to respect competent refusals of medical treatment and refusals to eat and drink.

What then are the ethical implications of providing palliative care to such a patient? Many commentators over the past two decades have argued that for patients who have expressed a wish to die by not eating or drinking, the provision of palliative care should be seen as part of the health professional’s role as a caregiver. Support for dying through stopping food and fluid, while not universal, has been expressed from both medical and nursing perspectives.

The article argues that the provision of palliative care to a patient dying as a result of a decision not to eat or drink is ethically sound. Respect for autonomy entails respecting a person’s desire to live and die in their own way. When the choice to die causes suffering, doctors have a professional obligation to relieve that suffering, for example by the provision of palliative care. Reasons not to provide medical care include that it is unlawful, a competent patient validly refuses it, it is itself harmful, or otherwise not cost-effective and so precluded by principles of distributive justice. But palliative care to relieve the suffering of self-chosen dying is none of these. Doctors ought to provide it.

Some might object that medical care should not be provided to those who inflict their suffering upon themselves. However, this would preclude much of current medical care: provision of care to

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46 Bernat et al, n 5; Berry, n 44.

47 Yale, n 44. See also Harvath TA et al, “Voluntary Refusal of Food and Fluids: Attitudes of Oregon Hospice Nurses and Social Workers” (2004) 10 Int J Palliat Nurs 236 where the authors reported support by nurses in hospice programs for patients who choose to die through the voluntary refusal of food and fluids.
smokers, alcoholics, obese people, those who engage in risky activities (including sexual activities),
those who harm themselves through physical violence, and so on. Clearly doctors have an obligation
to relieve suffering, whether or not it was self-inflicted.

The second ethical issue relates to the nature of the doctor’s obligation. If it is accepted that it is
ethical for doctors to provide palliative care to a patient who is dying in these circumstances, are they
morally required to provide palliation? It is important here to distinguish between moral obligations
and moral requirements. A moral obligation stipulates something there is a moral reason to do: what a
person ought to or should do. A moral requirement stipulates something a person must do, on pain of
legal or social sanction. For example, we ought to be more concerned about global inequality, poverty
and climate change but we are not required to make significant sacrifices, such as giving up larger
proportions of income, for these causes.

It has been argued above that doctors have an obligation to relieve suffering. However, to say that
something ought to be done is not to say that it must be done (that it is morally required). Some
doctors will, understandably, refuse to be complicit in what they regard as killing. They will
conscientiously object to assisting the patient to die. Thus doctors might legitimately decide not to
support a dying patient who has chosen to die by providing palliative care or other medical treatment
if they believe that person is acting for bad reasons. However, it is argued in this article that VPS is
not unlawful and that it should be permissible within medical practice. And where there are a range of
permissible practices (such as VPS), doctors do have a minimal obligation to respect autonomy by
directing a patient to other practitioners who might take a different view of the request. Conscientious
objection has limits and requires referral on, where a practice has been deemed lawful and generally
permissible in medicine.48

Whether a doctor should morally accede to such a request in a jurisdiction where providing
assistance is lawful turns on whether the person has a good reason to die. Existential suffering, ageing,
loss of one’s ideals could all be good reasons to die, in certain circumstances.49

CONCLUSION
This article has argued that it is both lawful and ethical to respect lethal refusals to eat and drink. This
proposition is neither legally nor ethically controversial. It has been further argued that it can be both
lawful and ethical to provide palliative care to reduce the suffering associated with such self-induced
dying. This second argument is more controversial, yet an important one to have in light of the
ongoing debate about whether competent adults should be entitled to assistance to die, and the
ongoing resistance of Australian Parliaments to enact laws that allow assistance to be given. There is
widespread but not unanimous community support to reform the law to allow assistance in dying. But
there would be unanimous support for the proposition that a person should not die suffering and in
pain. A lawful and ethical model (VPS) to achieve this end is therefore worth considering.

The VPS model presents an opportunity for that cohort for whom end-of-life decision-making
frameworks have struggled to assist – individuals who are sick (whether or not they are terminally ill)
and in pain, but not dependent on life-sustaining treatment. The model would also be an option for
elderly people who are “tired of living” and autonomously choose to die while they still have a quality
of life that is acceptable to them (as in the case of Lisette Nigot). These groups cannot lawfully receive
assistance to die in any jurisdiction which has enacted laws to facilitate voluntary euthanasia and
assisted suicide.

The argument in this article is not that palliative care physicians or other doctors be required to
provide the palliative care – only that they should be allowed to. And there can exist good moral
reasons to ground a moral obligation to provide palliative support to those who choose to die for good
reasons. There are also good reasons not to require doctors to engage in medical practices if they

49 Savulescu J, “Rational Desires and the Limitation of Life-Sustaining Treatment” (1994) 8 Bioethics 191; Savulescu J,
“Autonomy, the Good Life, and Controversial Choices” in Rhodes R, Francis LP and Silvers A (eds), The Blackwell Guide to
cause distress to doctors: these doctors may not perform the service adequately, and there are sufficient other doctors to provide the necessary palliative support. If there are insufficient doctors and other health professionals to provide palliative support to those who choose to die, there may be a need to readdress the extent of professional obligations to relieve the suffering of self-induced dying.

Taking as the starting point the case of Tony Nicklinson, it has been argued that VPS is both ethically justifiable according to current medical ethics and within what is already permitted by law. If the currently accepted position that a competent adult should be able to refuse to eat and drink is adopted, why then should deaths that occur in this way be painful? Some may argue that VPS is a step too far but if existing rights are taken seriously, it is hard to argue why a lawful death through refusing to eat and drink should occur in pain.

VPS is not ideal as a mode of dying. It requires courage and determination – it is not for everyone. There is the possibility of being declared incompetent and forcibly treated. There is the possibility of not receiving, or receiving inadequate, palliative care and subsequently suffering. People entertaining the option of VPS need to be aware of these possibilities and take steps to minimise their happening, for example, receiving in advance the assurances that their wishes will be respected. While VPS is likely to be an option accepted by the medical profession in cases of terminal illness, it is likely to be more unpopular when requested for non-terminal conditions. Since patients cannot demand medical treatment, it is likely to be more difficult to secure and people should ensure they have a willing physician to provide palliative care.

VPS has other shortcomings. It involves slow dying and many people wishing to die and many families will yearn for a quick death. And lastly, practising VPS may lead some to think that it renders legal reform around dying unnecessary, sapping political and social will to introduce voluntary euthanasia and/or physician-assisted suicide legislation.

This latter concern need not arise, however. The difficulties identified with VPS mean that it should only be a part of a comprehensive approach to assisted dying. In fact, that VPS is currently lawful and ethical should add weight to calls for reform and it can be seen as a bridge to the legalisation of voluntary euthanasia and/or physician-assisted suicide. We had no choice over how or when we entered this world but we can and should exercise choice over how and when we leave it.
INTRODUCTION

Attention is now paid to the need for effective medical treatment in order to improve patients' quality of life. The introduction of palliative care has been a significant development in this area, offering a holistic approach to patient care.

KEY POINTS

- Double Effect and Palliative Care Exceuses

CHAPTER 15
The Doctrine of Double Effect

It is a moral principle that allows for action even if it involves a type of action that is morally wrong. The principle is based on the idea that there can be a morally justifiable action if the primary intention is good and the harmful effect is a secondary intention. The doctrine is often used in discussions about medical ethics, war, and other situations where actions with negative consequences are taken for the greater good.

However, the doctrine is also criticized for oversimplifying complex moral situations and for potentially justifying morally unjustifiable actions. It is important to consider the context and the specific circumstances when applying the doctrine.

Conclusion:

In conclusion, the Doctrine of Double Effect is a complex moral principle that allows for actions with harmful consequences if they are taken for the greater good. It is important to carefully consider the context and circumstances when applying this doctrine, as its ethical implications can be significant.
Medicare Practice Standards

The standards and regulations of the Medicare program dictate the reimbursement of providers for services rendered. In order to be eligible for Medicare reimbursement, practitioners must meet certain criteria and adhere to specific protocols and guidelines. These standards are enforced by the Centers for Medicare & Medicaid Services (CMS) and are designed to ensure the quality and appropriateness of care provided to Medicare beneficiaries.

In practice, the Medicare Practice Standards require providers to:

1. Maintain accurate and up-to-date medical records.
2. Follow evidence-based guidelines and protocols.
3. Ensure patient confidentiality and privacy.
4. Report and audit services to ensure compliance with Medicare regulations.
5. Participate in quality improvement initiatives.

Meeting these standards is crucial for providers to continue receiving Medicare reimbursement. Non-compliance can lead to sanctions, including denials of reimbursement or even exclusion from the Medicare program.

Required Information

When submitting claims for Medicare reimbursement, providers must include detailed information to support the eligibility of the claim. This includes:

1. Patient information: Name, date of birth, Medicare number, current address, and contact information.
2. Clinical information: Diagnosis codes, procedure codes, and detailed narrative description of services provided.
3. Provider information: NPI number, name, and specialty.
4. Payment information: Amount due, and insurance details.

Proper documentation and accurate coding are essential to ensure correct reimbursement and avoid denials or audits.
Effect of Excise

150 (a) In the construction of the meaning of the expression, all similar and parallel concepts may be

summarized in their full. The above expression of the same cosine, the different intensions can be

assessed in context and in the same sense of a concept are not to imply that

in their unique and equal nature the relevant expression are there.

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FURTHER READING

Points for Consideration