



Research Service,
Parliamentary Library,
Department of Parliamentary Services

Current Issues Brief No. 2, 2008

MEDICAL TREATMENT (PHYSICIAN ASSISTED DYING) BILL 2008

A discussion of issues relevant to the Medical Treatment (Physician Assisted Dying) Bill 2008. The paper includes definitions, a description of current laws, an examination of the bill in detail, a summary of ethical considerations and positions, and a comparative overview of laws in other jurisdictions.

Parliamentary Library
Research Service
June 2008

This Current Issues Brief is part of a series of papers produced by the Library's Research Service. Current Issues Briefs are intended to provide in-depth coverage and detailed analysis of topics of interest to Members of Parliament.

Parliament of Victoria

NB: Readers should note that this paper was prepared prior to the passage of the Medical Treatment (Physician Assisted Dying) Bill 2008 through the Victorian Parliament. The Bill was defeated in the Legislative Council on 10 September 2008.

Contents

Introduction	1
1. Defining Euthanasia and Physician Assisted Dying	2
2. Background – Current Law	3
2.1 The Medical Treatment Act 1988 (VIC)	3
2.2 Other Relevant Statutes	5
2.3 Opinion Polls	6
2.4 Euthanasia and Other Jurisdictions	6
3. The Bill	7
3.1 Second Reading	7
3.2 Key Features of the Bill	8
4. Stakeholder Opinion	14
4.1 Rights	14
4.2 Pain and Suffering	17
4.3 Legal and Medical Guidance	20
5. Approaches to Physician Assisted Dying in Other Jurisdictions	23
5.1 Within Australia	23
5.2 Overseas	29
6. The Experience of Other Jurisdictions - Oregon & the Netherlands	34
6.1 Oregon – Death with Dignity Act (1998)	34
6.2 The Netherlands – Termination of Life On Request and Assisted Suicide Act (2002)	36
References	39
Appendix: A Comparative Overview	45

Acronyms

AMA – Australian Medical Association

DWDA – Death with Dignity Act (Oregon)

PAD – Physician Assisted Dying

PAS – Physician Assisted Suicide

ROTI – Rights of the Terminally Ill Act 1995 (Northern Territory)

Note

This paper is the product of a collegial effort by the DPS Parliamentary Library's Research Service: The Head of Research, Dr. Greg Gardiner, Statistical Analyst, Bella Lesman, Research Officers, Claire Higgins and Rachel Macreadie, and Research Assistant, Adam Delacorn.

Introduction

This paper examines the Medical Treatment (Physician Assisted Dying) Bill 2008, which is currently before the Legislative Council, and issues surrounding euthanasia. The Medical Treatment (Physician Assisted Dying) Bill was introduced into the Legislative Council by Greens Member Ms. Colleen Hartland as a Private Member's Bill and was first read on 28 of May. The second reading was given by Ms. Hartland on 11 of June. The Bill is co-sponsored by Mr. Ken Smith of the Liberal Party, MLA for the electoral district of Bass.

The paper comprises the following parts. Section One provides a summary of definitions of euthanasia, physician assisted dying and other key terms. Section Two examines the current legal regime in Victoria in relation to the medical treatment of dying patients, provides information on laws on refusal of medical treatment in other Australian jurisdictions, and briefly examines recent opinion polls on the issue of voluntary euthanasia. Section Two also provides a short overview of euthanasia and physician assisted dying legislation both here and overseas.

Section Three briefly describes the second reading speech, and examines the key provisions of the Bill in detail. Section Four examines the key arguments of proponents and opponents of euthanasia and physician assisted dying legislation.

Section Five looks in detail at euthanasia and physician assisted dying legislation in selected other jurisdictions: the Northern Territory, the Netherlands and Oregon, (the Appendix provides a comparative table of these jurisdictions with the Victorian Bill). Section Five also looks at recent attempts to introduce euthanasia laws in other Australian jurisdictions. Section Six examines the research that has been undertaken on the experience of the Netherlands and Oregon with their laws.

In the modern context, debates surrounding euthanasia have increased, in part, as a corollary to advances in medical science that have allowed for the prolongation of human life. However, it is important to bear in mind that attitudes towards death and the care of the dying, euthanasia and suicide, will often reflect deeply held cultural beliefs. It is also the case that such attitudes can vary significantly from one era or society to another. This paper does not attempt to characterise the various beliefs in relation to these matters that have emerged over time, nor does it offer a comprehensive account of every current position or perspective. It restricts itself to some of the key arguments as they have been presented in the contemporary context. For further information, Members are advised to consult the reference list which appears at the rear of this paper.

1. Defining Euthanasia and Physician Assisted Dying

The word 'euthanasia' is derived from Ancient Greek (combining 'eu' meaning 'good' or 'well' with thanatos meaning 'death' or the 'god of death'). Physician Assisted Dying (PAD) is a relatively new coinage, and is also referred to in some jurisdictions as Physician Assisted Suicide (PAS).

Euthanasia has been variously defined, but in the modern context usually concerns the act of ending a person's life in order to relieve the person of pain and suffering. Many commentators identify different forms of euthanasia, making distinctions between 'passive' and 'active' euthanasia, and/or 'voluntary' and 'involuntary' euthanasia. There is no universal agreement on the meanings of these distinctions. What follows are some commonly identified categories and their definitions, which should be taken as a guide to the different forms of euthanasia rather than as being definitive.

Passive voluntary euthanasia – at the patient's request, medical treatment is withdrawn resulting in the patient's death

Active voluntary euthanasia – at the patient's request, a medical intervention occurs resulting in the patient's death

Passive involuntary euthanasia - medical treatment is withdrawn resulting in the patient's death, at no request from the patient

Active involuntary euthanasia - a medical intervention occurs resulting in the patient's death, at no request from the patient

Non-voluntary euthanasia - a medical intervention occurs resulting in the patient's death, where the patient is unable to consent or to refuse consent

While proponents of Physician Assisted Dying (PAD) tend not to use the term euthanasia, PAD is often regarded as a form of voluntary euthanasia. The distinguishing feature of PAD (or PAS) is that it involves a process whereby a competent adult patient administers himself or herself with a life ending drug, with the assistance of a medical practitioner. It should also be noted that the Australian Medical Association (AMA) does not regard the withdrawal of medical treatment, or the administration of treatments intended to relieve symptoms which have a secondary consequence of death, in accordance with proper practice, as either euthanasia or assisted suicide.¹

There are two other important phrases that occur in debates concerning euthanasia and PAD; the 'doctrine of double effect', and 'advanced directives'.

¹ See Australian Medical Association (2007) 'Position Statement on the Role of the Medical Practitioner in End of Life Care', AMA, p.2, viewed 11 June 2008, <<http://www.ama.com.au>>.

An ‘advanced directive’ (sometimes referred to as a ‘living will’) can be described as a statement, usually in written form (although it can also be an oral statement), that expresses a competent person’s intentions in regard to refusal of medical treatment in the future, at which point the person is not in a position to make a competent decision. A form of advanced directive is permitted under South Australian law.

The doctrine of ‘double effect’ is a recognised principle of applied ethics. It refers to a principle whereby an action which has a bad effect is defensible provided that: the action itself was good or indifferent; the good effect must be the effect sincerely intended by the agent; the good effect must not be produced by the bad effect; and, there must be a proportionate reason for permitting the bad effect to occur. In the context of care of the dying, a doctor who foresees that as a consequence of administering a treatment to relieve pain that the patient’s death may be hastened, he or she is permitted to administer that treatment, if the sincere intention is to alleviate the patient’s pain, not to hasten death.²

2. Background – Current Law

This section deals with the current legal regime in Victoria concerning the treatment of the dying, refusal of medical treatment, and the laws on refusal of medical treatment in other Australian jurisdictions. It also briefly considers other statutes in, or relevant to Victoria, and the results of recent opinion polling on the issue of euthanasia. It is important to note that the common law right of self-determination, which subsists throughout Australia, has been interpreted by commentators and others to include the right to refuse unwanted medical treatment.³

2.1 The Medical Treatment Act 1988 (VIC)

In Victoria the right of a patient to refuse medical treatment is enshrined in the *Medical Treatment Act 1988*. The Medical Treatment Act establishes the right of refusal of a patient to general or a particular medical treatment and a procedure for certifying such refusal (s.5). It creates the offence of medical trespass, wherein a doctor is not permitted to undertake treatment of a patient who has refused treatment under the Act (s.6), and allows for the appointment of an enduring power of attorney, who is empowered to make decisions under the Act on behalf of an incompetent patient (sections 5A to 5F). Section 9 provides medical practitioners with professional, criminal and civil immunity for not performing medical treatment under the Act.

The Medical Treatment Act does not provide for ‘advanced directives’ (see above) and only allows for refusal of medical treatment for a current condition. The Medical Treatment Act was passed following a series of reports and parliamentary debates

² See A. McGee (2004) ‘Double Effect in the Criminal Code 1899 (QLD): A Critical Appraisal’, *QUT Law & Justice Journal*, AustLII, viewed 18 June 2008, <<http://austlii.edu.au>>; M. Battin (2005) *Ending Life: Ethics and the Way We Die*, Oxford University Press, pp. 22-23.

³ See C. Stewart (1999) ‘Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions’, *Melbourne University Law Review*, MULR 6, viewed 18 June 2008, <<http://www.austlii.edu.au>>; L. Willmott, B. White & M. Howard (2006) ‘Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment’, *Melbourne University Law Review*, Vol.30, pp. 211-243.

concerning the rights of the dying with regard to ongoing medical treatment. Such debate was not confined to Victoria. Through the 1970s and 1980s jurisdictions here and overseas were engaged in debates over the legal rights of dying and incurably ill patients to refuse treatment. Such debates were a natural corollary to advances in modern medicine and the development of treatments and machines that could extend an individual's life beyond previous limits. The issue was highlighted by cases in which patients with no prospect of recovery, or who were permanently unconscious, could be kept alive by artificial means.⁴

California was the first jurisdiction in the United States to enshrine the rights of a patient to make a decision about withholding and withdrawing treatment with the California *Natural Death Act* in 1976. The California Natural Death Act provides legal standing to 'living wills' (often referred to as advanced directives), which can provide for specific instructions on whether or not a person wishes to maintain treatment(s) in the event of terminal illness; the law also protected physicians from prosecution for a failure to treat in such circumstances.⁵

In Victoria, legislation enabling persons to refuse medical treatment had been proposed since December 1980 when the Hon. R.A. Mackenzie introduced a Private Member's Bill for this purpose. After the Medical Treatment Bill was amended and resubmitted in 1981, debate was adjourned, and the Bill and the matter were referred by the Minister for Health to the Health Advisory Committee in 1982. This committee found while that a common law right to refuse medical treatment existed in Victoria, legislation to provide for and clarify that right should be introduced.⁶

The issue was next the subject of examination by the all-party Social Development Committee in 1986. The Committee received 1,379 submissions, many of which also related to the issue of euthanasia. The Committee made 31 recommendations in their Final Report, tabled in April 1987, which included that legislation be introduced establishing an offence of medical trespass (recommendation 2).⁷ However, the Committee's first recommendation was that it was neither desirable nor practicable for any legislative action to be taken establishing a right to die. The Medical Treatment Bill was introduced into the Legislative Council in October 1987 by the then Cain Labor government. The Bill was substantially revised and presented as Medical Treatment Bill (No. 2) in 1988.⁸ This Bill incorporated a definition of palliative care, which explicitly states that the refusal of palliative care is not covered by the Act. Palliative care is defined within the Act, in section 3, to include:

⁴ See R. Gott & R. Linden (1993) *No Easy Way Out: The Euthanasia Debate*, Carlton, CIS Publishers, pp.6-9; M. Battin (2005) *op. cit.*

⁵ By the mid-90s all the US states had laws that authorise legally competent individuals to make advanced directives. In addition, a federal law, the *Patient Self-Determination Act*, which came into effect in 1991, requires federally certified health care facilities to notify competent adult patients of their right to demand or refuse treatment.

See T. Beauchamp (2008) 'Euthanasia', MSN Encarta, On-Line Encyclopedia, viewed 18 June 2008, <<http://encarta.msn.com>>.

⁶ See R. Gott & R. Linden (1993) *op. cit.*, pp.10-15; J. Anderson (2005) *The Medical Treatment Act 1988 (Vic): Its History, Applications, and Comparative Analysis*, Parliamentary Internship Report, Melbourne, Parliament of Victoria.

⁷ Victoria, Social Development Committee (1987) *Report upon the Inquiry into Options for Dying with Dignity: Second and Final Report*, Melbourne, F. D. Atkinson.

⁸ It was criticised by the Opposition, who maintained that the Medical Treatment Bill was a step towards euthanasia, see Victoria, Legislative Assembly (1988) *Debates*, 6 May 1988, pp. 2244, 2249.

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

The new Bill also stated that the only medical treatment that could be refused was the treatment pertaining to a current condition, meaning that an ‘advanced directive’ had no legal standing.⁹ The Bill also clarified that medical practitioners would be protected by the Act when acting in good faith. Before it passed, an enduring power of attorney mechanism was removed from the Bill.¹⁰

Various amendments have been made to the original Act, including, importantly, the reinstatement of the enduring power of attorney mechanism in 1990. A new section was also added in 1992 which set out provisions for the appointment of an alternative agent, in the event of an original agent having died, being un-contactable or incompetent.

Of the other states and territories, three jurisdictions have legislation relating to refusal of medical treatment: In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995*, in the Northern Territory, the *Natural Death Act 1988*, and in the ACT the *Medical Treatment (Health Directions) Act 2006*. Both the South Australian and Northern Territory laws allow for a form of advanced directive.¹¹

2.2 Other Relevant Statutes

In addition to the Medical Treatment Act, there are other important statutes that relate to this area. The Victorian *Crimes Act 1958* states that suicide is no longer a crime (s. 6A), but there are offences related to any person who incites any other person to commit suicide (s. 6B(2)(a)) or to any person who aids or abets any other person in the commission of suicide (s. 6B(2)(b)). In two recent cases in Victoria, (*R v Hood [2002] VSC 123* and *R v Maxwell [2003] VSC 278*) the court has imposed wholly suspended sentences on offenders found guilty under section 6B(2). There is also a section in Part 1, Division 1(1) of the Crimes Act that relates to homicide. Under the double effect doctrine, mentioned above, a medical practitioner who, in alleviating a

⁹ Victoria, Legislative Council (1988) *Debates*, 23 March 1988, p. 335.

¹⁰ It was finally passed in the Legislative Council on 23 March 1988 and in the Legislative Assembly on 6 May 1988.

¹¹ The South Australian *Consent to Medical Treatment and Palliative Care Act 1995* differs from the Victorian *Medical Treatment Act 1988* in that it sets out statutory rights of a patient to consent to, or refuse medical treatment. Under the Act competent persons 18 years and over can make a directive about consent to, or refusal of, medical treatment in the future. However, such directives only apply where the person is in the terminal phase of a terminal illness or in a persistent vegetative state. The ACT’s *Medical Treatment (Health Directions) Act 2006* allows for ‘health directions’ to be made regarding refusal of medical treatment by competent adults at any time, but requires the patient for whom such a direction is to apply to be fully competent, informed and as having confirmed the decision to withdraw or refuse treatment at the time such action would take place. The Northern Territory’s *Natural Death Act 1988* allows for competent adults to make directions concerning refusal of ‘extraordinary measures’ in the event of terminal illness. ‘Extraordinary measures’ are defined as those measures artificially prolonging life. There appears to be no other state with refusal of medical treatment legislation. However, in Western Australia, Queensland, and New South Wales respective state health departments make information available to those considering refusing medical treatment, and their rights.

dying patient's pain, hastens that patient's death is not criminally liable, provided that the sincere intention of the doctor is to alleviate pain, and not to hasten death.

The Commonwealth *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* restricts the ability of persons and organisations to electronically disseminate or transfer information regarding suicide and euthanasia. It does not restrict public debate on euthanasia, but it has had an impact on the operations of pro-euthanasia lobby groups, such as Exit International, who relocated the location of their website to New Zealand following the passing of the legislation.

2.3 Opinion Polls

Two of the most recent national polls on the subject of euthanasia are those conducted by Roy Morgan Research in 2002 and Newspoll in 2007. Roy Morgan Research conducted a survey of 1,232 people aged 14 years and over around Australia and found that 73% of respondents thought that doctors should be allowed to give a lethal dose to hopelessly ill patients who were without hope of recovery. In February 2007 Newspoll released their report into euthanasia which was commissioned by Dying with Dignity Victoria. It surveyed 2,423 people nationally aged 18 years and over and found that 80% of respondents thought that doctors should be allowed to give a lethal dose to hopelessly ill patients who had no hope of recovery.¹²

Opponents of euthanasia argue that the law and social policy in such a critical area of life and death should not be dictated by opinion polls, however much those polls are, or are not, truly indicative of public opinion.

2.4 Euthanasia and Other Jurisdictions

Australia

All forms of euthanasia are currently illegal in all states and territories of Australia. Private member's bills for either physician assisted suicide or euthanasia over the last decade and a half have been introduced into state or territory parliaments around the country with some frequency. The only time such a Bill has been successful was in the Northern Territory in 1995 when the Rights of the Terminally Ill Bill was introduced as a Private Member's Bill by the Chief Minister. When the Northern Territory Legislative Assembly passed the *Rights of the Terminally Ill Act 1995 (NT)* (ROTI Act) it became the first jurisdiction in the world to permit both physician-assisted suicide and active voluntary euthanasia in some circumstances.

Four people died under the Act before it was over-ridden by Kevin Andrew's *Euthanasia Laws Act 1997*. The Euthanasia Laws Bill 1996 (Cth) was passed in the Federal Parliament to supersede euthanasia laws in the territories of the Northern Territory, the Australian Capital Territory and Norfolk Island, using its power under Section 122 of the Australian Constitution. At the time of writing, Senator Bob

¹² The question asked to participants in the survey was 'Thinking now about voluntary euthanasia. If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovery asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?'. The question that was posed to respondents was the same as in the 2002 Roy Morgan Research poll. In both surveys respondents were contacted by telephone.

Brown, the Leader of the Australian Greens representing Tasmania, has introduced a Private Member's Bill into the Senate to repeal the Federal *Euthanasia Laws Act 1997* to restore the rights of the territories to make laws for the terminally ill. The ROTI Act is discussed in more detail in section five below.

Overseas

A small number of overseas jurisdictions have enacted legislation related specifically to forms of euthanasia. These include the State of Oregon in the United States, the Netherlands, Belgium, and, most recently, Luxembourg. In Switzerland euthanasia is not legal, but doctors are not prosecuted for practicing physician assisted suicide. Oregon's Death with Dignity Act (DWDA), implemented in 1997, has been particularly influential in the creation of the Victorian Bill, therefore particular focus will be given to the provisions contained within Oregon's legislation and the similarities and differences between Oregon's Act and the proposed Victorian legislation. The DWDA, and research conducted on the Oregon experience of physician assisted suicide are discussed in detail in sections five and six below.

The country with the longest experience with the practice of euthanasia is the Netherlands. However, these practices were not codified into statute law until 2002. The Netherlands legislation and research on the Netherlands experience with euthanasia and physician assisted suicide are discussed in detail in sections five and six below. It should also be noted that there are a number of other overseas jurisdictions in which attempts have been made over the last decade and a half to introduce various forms of legalised euthanasia without success. These include over 20 of the states of the United States. State legislatures in states such as California, New York and Vermont have each dealt with a number of bills concerning euthanasia, which have either not been voted on, or defeated in committee or on the floor of the House.

3. The Bill

3.1 Second Reading

On 11 June 2008 Greens Member Colleen Hartland gave the second reading speech for the Medical Treatment (Physician Assisted Dying) Bill 2008 (henceforth 'the Bill'). The purpose of this Bill, as Ms Hartland states, is 'to allow a person who is suffering intolerably from a terminal or advanced incurable illness from which there is no reasonable prospect of recovery to seek and obtain medical assistance to die peacefully on their own terms'.¹³

Ms Hartland cites the Oregon legislation as being influential in the development of the Victorian legislation and notes that Oregon's law has allowed physicians, patients and families 'to have open and honest conversations about all the available options'. The second reading speech outlines that the phrase 'physician-assisted dying' is given to the title of the Bill to emphasise that assistance is provided only at the patient's request and that the patient will 'take the drug themselves, knowing that it will end their life'. This distinguishes 'physician-assisted dying' from involuntary forms of

¹³ Victoria, Legislative Council (2008) *Debates*, 11 June 2008, pp. 2169-2175.

euthanasia. An assisted death under the provisions of this Bill is also not to be interpreted as suicide for the purpose of insurance, contracts and other legal arrangements, ‘recognising the sufferer’s rational decision and rigorous qualification process’. Ms. Hartland states that this is consistent with the cause of death recorded in cases where patients have hastened death by refusing medical treatment.

In accordance with section 28 of the *Charter of Human Rights and Responsibilities Act 2006*, Ms Hartland addresses, in her statement of compatibility, several sections of the Charter that relate to the Bill, these being:

- section 9: right to life and right not to be arbitrarily deprived of life; and
- section 10: protection from torture and cruel, inhuman or degrading treatment; and
- section 14: freedom of thought, conscience, religion and belief; and
- section 15: freedom of expression.

Ms Hartland states that the Bill is compatible with the above human right protections as the Bill does not ‘arbitrarily deprive’ an individual of life (i.e. against the sufferer’s beliefs or wishes).

3.2 Key Features of the Bill

The following section outlines the key features of the Bill.

Conditions for Physician Assisted Dying

The Bill outlines several conditions under which the treating doctor may provide assistance. These are outlined in clause 5 of the Bill. Prior to detailing these requirements, the Bill states that doctors must ‘always assume that persons usually have a strong wish to continue with life’ and that the request for assistance to end life ‘is an unusual request that is treated with both caution and respect’ (clause 4). In order for a sufferer to qualify for physician assisted dying, all of the following conditions must be met.

That the sufferer:

- Makes a request that the treating doctor provide assistance to that sufferer to end his or her life;
- Be an adult;
- Be mentally competent at all times;
- Be informed of the nature of his or her illness, its likely course, and medical treatments, including palliative care;
- Has had his or her settled or usual residence in the State of Victoria for a minimum of 12 months;
- Has a terminal or incurable illness that is causing the sufferer intolerable suffering;
- Has received the advice of a doctor practising in palliative care (and an additional consultation if the sufferer has an incurable illness that is not terminal);
- Sees no other medical treatment, including palliative care, as acceptable and likely to relieve the sufferer’s intolerable suffering;
- That the sufferer’s decision to end his or her life has been made freely, voluntarily and after due consideration and is not being influenced by a treatable mental illness; and,

- That 48 hours has lapsed between the signing of Part A and Part C of the Certificate of Request (including an additional cooling off period of 14 days for an incurably ill sufferer).

These conditions being satisfied, the treating doctor must fulfil the following:

- Witnesses the sufferer's signature (or his or her appointed agent) of Part A of the Certificate of Request;
- Have an independent doctor review, interview and examine the sufferer, discussing the case with the treating doctor and the sufferer, and confirm that the sufferer is an adult, mentally competent and is experiencing intolerable suffering from a terminal illness or incurable illness and is not being unduly influenced. The independent doctor must then sign Part B of the Certificate of Request;
- Ensure that Part C is signed by the patient (and witnessed by a person who is not the treating doctor or independent doctor) at least 48 hours after Part A is signed by the patient; and
- Provide copies of all documentation to the State Coroner within 48 hours of the completion of Part C of the Certificate of Request and to the manager of the health care provider before providing assistance.

Furthermore, the treating doctor must not believe that he or she, or the independent doctor, or a close relative or associate of either of them, or the Certificate of Request C witness, will gain a financial or other benefit as a result of the death of the sufferer under the provisions of the Act. The treating doctor must also not be related to the sufferer by blood, marriage or close personal relationship. In addition, either the treating doctor or the independent doctor must have a special or particular knowledge and experience in the sufferer's type of illness. The treating doctor is also responsible for ensuring at various stages that the sufferer is mentally competent and still wants to end his or her life.

Role of the Doctor

There are also provisions about the relationship between doctor and patient and/or the potential benefits a doctor or relative may stand to gain from assisted dying (clause 5(a) and clause 5(r)). The Bill also contains a definition of 'doctor', which in addition to an individual who is a legally qualified medical practitioner in the State of Victoria, also specifies that the individual must have been a legally qualified medical practitioner for at least 5 years.

There are also several conditions that relate to receiving further advice or consultation by medical professionals and health care providers regarding alternative options or assessments of medical competency. Importantly, as will be discussed below, the conditions for terminally ill patients as opposed to those who are incurably (but not terminally) ill are different. However, all sufferers must receive the advice of a doctor practising in palliative care (clause 5(e)) and an independent doctor must review, interview and examine the sufferer, discussing the case with the treating doctor and the sufferer. Throughout this process the independent doctor must confirm the treating doctor's observations that the patient is an adult, is mentally competent, is experiencing intolerable suffering from a terminal illness or incurable illness and that the patient's request for assistance in dying is made with due consideration and without undue influence (clause 5(m)).

The following provision, clause 5(n) requires that either the treating doctor or the independent doctor has special or particular knowledge and experience in the sufferer's type of illness. The Bill requires that the sufferer must be fully informed of the nature of his or her illness, its likely course, and the medical treatments, which might be available, including palliative care (clause 5(d)).

Residency

To avoid so-called 'death tourism', a provision relates specifically to the sufferer having had his or her settled or usual residence in the State of Victoria for a minimum of 12 months (clause 5(b)). It is the treating doctor's responsibility to ensure this condition is met. The Northern Territory *Rights of the Terminally Ill Act 1995* made no such provision and consequently had notable incidences of suffering individuals travelling interstate in order to have their deaths assisted. There have also been news reports of similar incidences occurring overseas, most notably with several British couples who flew to Switzerland in order to have their deaths assisted.¹⁴

Defining Assistance

The Bill defines assistance (in clause 3) as giving information, the prescribing of a drug, the preparation of a drug, the providing of a drug and the providing of assistance to the sufferer to ingest a drug. This describes the roles that the treating doctor, independent doctor, pharmacist and appointed agent (if any) fulfil with regards to the Act. The Bill also gives the Health Minister a role in issuing guidelines in relation to the procedures followed and other administrative matters (clause 20). The Health Minister may issue guidelines, for example, in respect of the provision of the lethal dose to the sufferer and the disposal of any remaining drug. The Bill is quite clear in stating that 'assistance' cannot be given by way of an injection through a needle, as was a method utilised in the period of legalised physician-assisted dying in the Northern Territory.

Mental Competency

There are also provisions that relate to the mental stability and competence of the sufferer. These do not exclude a sufferer who is also suffering from a mental illness from obtaining assistance under the Act, unless the suffering caused by the mental illness is influencing the sufferer to make the decision to end his or her life prematurely. Intolerable suffering is broadly defined to include not only physical suffering, but psychological and existential suffering and/or distress.

The individual must be mentally competent at all times throughout the process. At several stages in the process the treating doctor is required to ensure the sufferer is mentally competent, that no alternative options are acceptable to the sufferer and that the sufferer is making a decision that is free, voluntary and after due consideration (for example, see clauses 5(f), 5(g), 5(h), 5(i), 5(j)). The independent doctor is also required to confirm the sufferer's mental competency (clause 5(m)). After all the steps have been followed, including the consultation with the independent doctor and the signing of all forms, the treating doctor must, at the stage of providing assistance, make a final check that the sufferer is still mentally competent and still wants to end his or her life (clause 5(s)).

¹⁴ M. Leidig & P. Sherwell (2004) 'Swiss to crack down on suicide tourism', *Telegraph*, 14 March.

A sufferer may be physically incompetent and may appoint an agent to assist the process if he or she is physically unable to partake in certain aspects, such as in signing the Certificate of Request or ingesting the drug (clause 5(k)). However, if at any stage the sufferer loses the ability to be mentally competent, the request for assistance would be invalid and would have to be denied by the treating doctor. The Bill allows for the sufferer to appoint an agent to assist the process, even to the point of being physically assisted in ingesting the medication, but it does not allow for an 'advanced directive' in the instance that a sufferer is no longer mentally competent to consent to decisions being made.

Incurable Illness

The Bill allows a mentally competent adult who is suffering intolerably from an incurable illness to seek assistance under the Act. Incurable illness is defined in the Bill as meaning 'an advanced illness which is incurable despite all reasonable and available medical treatment, but is not a terminal illness'. Furthermore, the sufferer must define their suffering as intolerable, which is defined as 'profound suffering and/or distress, whether physical, psychological or existential'.

In addition to the conditions outlined above, a sufferer with an incurable illness that is not terminal must fulfil further requirements to be eligible to receive assistance in dying. These include that the treating doctor obtain the opinion of a qualified psychiatrist that the sufferer is mentally competent and not suffering from a treatable mental illness that could influence his or her decision to request assistance (s. 5(j)(i)).

The treating doctor must also arrange a consultation with a doctor who practices in palliative care to advise the sufferer of the availability of palliative care and of its possible benefits (s. 5(j)(ii)). This provision is similar to the provision in section 5(e) where a sufferer (of both terminal and incurable illness) must receive the 'advice' of a doctor practising in palliative care. The difference is that a patient suffering from a terminal illness only needs to receive 'advice', while a patient suffering from an incurable illness must receive 'advice' and a further 'consultation' with a doctor practising in palliative care. In addition, following the palliative care consultation and the psychiatric assessment, a patient suffering from an incurable illness must allow a cooling off period of 14 days to take place before signing Part A of the Certificate of Request (s. 5(j)(iii)).

Immunity

The Bill includes several protections for doctors and health care providers, both in providing assistance and in declining assistance. In particular, clause 7 grants immunity from criminal, civil or disciplinary proceedings to treating doctors who provide assistance in accordance with the Act. This does not relieve the doctor from liability for negligence in providing the assistance. This immunity also extends to nurses, health care providers or pharmacists under instruction from the treating doctor and any person who is present at or before the time the sufferer ends his or her life. Clause 10 also protects a person providing assistance under the Act from censure, discipline, suspension, loss of licence, certificate or other authority to practice, loss of privilege, loss of membership or other prejudicial pressure or penalty for anything that, in good faith and without negligence, was done or refused to be done by the person.

Related to informing a patient of his or her options in seeking an assisted death, Clause 8 states that a doctor, nurse, lawyer or other individual is immune from criminal, civil or disciplinary proceedings in relation to providing information or advice to a sufferer, agent or sufferer's relatives in good faith concerning this Act or what can be done under it. This provision distinguishes informing the patient of their options in seeking an assisted death under the Act with offences in both Victorian State and Commonwealth legislation related to aiding and abetting suicide. Section 6B(2) of the Victorian *Crimes Act 1958* states that a person who;

- (a) incites any other person to commit suicide and that other person commits or attempts to commit suicide in consequence thereof; or
- (b) aids or abets any other person in the commission of suicide or in an attempt to commit suicide

shall be guilty of an indictable offence and liable to level 6 imprisonment (5 years maximum).¹⁵

With further regard to suicide, the Bill explicitly states that none of the actions taken under the provisions of this Act including a death resulting from these provisions, shall constitute suicide, aiding or abetting suicide, mercy killing, manslaughter or homicide (clause 17).

Choice

While the Bill stresses that there is no obligation or duty for a doctor or health care provider to provide assistance under this Act, the Bill does emphasise that the sufferer must be informed of all his or her options. A doctor declining to provide assistance for conscience, professional or other reasons, must inform the sufferer that other doctors may be willing to provide assistance. Doctors who fail to do so are guilty of an offence with a fine of 5 penalty units being applicable for this offence (clause 9(1)).

However, a doctor must also respect the environment in which he or she is employed. As such, the immunity granted in clause 10 which grants protection for a person providing assistance under the Act from discipline and loss of professional standing does not apply to a 'person who knew or reasonably ought to have known that the health care provider did not allow in its facility or under any arrangement with it, assistance which is provided for in this Act' (clause 10(2)). This provides choice for both the doctor and the health care provider in deciding whether to provide or decline assistance and is intended to cater for the moral, conscience, religious or philosophical stance of individuals, institutions and health care providers.

A fine not exceeding 500 penalty units applies to an organisation, association or health care provider that disciplines, censures or causes other loss of professional standing for a person lawfully providing assistance under the Act where the institution or organisation does not have a known position disallowing assistance under the Act. In short, organisations must not discriminate against doctors who provide or refuse to provide assistance (clause 10(1)). However, the above provision does not apply to a

¹⁵ As mentioned previously, there is also Commonwealth legislation concerning the distribution of materials and information related to assisting suicide, contained within section 474.29A of the *Criminal Code Act 1995*. This section relates more specifically to using a carriage service for transmitting suicide related material and has previously affected the ability of pro-euthanasia websites, such as Exit International, to operate within Australia.

health care provider in respect of a person who provides assistance under the Act in opposition to the policy and ethical framework of the health care provider (clause 10(2)). These provisions imply that institutions, health care providers and organisations need to provide a clear understanding of the policies, ethical structure and values of the institution, provider or organisation, particularly with regards to what kinds of assistance may be allowed, if any, to health care professionals.

Revocation of Request

The sufferer or his or her agent may revoke a Certificate of Request at any time. The Bill states in clause 6 that, 'Immediately upon revocation the sufferer or their agent must return in full to a pharmacist any prescription that has been issued in respect of the Certificate'.

The Role of the Coroner

The State Coroner has a specific role to play within this Bill. In particular, the Coroner is required to be informed of the process at several key stages, receive copies of all documentation and report annually on the implementation and use of the Act.

The treating doctor must send a copy of the Certificate of Request (Parts A, B and C) as well as the Certificate of Appointment of Agent (if any) to the State Coroner within 48 hours of the completion of Part C of the Certificate of Request (clause 12(2)). The pharmacist must also send a copy of the record of fulfilment of the prescription to the Coroner within 48 hours of fulfilment (clause 12(3)). The doctor must provide the Coroner with a copy of the death certificate within 48 hours (clause 16).

If the request is revoked, the Coroner must be informed of the revocation within 48 hours by the treating doctor (clause 6).

Clause 19 stipulates that the Coroner must provide an annual report detailing the nature and frequency of assistance and deaths under this Act. This report must be reviewed by a joint, all-party Parliamentary Committee.

Keeping Records

In addition to the Coroner receiving copies of the documentation outlined above, the health care facility within which the assistance is being provided must also receive copies of the documentation (clause 5(q)). In terms of the patient's medical record and file, if the health care facility declines to participate in the provision of assistance to a sufferer in accordance with the Act and is unwilling to permit any such assistance within its facility, the health care provider must, on request, transfer a full copy of the patient's medical relevant records to the new health care provider. A fine of 5 penalty units applies for health care facilities that fail to abide by this provision (clause 9(2)). All records about a sufferer must remain confidential and may not be disclosed without the sufferer's consent except as this Act or any other law may require (clause 13).

The Death Certificate

Clause 16 states that the certificate of death must note that the person ended his or her life with the treating doctor's assistance. It also states that the cause of death is to be recorded as the terminal illness or incurable illness that led to the request for assistance.

4. Stakeholder Opinion

Proponents for and against physician assisted dying (PAD) are concerned with a myriad of complex ethical, moral and legal questions. The main arguments of both sides however, fall under three key themes: the rights of those involved; the pain and suffering of those involved; and legal and medical guidance. Stakeholder opinion has been detailed under these respective headings below, although the arguments are interrelated and will intersect across the three themes. Some of the arguments detailed here have been expressed by stakeholders themselves, others within more neutral academic publications.

4.1 Rights

Proponents

For proponents of PAD, the rights of the patient and associated ethical considerations are of foremost importance. This stems in part from the civil libertarian context in which the euthanasia movement developed from the 1960s onward, which values the individual's right to determine the course of their own life. As such, dignity, emotional wellbeing and – above all – personal autonomy take precedence over other issues, and are at the heart of the patient's end of life experience. As Monash University ethicist, Professor Helga Kuhse writes, 'pain is not the central issue. The central issue is one of dignity... of respect for the patient's values and beliefs'.¹⁶ Proponents of PAD therefore argue that every patient has the right to make a rational decision about death; the right to have control over their life (and therefore their death); and the right to die with dignity surrounded by family and friends.

The concept of autonomy has been defined in this context as 'the ability to choose and the freedom to choose between competing conceptions of how to live'.¹⁷ Proponents of PAD readily accept that this right to personal autonomy may mean that a person chooses to continue fighting their illness and/or to enter palliative care. It is the ability to choose which is important, and for that choice to be respected by family, the medical profession, and the state. Dr Rodney Syme, a Victorian physician who has argued prominently for PAD legislation, believes that 'if patients wish to end their lives because of great suffering, then that is essentially their moral right and their responsibility'.¹⁸

These rights-based arguments have been shaped by the ethics of utilitarian and humanist philosophy, which respectively hold that the moral worth of an action is defined by the benefit to those involved, and that an individual has the capacity to make rational, autonomous choices. Peter Singer, the Australian bioethicist and philosopher, has argued that terminally ill patients who choose to end their lives are not harming others:

¹⁶ H. Kuhse (1994) *Willing to Listen, Wanting to Die*, Ringwood, Penguin Books, pp. 255–256.

¹⁷ House of Lords (1994) *Report of the Select Committee on Medical Ethics*, House of Lords Paper, viewed 5 June 2008, < <http://www.parliament.the-stationery-office.co.uk>>.

¹⁸ R. Syme (1994) 'From Innocent to Advocate', in Kuhse (ed.) op. cit., p. 165.

The state has no grounds for interfering, once it is satisfied that others are not harmed, and the decision is an enduring one that has been freely made, on the basis of relevant information, by a competent adult person.¹⁹

Indeed, other philosophers and stakeholders contend that to deny a competent adult such a choice may actually cause them harm, not only physically but in an existential and emotional sense as well. John Harris, a professor of bioethics and applied philosophy at the University of Manchester, has posited that respect for other people essentially involves concern for their welfare and respect for their wishes. In the case of PAD, if these cannot co-exist one must ultimately give way to the other, because concern for an individual's welfare will 'cease to be legitimate' if it encroaches on their personal autonomy.²⁰ Legal philosopher Ronald Dworkin has taken this argument further by identifying euthanasia as an issue of such importance that no individual can accept 'other people's orders' on the subject. To impose such orders on a patient who doesn't believe in them is grossly unjust:

Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.²¹

To reject the right of an individual to self-determine their own death, a fundamental event in our existence, is, according to Melbourne journalist the late Pamela Bone, an anomaly in a contemporary Western world where the concept of human rights is so prominent and conclusive.²²

Opponents

Opponents of PAD counter these rights-based arguments with two ethical and moral principles: that no one has the right to kill, and that no one has the right to ask another to kill. These are based on the belief that the taking of a life, whether through suicide or homicide, is intrinsically wrong. While for some opponents of PAD these arguments are based on religious beliefs, they are generally presented as fundamental components of common law and civil society.

The intrinsic wrongness of homicide is in concert with the philosophical frameworks discussed above: within an individual's capacity for self-determination it is, as Singer stated, essential to ensure 'that others are not harmed'. It is on this very point that arguments for and against PAD align, despite their competing intentions and vastly different conclusions. Opponents of PAD have labelled the idea that it does not impact harmfully upon others as 'mere self-deception', and are concerned with the potential harm caused at a broad, societal level. In its submission to the Senate Legal and Constitutional Committee's Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008, the Australian Christian Lobby (ACL) referenced Article 29 of the *Universal Declaration of Human Rights 1948*, which states that people may be subjected to limitations on their freedom partly in order to

¹⁹ P. Singer (1994) *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, Melbourne, Text Publishing, p. 197.

²⁰ J. Harris (1995) 'Euthanasia and the Value of Life', in J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge, Cambridge University Press, p. 11.

²¹ R. Dworkin (1993) *Life's Dominion*, London, Harper Collins, p. 217.

²² P. Bone (2008) 'Foreword' to R. Syme, *A Good Death: An Argument for Voluntary Euthanasia*, Carlton, Melbourne University Press, p. vii.

meet ‘the just requirements of morality, public order and general welfare in a democratic society’.²³

Central to their desire to preserve this morality and ‘general welfare’, opponents have argued that rather than enhancing an individual’s autonomy, legalised euthanasia actually ‘rejects the innate value of each person’.²⁴ This is closely linked to the idea of a ‘slippery-slope’, which shall be discussed later in this section, and was cited by the House of Lords Select Committee on Medical Ethics in 1994:

... society’s prohibition of intentional killing... [is] the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.²⁵

Further, opponents have argued that the idea of a terminally ill patient having the capacity to make an autonomous, rational decision is unsound; external and internal factors may heavily influence a patient’s choice. They may feel like a burden upon their carers and family or, as bio-ethicist Margaret Battin articulates, be suffering from depression:

... a frequent concomitant of terminal illness that narrows one’s view of the range of alternative futures...[which compounds the fact that] the person making this choice can have no objectively confirmable belief about what might happen to him after suicide.²⁶

Opponents believe these external and/or emotional pressures negate a patient’s autonomy. Dr. Robert Twycross, a palliative care specialist from the University of Oxford, has cited the apparent prevalence of depression, anxiety or ‘emotional adjustment disorders’ amongst patients who are suicidal. They have ‘fewer psychological resources’ and ‘have made a poorer adjustment to their illness’ than other patients.²⁷ These difficulties often stem from an inability to accept death, a feeling of having lost control and self-determination. Opponents do not believe that PAD is an adequate means of restoring a patient’s sense of control; rather, some fear that a suicidal patient’s request for euthanasia is a misplaced desire to regain control, which – most importantly - may not be binding.²⁸

²³ Australian Christian Lobby (2008) *Submission to the Senate Legal and Constitutional Committee’s Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, ACL, p. 7.

²⁴ *ibid.*, p. 3.

²⁵ House of Lords (1994) *op. cit.*

²⁶ Battin (2005) *op. cit.*, p. 27.

²⁷ R. Twycross (1995) ‘Where there is Hope, there is Life: a View from the Hospice’, in Keown (ed.), *op. cit.*, p. 145. See also: R. Hunt (1994) ‘Palliative Care: the Rhetoric-Reality Gap’, in Kuhse (ed.), *op. cit.*, p. 120; *Lateline* (2002) ‘Euthanasia Debate’, ABC Television, online transcript, viewed 10 June 2008, <<http://www.abc.net.au>>.

²⁸ See further: M. Cosic (2003) *The Right to Die? An Examination of the Euthanasia Debate*, Sydney, New Holland, pp. 240–242.

4.2 Pain and Suffering

Proponents

The pain and suffering experienced by terminally and incurably ill patients is consistently cited by proponents of PAD as the fundamental, compelling reason for their advocacy. It is at the heart of the issue, and an essential tenet of the rights-based approach discussed above: for a terminal or incurably ill patient to endure significant pain and suffering is needless and cruel. Moreover, a patient has the right to judge the level of suffering that is acceptable and tolerable to his or herself.

Consultant Ethicist Nicholas Tonti-Filippini is an opponent of PAD, but he came to realise two things through his consultations with John McEwan, the quadriplegic Victorian man whose case helped initiate the *Medical Treatment Act 1988*. McEwan's condition was not improving and he could not be cured:

...John had no moral obligation to continue the burdensome treatment he was receiving (even though it was desirable that he should try to do so); and secondly, that no one had the right to demand of him that he endure the treatment.²⁹

More directly, proponent Dr Rodney Syme has vividly recalled the 'impotence, shame and guilt' that he felt at being unable to assist terminally ill patients during his early career; worse still, he knew these feelings were incomparable to the patients' 'emotional and physical anguish'.³⁰

Most significantly, the issue of pain and suffering has drawn on religious tenets of compassion and mercy. Victorian Liberal MP Ken Smith has felt compelled by his Christian beliefs to advocate for PAD: 'God, my God doesn't want his people to suffer pain and agony from terminal illness'.³¹ Smith also believes that family members should be spared the anguish of watching their loved ones deteriorate without being able to assist. Greens MLC Colleen Hartland defines herself as a Christian, and has also ascribed her support for PAD to having witnessed the deaths of loved ones.³²

The main point of contention between proponents and opponents of PAD on this subject is the efficacy of palliative care. Firstly, the quality of care is dependent on wider bureaucratic and administrative forces, such as funding, demand and the successful integration of specialised services. Secondly, given the heterogenous nature of illness and pain, proponents do not believe that palliative care can provide treatment that is sufficient or acceptable to every patient. PAD would therefore be 'a matter of mercy'.³³ Certainly proponents recognise the benefits of good palliative care; Syme believes it is 'usually very successful'. Others are more frank; Australian

²⁹ N. Tonti-Filippini (1994) 'Withdrawing Ventilation at a Patient's Request', in Kuhse (ed.) op. cit., p. 175.

³⁰ R. Syme (1994) 'From Innocent to Advocate', in Kuhse (ed.), op. cit., pp. 159–162.

³¹ See K. Smith (2007) 'Dying with Dignity', Speech, Death With Dignity Victoria, viewed 11 June 2008, <<http://www.dwdv.org.au>>.

³² See further: Victoria, Legislative Council (2006) *Debates*, 20 December, p. 100; Victorian Greens (2008) *Current Campaigns*, viewed 6 June 2008, <<http://www.electedgreensvictoria.org.au>>.

³³ Battin (2005) op. cit., p. 29.

palliative care specialist Roger Hunt has plainly stated that hospice and palliative care may be inadequate for some patients, due to both their physical and emotional suffering:

The dying person undergoes enormous physical and mental changes, many of which are the source of suffering. ... hopelessness, futility, meaninglessness, disappointment, remorse, and a disruption of personal identity are frequently experienced... I suspect that many of the psychological and existential problems of dying patients cannot be solved by palliative intervention.³⁴

Hunt therefore believes that the idea of providing 'a pain-free, comfortable death with dignity' through hospice or palliative care 'is usually unobtainable and should not be promised'. The danger here is that the expectations of staff and patients become 'unrealistically high', ultimately damaging the morale of those involved and their relationships with each other. Hunt is chiefly concerned with the outcome for patients suffering from such cruel, degenerative conditions as AIDS, cancer and motor neurone disease. For these patients, Hunt says, the idea that hospice or palliative care can relieve *all* suffering 'is a rhetorical myth'.³⁵

Opponents

Opponents of PAD seriously question these claims, primarily in the belief that modern palliative care serves a vital purpose for the patient and within the community as a whole. As Nicholas Tonti-Filippini has noted, the real question in the PAD debate should be about what we as a society can do for patients 'while they are alive'.³⁶

For the patient, opponents of PAD believe that palliative care techniques have developed to the point that they can relieve virtually all pain. Patients can obtain 'physical comfort'.³⁷ The small part that cannot be relieved by pharmaceutical medicine is the emotional distress, which Twycross argues manifests itself through physical suffering. He writes that some patients do not initially obtain relief 'because their pain is being used as a channel for the expression of mental anguish'. Herein lies the role of integrated palliative care services, to calm a patient, to help them to come to terms with their fate and prepare them for it. Through holistic care, the patient can reach a state of acceptance that would otherwise not happen should they have access to PAD.

Further, opponents believe such acceptance can only occur over time, after working through the desire for death which, as indicated in the previous section, may not last. Sydney author Miriam Cosic interviewed hospice and palliative care workers for her book, *The Right to Die?* (2003) who spoke of their firm belief in a patient's need for attentive, supportive care to ease their existential pain:

...I say to them, 'So do you want to end your life? Or do you want to end the pain?... I've never heard anyone say, 'I want to end my life and I want to end it now'.³⁸

³⁴ Hunt (1994) op. cit., pp. 119–121.

³⁵ *ibid.*, p. 121.

³⁶ J. Maley (2007) 'The troubling question of life or death', *Sydney Morning Herald*, 29 January.

³⁷ See further: Twycross (1995) op. cit., pp. 162–163.

³⁸ Cosic (2003) op. cit., pp. 240–241.

...What they're really saying is, 'I am suffering. Listen to me'.³⁹

Opponents believe that a large proportion of patients who request euthanasia have second thoughts. Australian-Canadian bioethicist Margaret Somerville told the ABC's *Lateline* in 2002 that over 40 per cent of Oregon patients never use the euthanasia drug they are prescribed 'when they are given significant palliative care interventions'.⁴⁰ Through 20 years of hospice work, Twycross also found that 'patients who request euthanasia almost invariably change their minds'.⁴¹

For opponents, any decision to hasten death is therefore laden with uncertainty. Moreover, choosing a deliberate, quick death can be emotionally disadvantageous for those involved. Twycross has argued that to administer euthanasia at the height of a patient's physical distress does not allow them or their family to reach a kind of 'peace'. Cosic has called this 'the process of summation which gives meaning to everything that came before'.⁴² Opponents of PAD couch the process in various religious and non-religious terms; it is seen as spiritual, potentially redemptive, a manifestation of love and 'an agent of healing'.⁴³

Within the community, palliative care represents society's duty to care for the vulnerable and the elderly. It is the point at which an individual 'receives' from the community which they have hitherto contributed to.⁴⁴ Opponents believe that legalising PAD will undermine this fundamental social custom, further promoting a kind of contemporary individualism that de-values the less fortunate. The Australian Christian Lobby (ACL) expressed these concerns in its recent submission to the Senate Inquiry:

Euthanasia emphasises a person's worthlessness and isolation. Instead we should emphasise community support and solidarity with those who are suffering.⁴⁵

To extrapolate these concerns further, opponents believe that elderly or incapacitated people will feel pressured to opt for PAD, or tempted to choose a 'quick-fix' to their physical pain. In doing so, they will not deal with any underlying fear, loneliness or existential anxiety. Good palliative care is the alternative: as Twycross writes, it means a patient can obtain pain relief, be treated for depression, and 'no longer feel abandoned and alone'.⁴⁶

³⁹ *ibid.*, p. 241.

⁴⁰ *Lateline* (2002) *op. cit.*

⁴¹ Twycross (1995) *op. cit.*, p. 155.

⁴² Cosic (2003) *op. cit.*, p. 240.

⁴³ Twycross (1995) *op. cit.*, p. 155.

⁴⁴ See further: Maley (2007) *op. cit.*

⁴⁵ Australian Christian Lobby (2008) *op. cit.*, p. 16.

⁴⁶ Twycross (1995) *op. cit.*, p. 155.

4.3 Legal and Medical guidance

Proponents

For proponents, the movement for PAD is an exigency that can no longer be ignored. Euthanasia is practised already, in many and varied forms. It is unregulated, undocumented and open to abuse. Where patients should have the right to a dignified death, they are instead faced with uncertainty and isolation. Proponents believe that a legal framework for PAD, complemented by appropriate medical guidance, will ensure the safety and peace of mind of all involved.

Currently, the proscription of PAD places patients in a bind; to take their own lives alone, using crude, unreliable and covert methods, or to ask a family member to assist them and then live with the legal and emotional consequences. The agonising results of these efforts in Australia have been catalogued by Khuse in her 1994 book, *Willing to Listen: Wanting to Die*. Prefacing the very personal, often anonymous stories of suicide and assisted suicide, Khuse argues that as a pluralist, civilised society we must take responsibility for dealing with death, because ‘the cost of continued indifference is too high’.⁴⁷

Proponents believe this indifference primarily exists within executive government. According to Morgan / Gallup Polls from 1962 to 1995, and a more recent Newspann from 2007, the Australian public has expressed increasing and widespread support for a legalised form of euthanasia.⁴⁸ More tellingly, there are prominent cases in Australia and overseas in which persons tried in relation to assisted suicide or attempted assisted suicide have been acquitted or given light sentences. Syme argues that ‘the Australian judiciary has been sending a persistent signal to our parliaments on the issue... but our politicians have been deaf to this signal’.⁴⁹

As proponents point out, two equivocal forms of euthanasia are already practiced every day in Australia and they are both unsatisfactory. The first is a patient’s right to refuse medical treatment. Yet the mere refusal of life sustaining treatment may not be sufficient for some patients; indeed, it can cause a lingering, cruel death. As Syme writes in his recent book, *A Good Death*, this process essentially means that a patient could die of dehydration ‘while still being cognitively aware’.⁵⁰ Moreover, Syme believes that patient directives are not always respected by medical staff, particularly as the exact definition of ‘life sustaining treatment’ is contested.

The second is the doctrine of ‘double effect’. A practice carried out under this doctrine is sometimes referred to as ‘terminal sedation’. This procedure relies on ‘maximum palliation’, in order to relieve suffering, with the possible but *unintended* consequence of hastening a patient’s death. Approved by Pope Pius XII in the late 1950s, and again by the AMA in the 1990s, according to proponents it remains legally undefined in many Australian jurisdictions; while an interpretation of the *Medical*

⁴⁷ Kuhse (ed.) op. cit., pp. 1-5.

⁴⁸ See further: R. Hunt (1996) ‘Clinical, Legal and Ethical Aspects of Euthanasia’, in L. Burns and I. Hunt (ed.) *The Quality of Death: Euthanasia in Australia*, Adelaide, Flinders University Press, p. 70; H. Ife (2007) ‘Eight Out of 10 Support Euthanasia’, *Herald Sun*, 5 March.

⁴⁹ R. Syme (2008) *A Good Death: An Argument for Voluntary Euthanasia*, Carlton, Melbourne University Press, p. 53. See also: Singer (1994) op. cit., pp. 134–146.

⁵⁰ Syme (2008) op. cit., p. 110.

Treatment Act 1988 (Vic) may indicate tacit approval, the theory, implementation and legality of this procedure remain problematic.

Proponents and opponents alike continue to debate the ethical distinction between ‘killing’ and ‘letting die’, while medical staff are left in a state of uncertainty; in Syme’s opinion, ‘patients don’t know that they can ask for it, and doctors don’t know that they can deliver it’.⁵¹ Other anecdotal evidence suggests that terminal sedation is extremely common in Australia, but is largely undocumented and unregulated.⁵²

Overall, proponents firmly conclude that this is a most imperfect situation which can only be remedied through the creation of a legal framework. Therein the position of patients and medical staff would be clarified and secure, and the procedure itself safer for all concerned; as Battin argues, legalisation ‘and the openness it brings are the best protection against [any] abuse’.⁵³ Far from PAD being over-emphasised and patients unable to trust their physicians, proponents predict that the relationship between patients and medical staff would greatly improve. Proponents believe that legalised PAD will allow frank, trusting and normalised discussion between those involved:

The rapport that can be established with a patient through such honest discussion is thoroughly rewarding to doctor and patient.⁵⁴

By being fully informed of all their options, patients will have peace of mind and can make a rational, supported decision with full confidence in their physician’s advice.

Opponents

Opponents have a number of concerns about the outcome of legally and medically endorsed PAD. These are based upon extrapolative fears of publicly sanctioned and institutionalised suicide, in which the role of the patient and the physician are fundamentally altered. This would have harmful and far-reaching consequences for the integrity of the medical profession and the community as a whole.

Firstly, and in response to the arguments presented above, opponents predict that legalised euthanasia would irreparably compromise the medical profession. Doctors would become ‘executioners’, with greater influence over the survival of their patients.⁵⁵ The trust that patients customarily place in medical staff would be broken. Opponents believe this issue is particularly pertinent to Indigenous Australians and other disadvantaged minority groups, who may be wary of the health system already.⁵⁶

Furthermore, any discussion of PAD could be heavily influenced by the personal opinions of those involved rather than the best interests of the patient. Peripheral

⁵¹ Cosic (2003) op. cit., pp. 195–196. See further: Battin (2005) op. cit., pp. 22–24; Singer (1994) op. cit., p. 157; J. Finnis (1995) ‘A Philosophical Case Against Euthanasia’, in J. Keown (ed.), op. cit., pp. 25–30.

⁵² A. Vedig (1996) ‘Euthanasia in Hospitals’, in L. Burns and I. Hunt (ed.) op. cit., pp. 60–66. See also: Singer (1994) op. cit., pp. 154–155.

⁵³ Battin (2005) op. cit., p. 27.

⁵⁴ Syme (1994) op. cit., p. 160.

⁵⁵ Australian Christian Lobby (2008) op. cit., p. 3.

⁵⁶ See further: Maley (2007) op. cit.

considerations, such as hospital resources and a patient's financial situation may also come into play. As the ACL has argued, the original intention of PAD would change:

It places vulnerable patients at risk as the so-called 'right to die' solidifies into the 'duty to die' to spare families or the government the burden of care. Voluntary euthanasia is never a truly free decision and its availability leads to the inevitable practice of involuntary euthanasia as doctors and family members become used to determining which patients should live and which ones should die.⁵⁷

The safeguards that a legalised version of PAD will contain may also be circumvented. Opponents believe that patients who are initially denied PAD will engage in 'doctor shopping' to achieve the desired professional approval. While these are all predictive arguments, they are based on the sense that legalised PAD contradicts an essential principle of the Hippocratic Oath.

Opponents of PAD also feel that the current alternative – the 'double effect' – is more than sufficient. The doctrine is supported by the Australian Medical Association, the American Medical Association, and similar professional bodies worldwide. As mentioned above, the Australian Medical Association's position statement asserts that 'the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death' does not constitute either PAD or any form euthanasia.⁵⁸

Finally, and most importantly, opponents believe that to legalise PAD and therefore formally endorse a specific form of suicide risks the so-called 'slippery-slope' of policy making and public opinion, in which the idea of other more morally problematic forms of euthanasia may gain currency. The 'slippery-slope' also refers to the possibility that PAD will become so routine and normalised as to transgress the welfare of those involved - elderly or vulnerable patients may feel pressured to choose PAD by their families or physicians.

The 'slippery-slope' has become a popular rhetorical and conceptual tool for opponents of euthanasia, involving 'predictive empirical issues' about possible future consequences, and constituting 'a supplement' to the idea that killing is morally wrong.⁵⁹ It also articulates the trepidation that stakeholders contend with in contemplating PAD. Returning to the more elementary arguments about the wrongness of killing, it is a sense that legalising the procedure transgresses fundamental medical, ethical and social boundaries, as expressed here by Twycross:

The dangers of crossing the Rubicon are so great that, even though I may be forced by extreme circumstances to put one foot into the river, I will continue to respect the necessity of this ultimate barrier.⁶⁰

⁵⁷ Australian Christian Lobby (2008) op. cit., p. 3.

⁵⁸ See further: Australian Medical Association (2007) op. cit., viewed 17 June 2008, <<http://www.ama.com.au>>.

⁵⁹ Battin (2005) op. cit., pp. 26-27.

⁶⁰ Twycross (1995) op. cit., p. 166.

In Battin's opinion, the risk of a 'slippery-slope' is the sole reason why particular academics and physicians have not supported legalising forms of euthanasia, despite their acceptance of the practice in principle.⁶¹

5. Approaches to Physician Assisted Dying in Other Jurisdictions

5.1 Within Australia

Physician assisted dying is currently illegal in all states and territories of Australia. Private member's bills for either physician assisted suicide or euthanasia over the last decade have been introduced into state parliaments around the country with some frequency; South Australia in particular appears to introduce a Bill almost annually. Often these Bills sit on the notice papers until the Parliament is prorogued. The only time such a Bill has been successful was in the Northern Territory in 1995 when the Rights of the Terminally Ill Bill was introduced as a Private Member's Bill by Marshall Perron, the then Chief Minister of the Northern Territory. Clearly, the difficulty with private member's bills, particularly if they are initiated from Opposition Members, is their inability to have them proceed to a full debate in the Parliament.

In 1995, the Northern Territory Legislative Assembly passed the *Rights of the Terminally Ill Act 1995 (NT)* (ROTI Act) and became the first jurisdiction in the world to permit both physician assisted suicide and active voluntary euthanasia in some circumstances, and under strict conditions. The legislation was in operation for nine months until it was made ineffective by Kevin Andrews' Euthanasia Laws Bill 1996 (Cth) which was passed in the Federal Parliament to supersede euthanasia laws in the territories of the Northern Territory, the Australian Capital Territory and Norfolk Island, using its power under Section 122 of the Australian Constitution.

At the time of writing, Senator Bob Brown, the Leader of the Australian Greens representing Tasmania, has introduced a Private Member's Bill into the Senate to repeal the Federal *Euthanasia Laws Act 1997* and thereby restore the rights of the Northern Territory, the Australian Capital Territory and Norfolk Island to make laws for the terminally ill. On 12 March 2008, the Senate referred the above Bill to the Senate Standing Committee on Legal and Constitutional Affairs for inquiry and report by the 23 June 2008.⁶²

Northern Territory

The Rights of the Terminally Ill Act 1995 (NT) (ROTI Act)

From enactment in July 1996 to its invalidation by Federal legislation in March 1997, the ROTI Act was in operation for 9 months. Its short history was controversial, with several failed attempts to have the legislation repealed from within the NT Legislative Assembly. There was also a challenge to the validity of the legislation in the Northern Territory Supreme Court by the President of the Northern Territory Branch of the Australian Medical Association, Dr Chris Wake, and an Aboriginal Uniting Church Minister, the Reverend Dr Djiniyini Gondarra. It was rejected by a majority of two to

⁶¹ Battin (2005) op. cit., p. 21.

⁶² Senate Legal and Constitutional Committee (2008) 'Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008', viewed 11 June 2008, <<http://www.aph.gov.au>>.

one. An appeal against the decision was made to the High Court of Australia, but the application was adjourned pending the outcome of Kevin Andrews' Private Member's Bill to overrule the NT legislation in the Federal Parliament. Kevin Andrews' Euthanasia Laws Bill 1996 (Cth) was passed by the House of Representatives on December 9 1996 with a vote of 88 to 35 and in the Senate on March 25 with a vote of 38 to 33.

A Selective Chronology of the ROTI Act

February 22 1995

On the February 22 1995, Marshall Perron, the then Chief Minister of the Northern Territory introduced The Rights of the Terminally Ill Bill 1995 (NT) into the Legislative Assembly of the Northern Territory as a Private Member's Bill.⁶³

May 25 1995

It was passed on May 25 after 50 amendments had been made to the Bill and at a vote of 15 votes to 10. It then became the first jurisdiction in the world to permit both physician assisted suicide and active voluntary euthanasia in some circumstances, and under strict conditions.⁶⁴ There was no requirement in the Act for the person to be a Territory resident.

Main Features of the *Rights of the Terminally Ill Act 1995* (NT) (ROTI)

- The Act confirms the right of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life in a humane manner; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance; to provide procedural protection against the possibility of abuse of the rights recognised by the Act;
- The definition of "assist" under the Act states: in relation to the death or proposed death of a patient, includes the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of a substance to the patient;
- This authorises both physician assisted suicide and active voluntary euthanasia;
- The patient must have reached 18 years of age.

Under the ROTI Act:

- A terminally ill patient, experiencing pain, suffering, and distress to an extent deemed unacceptable, could request a medical practitioner for assistance to end his or her life;
- The doctor must be satisfied on reasonable grounds that the illness was terminal and would result in the patient's death in the normal course and without application of extraordinary measures;

⁶³ His second reading speech and the Bill, Act and Amendment Act can be viewed at <http://www.nt.gov.au>.

⁶⁴ N. Cica (1997) 'Euthanasia- the Australian Law in an International Context' *Research Paper No. 4 1997-97*, Canberra, Parliamentary Library, p. 2.

- It must also be established that there were no medical measures acceptable to the patient which could reasonably be undertaken to effect a cure, and that any further treatment was only palliative in nature;
- The doctor needs to certify that the patient was of sound mind and making the decision freely, voluntarily, and after due consideration;
- A second medical practitioner, a resident of the Northern Territory, is required to examine the patient to confirm the existence and terminal nature of the illness, and to give an opinion on prognosis to be recorded on the schedule used for certifications under the Act;
- The regulations required that this practitioner hold a qualification in a medical specialty related to the terminal illness, recognised by fellowship of a specialist college in Australia;
- If the first medical practitioner did not have special qualifications in palliative care, defined by the regulations as either 2 years' full-time practice in palliative medicine or not less than 5 years' general practice, a third doctor with such qualifications was required to give information to the patient on the availability of palliative care;
- A psychiatrist was also required to examine the patient and confirm that he or she was not suffering from a treatable clinical depression in respect of the illness;
- The Act required a period of 7 days to pass between the initial request to end life made to the first doctor and the patient's signing of an informed-consent form, witnessed by two medical practitioners. A further 48 hours later, assistance to end life would be provided; and
- A death as the result of assistance given under the Act was not taken to be unnatural, but a copy of the death certificate and relevant section of the medical record relating to the illness and death in each case had to be forwarded to the Coroner. The Coroner was subsequently required to report to Parliament the number of patients using the Act.⁶⁵

February 20 1996

The Rights of the Terminally Ill Amendment Bill was passed.

A proposal to insert a sunset clause into the Act failed. The Amendment Bill made the following changes to the Act:

- Increased the number of doctors from 2 to 3 that were required to examine and certify that a patient meets the statutory criteria under the Act;
- Specified that one of the doctors must be a qualified psychiatrist and another must be a specialist in the patient's illness;
- Clarified the qualifications of interpreters.⁶⁶

July 1 1996

The Rights of the Terminally Ill Act (NT) (ROTI) came into effect.

The President of the Northern Territory Branch of the Australian Medical Association, Dr Chris Wake, and Aboriginal leader Reverend Dr Djiniyini Gondarra lodged a writ in the Northern Territory Supreme Court challenging the validity of the

⁶⁵ D. Kissane et.al (1998) 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia', *The Lancet*, vol. 352, pp. 1097-1098.

⁶⁶ Cica (1997) op. cit., p. 13

legislation. The Northern Territory Supreme Court heard the case on 1-2 July 1996 and reserved its decision until July 24 1996. The claim was rejected and an appeal was made to the High Court of Australia.

Max Bell, a 66 year old taxi driver from Broken Hill in New South Wales with terminal stomach cancer declares his intent to use the law. The legal challenge made it difficult for him to obtain the requisite medical signatures and after driving 3,000 kilometres to Darwin he returned home to die of 'natural causes' on August 22 1996.⁶⁷

September 9 1996

On September 9 1996 Kevin Andrews, the Federal Member for Menzies, introduced a Private Member's Bill entitled Euthanasia Laws Bill 1996. The purpose of the Bill was to prevent the Northern Territory, the Australian Capital Territory and Norfolk Island from passing laws permitting euthanasia. It was passed by the House of Representatives on December 10 1996 with a vote of 88 to 35 and in the Senate on March 25 1997 with a vote of 38 to 33.

September 22 1996

Robert Dent, a 66-year-old Darwin man, who had suffered from prostate cancer for five years, became the first person to die under the Act.

January 2 1997

Janet Mills, a South Australian suffering from skin disease Mycosis Fungoides, was the second person to die under the Act.

January 20 1997

A 69 year old Darwin man with stomach cancer becomes the third person to die under the Act.

March 1 1997

A 72 year old Sydney woman with terminal breast cancer becomes the fourth and final person to die under the Act.

Patients Who Made Use of the Act

Seven patients made formal use of the ROTI Act during the 9 months of its operation between July 1996 and March 1997. Of these, four died under the Act, two patients sought euthanasia but died before the Act became law, and one died after it was made ineffective by Federal legislation.⁶⁸

New South Wales

The following provides a brief overview of recent attempts to introduce euthanasia laws in New South Wales.

- Voluntary Euthanasia Trial (Referendum) Bill 2003 – Private Member's Bill introduced by Ian Cohen, member of the Greens in the Legislative Council.

⁶⁷G. Alcorn (1996) 'The fight to end a life', *Sydney Morning Herald*, September 27 viewed 26 May 2008, <<http://www.smh.com.au/articles/2002/05/30/1022569809394.html>>.

⁶⁸Kissane (1998) op. cit., pp. 1097-1102. This article provides excellent case studies of the seven patients.

This Bill was to provide for a referendum in relation to a legally and medically supervised trial of voluntary euthanasia for a period of 18 months. It was negatived on division at the Second Reading on November 13, 2003.

- Rights of the Terminally Ill Bill 2001 - Private Member's Bill introduced by Ian Cohen, member of the Greens in the Legislative Council.

This Bill was to establish and confirm the right of a person who is terminally ill to request assistance from a medically qualified person to voluntarily terminate his or her life in a humane manner; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance; to provide procedural protection against the possibility of abuse of the rights recognised by this Act; and for related purposes. It was negatived on division at the Second Reading on March 21, 2002.⁶⁹

Western Australia

The following provides a brief overview of recent attempts to introduce euthanasia laws in Western Australia.

- Voluntary Euthanasia Bill 2002 - Private Member's Bill introduced by Hon. Robin Howard Chapple MLC member of the Greens WA.

The purpose of the Bill was to develop an administrative framework for allowing voluntary euthanasia in Western Australia. Its aim was to establish an administrative structure that could only be enacted by mentally competent adults, suffering a medically diagnosed illness that is likely to cause death. It would legalise an adult person's intention to terminate his or her life in this circumstance and provide immunity to a person assisting that person providing it occurred according to the requirements of the Bill.

The second reading occurred on 18 September 2002, debate was resumed on 11 September 2003, and the Bill lapsed on January 23 2005.⁷⁰

⁶⁹Parliament of New South Wales (2008) 'Bills', viewed 11 June 2008, <<http://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/V3BillsHome>>.

To view a pdf of the 2003 Bill go to,

<[http://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/1484fd8a7ada6a26ca25691c001793ed/eeea6bac105fb0deca256a000016cd8e/\\$FILE/b01-950-p01.pdf](http://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/1484fd8a7ada6a26ca25691c001793ed/eeea6bac105fb0deca256a000016cd8e/$FILE/b01-950-p01.pdf)>.

To view a pdf of the 2001 Bill go to,

<[http://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/1484fd8a7ada6a26ca25691c001793ed/eeea6bac105fb0deca256a000016cd8e/\\$FILE/b01-950-p01.pdf](http://www.parliament.nsw.gov.au/prod/parliament/nswbills.nsf/1484fd8a7ada6a26ca25691c001793ed/eeea6bac105fb0deca256a000016cd8e/$FILE/b01-950-p01.pdf)>.

⁷⁰Parliament of Western Australia (2008) 'All Bills', viewed 12 June 2008,

<<http://www.parliament.wa.gov.au/web/newwebparl.nsf/iframewebpages/Bills++All>>

To view a pdf of the 2002 Bill go to,

<<http://my.lawlex.com.au/default.asp?itid=0&ntid=0&nid=&cid=65200&jurid=&alpha=&alphaid=&ihl=&nhl=&fp=&rdt=&vaftype=&requirelogin=&tab=ind&pact=coredoc&top=exp&nav=col&docview=true>>.

To view a pdf of the 2000 Bill go to,

<<http://my.lawlex.com.au/default.asp?itid=0&ntid=0&nid=&cid=46440&jurid=&alpha=&alphaid=&ihl=&nhl=&fp=&rdt=&vaftype=&requirelogin=&tab=ind&pact=coredoc&top=exp&nav=col&docview=true>>.

- Voluntary Euthanasia Bill 2000 - Norm Kelly MLC, Democrat
The second reading occurred on 19 October 2000, debate was adjourned, and the Bill lapsed on 10 January 2002.
- Voluntary Euthanasia Bill 2000 - Norm Kelly MLC, Democrat
The second reading occurred on 10 June 2000, debate was adjourned, and the Bill lapsed on 1 July 2000.

South Australia

The following provides a brief overview of recent attempts to introduce euthanasia laws in South Australia.

- Voluntary Euthanasia Bill 2007⁷¹ (SA) - Introduced by Hon Bob Such MP, an Independent for the electorate of Fisher.

A Bill for an act to provide for the administration of medical procedures to assist the death of a limited number of patients who are in the terminal phase of a terminal illness, who are suffering unbearable pain and who have expressed a desire for procedures subject to appropriate safeguards; and for other purposes.

The debate was adjourned on the Second Reading. Although still on the 2008 Bills List, it is unlikely to proceed any further.

- Voluntary Euthanasia Bill 2006 - R. B. Such Ind MLA
After the second reading debate was adjourned, and the Bill lapsed on 5 April July 2007.
- Dignity in Dying Bill 2005 - R.B. Such Ind MLA
The second reading occurred on 16 February 2005, debate was adjourned, and the Bill lapsed on 8 December 2005.
- Dignity in Dying Bill 2003 - R. B. Such Ind MLA
The second reading occurred on 24 September 2003, debate was adjourned, and the Bill lapsed on 12 August 2004.

⁷¹Government of South Australia, Attorney-General's Department (2008) 'Bills of the Parliament of South Australia' *South Australian Legislation*, viewed 12 June 2008, <<http://www.legislation.sa.gov.au>>.

5.2 Overseas

The State of Oregon in the US

The Oregon Death with Dignity Act (DWDA), also often referred to as Measure 16, was first passed in November 1994 as a result of a 51 percent majority result in a citizens initiative at the state's general election, but wasn't implemented until 1997.

The DWDA allows terminally-ill residents of Oregon, that is, those who have an expectation of death within 6 months, to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. The Oregon legislation therefore allows physician assisted suicide.

In common with the Northern Territory experience, there were moves to overturn the legislation both from within Oregon's Legislative Assembly as well through the judiciary. A legal injunction delayed its implementation until it was lifted in October 27 1997 by the Ninth Circuit Court of Appeals. This was followed in November 1997 by a referendum to repeal the Act at the next state election. It was rejected by the electorate, resulting in a more emphatic endorsement of the legislation at the second plebiscite, with a 60 percent majority result.

As a result of the ballot the Death with Dignity Act was retained, and Oregon became the only state in the US to allow terminally ill Oregon residents to obtain and use prescriptions from their physicians for self-administered, lethal medications.

There were multiple attempts however, by the US Attorney General John Ashcroft and his successor Alberto Gonzales to thwart the legislation by issuing a new interpretation of the Controlled Substances Act which would have prohibited doctors from prescribing controlled substances for use under the DWDA. It was rejected by several levels of the U.S. courts, most recently on January 17 2006 when the Supreme Court affirmed a lower court's decision.⁷²

The *Oregon Death With Dignity Act*

- Allows terminally ill Oregon residents to obtain and use prescriptions from their physicians for self-administered, lethal medications (that is, physician assisted suicide);
- Prohibits euthanasia, where a physician or other person directly administers a medication to end another's life.

To request a prescription for lethal medications, the DWDA requires that a patient must be:

- An adult (18 years of age or older);
- A resident of Oregon;
- Capable (defined as able to make and communicate health care decisions); and,
- Diagnosed with a terminal illness that will lead to death within six months.

⁷² The case is often referred to as *Gonzales v. Oregon*.

Oregon Department of Human Services (date unknown) 'Death with Dignity Act History' viewed 11 June 2008, <<http://www.oregon.gov>>.

To receive a prescription for lethal medication, the following steps must be fulfilled:

- The patient must make two oral requests to his or her physician, separated by at least 15 days;
- The patient must provide a written request to his or her physician, signed in the presence of two witnesses;
- The prescribing physician and a consulting physician must confirm the diagnosis and prognosis;
- The prescribing physician and a consulting physician must determine whether the patient is capable;
- If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination;
- The prescribing physician must inform the patient of feasible alternatives to DWDA, including comfort care, hospice care, and pain control;
- The prescribing physician must request, but may not require, the patient to notify his or her next-of-kin of the prescription request.

Physicians must report to the Department of Human Services (DHS) all prescriptions for lethal medications. A requirement was added in 1999, that pharmacists must be informed of the prescribed medication's intended use. Physicians and patients who adhere to the requirements of the Act are protected from criminal prosecution, and the choice of DWDA cannot affect the status of a patient's health or life insurance policies. Physicians, pharmacists, and health care systems can choose not to participate in the DWDA. Action taken in accordance with the DWDA does not constitute suicide, mercy killing or homicide under the law.⁷³

The Netherlands

Unlike the situation in the Northern Territory and Oregon, euthanasia and physician assisted suicide have been practised in the Netherlands since the 1970s and the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, which became effective April 1 2002, basically represents the legislative codification of existing practices largely determined by case law since the 1970s. There has been much open discussion about euthanasia over the period and an acceptance that euthanasia is practised, therefore regulation is focussed on encouraging transparency of all the processes involved so that every patient's case can be tracked and reviewed.⁷⁴ The approach in the Netherlands has been broadly one of the regulation and monitoring of euthanasia.

The evolution of case law since 1973 has demonstrated a reluctance by courts to penalise and incarcerate doctors for practising euthanasia or assisted suicide, provided particular criteria were met, namely: that the patient have an incurable, terminal-illness and be suffering from unrelenting physical or psychic pain as a result of that illness and that the goal of the treatment must be the relief of that patient's physical or psychic pain.⁷⁵

⁷³ Oregon Department of Human Services (date unknown) 'Death with Dignity Act Requirements' viewed 11 June 2008, <<http://www.oregon.gov>>.

⁷⁴ S. Gevers (1996) 'Euthanasia: law and practice in The Netherlands', *British Medical Bulletin*, vol. 52, p. 326.

⁷⁵ L. Bradbury (2003) 'Euthanasia in the Netherlands: Recognizing Mature Minors in Euthanasia Legislation', *New England Journal of International and Comparative Law*, vol. 9, pp. 224-225.

In 1984, the Supreme Court of the Netherlands allowed physicians to apply the doctrine of *force majeure* (necessity) as a defence against prosecution for euthanasia, that is, that a doctor's duty to preserve life should not conflict with the duty to relieve unbearable suffering and that 'a physician's duty to assist a terminally ill patient outweighs his or her duty to adhere to the law'.⁷⁶

Subsequently, the Dutch Medical Association, in collaboration with the Nurses Association, instituted the 'Guidelines for Euthanasia' in 1986 which then led to an agreement by the Dutch Ministry of Justice and the Royal Dutch Medical Association in 1990 that would enable doctors to practice euthanasia and assisted suicide with immunity as long as the guidelines were adhered to.

A new reporting procedure was passed by the Dutch Government in 1994 based on the Guidelines and in response to the Rummelink Commission. These Guidelines form the basis of the Due Care Criteria under Section 2 of the current legislation in the Netherlands, namely, *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act* which came into effect on 1 April, 2002.

The Rummelink Commission

The Commission of Inquiry into the Medical Practice Concerning Euthanasia was established by the Dutch Government in 1990 and commonly referred to as the Rummelink Commission (after Jan Rummelink, the then Attorney-General of the Dutch Supreme Court and Chairman of the Committee).

It found:

- 2,300 cases of active voluntary euthanasia, representing 1.8 per cent of all deaths;
- 400 cases of physician-assisted suicide, representing 0.3 per cent of all deaths;
- 22,500 cases where death followed the administration of drugs to alleviate pain and symptoms in such dosages that the risk of shortening the patient's life was considerable. This represented 17.5 per cent of all deaths;
- 22,500 cases where death had resulted from non-treatment decisions (ie withdrawal or withholding of medical treatment) representing 17.5 per cent of all deaths;
- 1,000 cases where a doctor had deliberately ended the life of a patient without a clear and explicit request from the patient, representing 0.8 per cent of all deaths.⁷⁷

Termination of Life on Request and Assisted Suicide (Review Procedures) Act.⁷⁸

Euthanasia (article 293) and assisted suicide (article 294) are both prohibited under the Dutch Penal Code, but under the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* they are not regarded as offences if a doctor complies with the due care criteria set out in section two of the Act and reports his actions to the municipal pathologist.

⁷⁶ *ibid.*, pp. 226-227.

⁷⁷ Cica (1997) *op. cit.*, p. 19.

⁷⁸ Netherlands Department of Foreign Affairs (date unknown) 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act', viewed 13 June 2008, <<http://www.minbuza.nl>>.

The Due Care criteria under Section 2 of the Act are as follows.

A doctor who ends a patient's life must:

- be satisfied that the patient's request is voluntary and well-considered;
- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;
- inform the patient of his or her situation and further prognosis;
- discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed in the four points above;
- exercise due medical care and attention in terminating the patient's life or assisting in his/her suicide.⁷⁹

Regional Review Committees

Since 1 November 1998, regional review committees have been assessing whether doctors' actions satisfy the due care criteria. They consist of an odd number of members that must include a legal expert, a physician and an ethicist. They are obliged to report cases to the Public Prosecution Service if they feel that the statutory due care criteria have not been met. They are also responsible for the registration of cases of termination of life on request or assisted suicide notified to them. The Public Prosecution Service is still free to institute an investigation in any case where there is reason to suspect that a crime has been committed.⁸⁰

The Act applies to:

- terminally-ill patients;
- the chronically-ill;
- mental suffering;
- minors: for minors aged 16-18 the parents or guardian must be consulted, for minors aged 12-16 consent must be given by the parents or guardian.⁸¹
- advanced directives.⁸²

With regard to foreign patients, according to the Netherlands Ministry of Health, Welfare and Sport the close doctor-patient relationship required under the Act would tend to exclude patients from other countries being entitled to access euthanasia or physician assisted suicide in the Netherlands.⁸³

⁷⁹ Regionale toetsingdommissies euthanasia (2005) 'Legislation' viewed 11 June 2008, <<http://www.toetsingscommissies euthanasie.nl>>.

⁸⁰ Netherlands Ministry of Foreign Affairs (2001) 'Q & A Euthanasia 2001: A guide to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

⁸¹ I. Ireland (2001) 'The Netherlands Euthanasia Legislation', *Research Note 31 200-2001*, Canberra, Parliamentary Library, p. 2.

⁸² C. Meek (2007) 'Pharmacy and Assisted Suicide and Euthanasia – International Experience' London, Policy Development Unit of the Royal Pharmaceutical Society of Great Britain, p. 12, viewed 12 June 2008, <<http://www.rpsgb.org/informationresources/downloadsocietypublications/>>.

⁸³ Netherlands Ministry of Health, Welfare and Sport (2007) 'Euthanasia', viewed 12 June 2008, <<http://www.minvws.nl>>.

Neonates – the termination of neonates is not included in the Act, but in 2006 the State Secretary for Health, Welfare and Sport and the Minister of Justice proposed a review procedure in conjunction to guidelines that were based on the Groningen Protocol – a joint local protocol between the public prosecution service in Groningen and paediatricians which established a set of due care criteria. Compliance with the criteria and mandatory reporting procedures would not guarantee doctors that they will not be prosecuted.

In terminating the life of a neonate, the physician has acted with due care if:

- according to prevailing medical opinion, the child's suffering was unbearable and without prospect of improvement, which means that the decision to withhold treatment was justified. There was therefore no doubt about the diagnosis and prognosis, in the light of prevailing medical opinion;
- the child's parents gave their consent;
- the physician fully informed the child's parents of the diagnosis and prognosis. This means that together with the parents the physician came to the firm conclusion that there was no reasonable alternative in the light of the child's situation;
- the physician consulted at least one other, independent physician who saw the child and gave a written opinion on compliance with these due care criteria. Alternatively, the physician could have asked for the views of the medical team attending the child;
- the termination was performed with due medical care and attention.⁸⁴

⁸⁴ Netherlands Ministry of Health, Welfare and Sport (2005) 'Termination of Life (Neonates)' viewed 13 June 2008, < <http://www.minvws.nl/en/kamerstukken/ibe/2005/termination-of-life-neonates.asp>>.

6. The Experience of Other Jurisdictions – Oregon and the Netherlands

6.1 Oregon - Death with Dignity Act (1998)

In 1998, the first year of Oregon's Death with Dignity Act, physicians issued 24 prescriptions for lethal medication. However, only 16 people used the prescription to end their life while six died from their illness and two were still alive as of January 1, 1999.⁸⁵ The median age of those who died was 69 years and 52 per cent were male.⁸⁶ All of these cases were submitted to the Oregon Health Department (OHD) for review and were found to comply with the law.⁸⁷

Over the entire period of reporting, from 1998 to 2007, the average number of physician assisted suicide (PAS) cases in a year has been 34, with the highest number reported being 49 in 2007.⁸⁸ From 1998 to 2007 the average number of deaths (of persons 18 years of age and over) in Oregon has been 29,758 per year with an average of 0.11 per cent of those being due to PAS.⁸⁹

From year to year, increases in the number of PAS cases has been minimal with the highest being from 2001 to 2002 in which the number of PAS deaths increased from a total of 21 to 38 cases, or 0.07 per cent to 0.12 per cent of all recorded deaths of persons 18 years of age and over (see Figure 1.1a). This increase, however, comes after a decrease in the total number of cases from 27 in 2000 to 21 in 2001 or 0.09 per cent to 0.07 per cent of all recorded deaths 18 years of age and over.

The most significant trend to emerge since reporting began has been the difference between the total number of PAS deaths and the total number of lethal prescriptions issued (see Figure 1.1b). Over the total reporting period, 1998-2007, the average number of prescriptions for lethal medication has been 54 per annum while the average number of PAS deaths is 34 per annum. This difference was most significant in 2001 when over 50 per cent of people issued a lethal prescription chose not to use it in that year. Consequently, the number of PAS deaths decreased by 22 per cent from 2000 to 2001, while the number of prescriptions increased by 12 per cent. While this

⁸⁵ Oregon Health Division (1999) *Oregon's Death with Dignity Act: the First Year's Experience*, Oregon Health Division, Portland, p. 4.

⁸⁶ *ibid.*, p. 4.

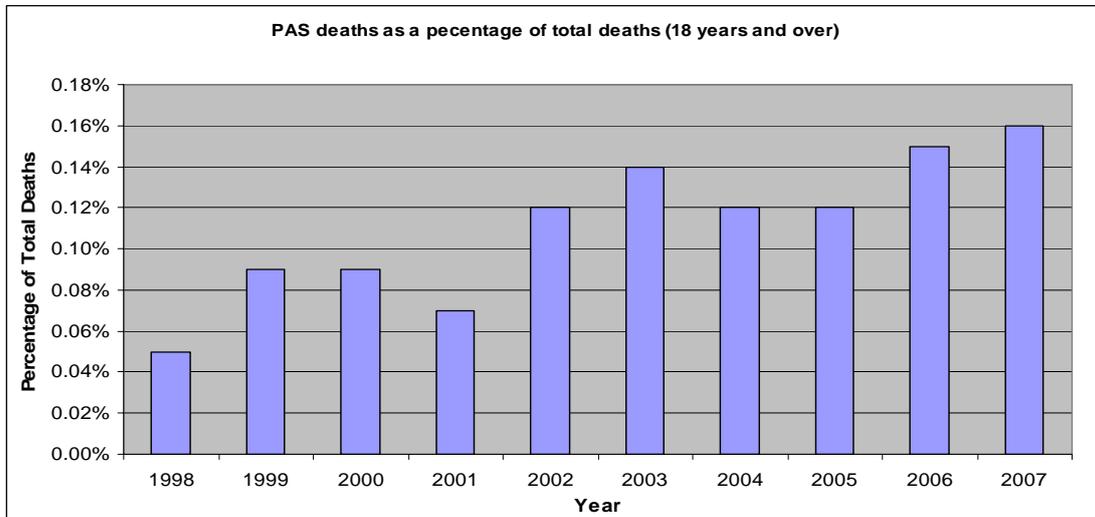
⁸⁷ *ibid.*, p. 5.

⁸⁸ Oregon Health Division (1999) *op. cit.*; Oregon Health Division (2000) *Oregon's Death with Dignity Act: the Second Year's Experience*, Portland, Oregon Health Division; Oregon Health Division (2001) *Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide*, Portland, Oregon Health Division; Department of Human Services (2002) *Fourth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division; Oregon's Health Division (2003) *Fifth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division; Oregon's Health Division (2004) *Sixth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division; Oregon's Health Division (2005) *Seventh Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division; Oregon's Health Division (2006) *Eighth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division; Oregon Health Division (2007) *Summary of Oregon's Death with Dignity Act – 2006*, Portland, Oregon Health Division; Oregon Health Division (2008) *Summary of Oregon's Death with Dignity Act – 2007*, Portland, Oregon Health Division.

⁸⁹ Oregon Department of Human Services (2008), Centre for Health Statistics, viewed 10 June 2008, <<<http://www.oregon.gov>>>.

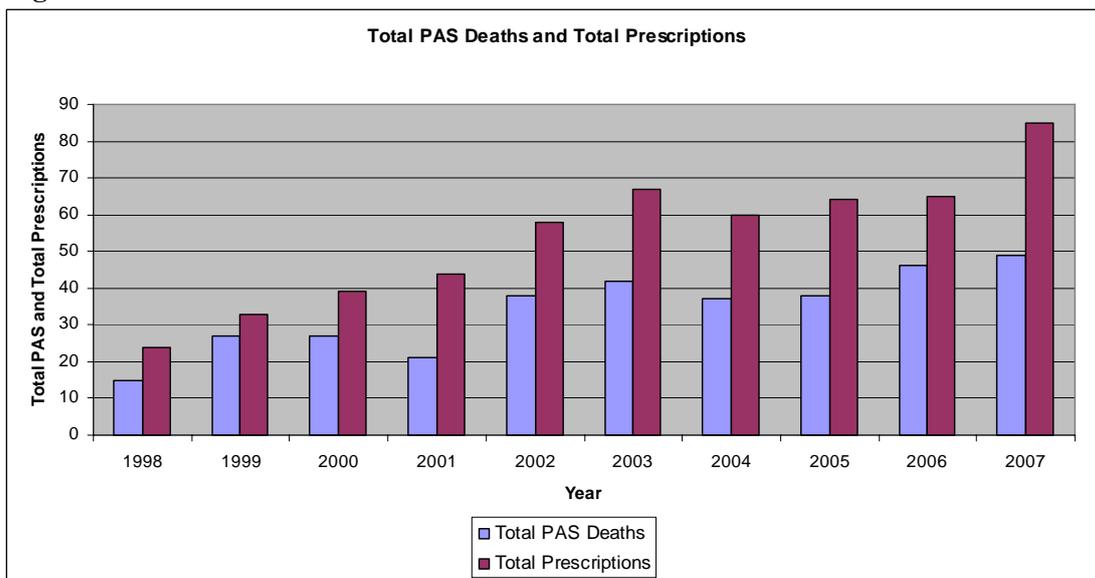
inverse relationship did not occur in subsequent years, there continued to be a significant difference between PAS deaths and prescriptions issued in each year.

Figure 1.1a



Source: Data taken from Oregon Department of Human Services Annual Reports into the Dying with Dignity Act 1998-2007.⁹⁰

Figure 1.1b



Source: Data taken from Oregon Department of Human Services Annual Reports into the Dying with Dignity Act 1998-2007.⁹¹

⁹⁰ Oregon Health Division (1999) op. cit.; Oregon Health Division (2000) op. cit.; Oregon Health Division (2001) op. cit.; Department of Human Services (2002) op. cit.; Department of Human Services (2003) op. cit.; Department of Human Services (2004) op. cit.; Department of Human Services (2005) op. cit.; Department of Human Services (2006) op. cit.; Oregon Health Division (2007) op. cit.; Oregon Health Division (2008) op. cit.

⁹¹ Oregon Health Division (1999) op. cit.; Oregon Health Division (2000) op. cit.; Oregon Health Division (2001) op. cit.; Department of Human Services (2002) op. cit.; Department of Human Services (2003) op. cit.; Department of Human Services (2004) op. cit.; Department of Human Services (2005) op. cit.; Department of Human Services (2006) op. cit.; Oregon Health Division (2007) op. cit.; Oregon Health Division (2008) op. cit.

Over the period 1998-2007 the basic demographic features of those seeking PAS changed little from the initial 1998 data with males and females constituting 53.7 per cent and 46.4 per cent of the total number of PAS deaths respectively, and the median age remaining at 69 years.⁹²

Over the reporting period, details about patients key end-of-life concerns, education levels, health insurance, and type of illness showed some consistent results. In 89 per cent of the total cases the primary concern was loss of autonomy. Being less able to engage in activities that make life enjoyable, and loss of dignity, were also key concerns with 86.6 per cent and 81.6 per cent of the total cases respectively citing these reasons for seeking PAS.⁹³

In 92.1 per cent of the cases patients had at least a high school degree with 64.2 per cent having at least some college education.⁹⁴ In 82.1 per cent of the total cases patients had a form of neoplasm and in 85.8 per cent of the total cases patients were enrolled in some form of hospice care before their death.⁹⁵ Results for the level of health insurance of patients showed that 99.1 per cent of the total cases had some form of health insurance with 62.9 per cent having private insurance and 36.2 per cent having either Medicare or Medicaid.⁹⁶

Over the course of Oregon's experience with the Death with Dignity Act, there have been 18 cases reported to the Board of Medical Examiners for review with the highest being 10 cases reported in 2006. In all of these cases, the reason for referral involved incorrectly filling out forms. In all cases, however, the Board of Medical Examiners found no violations of 'good faith compliance' and no physicians were sanctioned regarding their conduct.⁹⁷

6.2 The Netherlands - Termination of Life on Request and Assisted Suicide Act (2002)

There have been a total of four nation-wide government investigations into euthanasia and PAS cases in the Netherlands over the period 1990-2005.⁹⁸ In each of these investigations statistical data was gathered on end of life decisions made by physicians and patients. The government initiated a review process and released a report in 2007 highlighting the key developments in the Dutch law and review process and made recommendations for further improvements.⁹⁹

⁹² Oregon Department of Human Services (2008) op. cit.

⁹³ *ibid.*

⁹⁴ *ibid.*

⁹⁵ *ibid.*

⁹⁶ Oregon Department of Human Services (2008) op. cit.

⁹⁷ *ibid.*

⁹⁸ Oregon Department of Human Services (2007) op. cit.

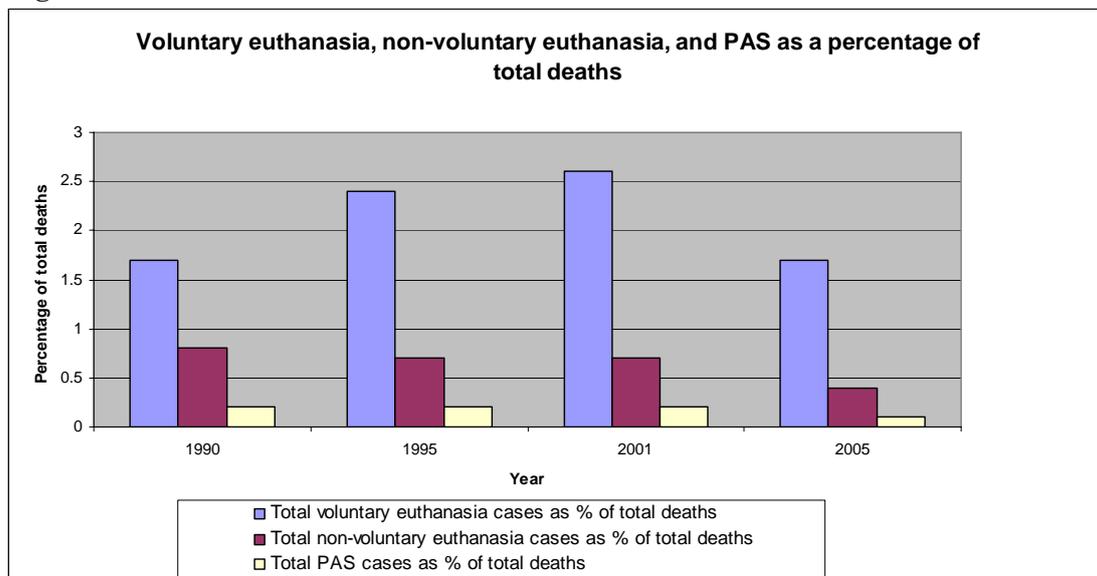
⁹⁸ P.J. van der Maas (1991) 'Euthanasia and other medical decisions concerning the end of life', *Lancet*, vol.338, iss.8768, pp. 669-674; P.J. van der Maas et al. (1996) 'Euthanasia, physician-assisted suicide, and other medical practices involving end of life in the Netherlands 1990-1995', *The New England Journal of Medicine*, vol.335, pp. 1699-1705; B.D. Onwuteaka-Philipsen et al. (2003) 'Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001', *Lancet*, vol.362, pp. 395-399; A. van der Heide et al. (2007) 'End-of-Life Practices in the Netherlands under the Euthanasia Act', *The New England Journal of Medicine*, vol. 356, pp. 1957-1965.

⁹⁹ Ministry of Health, Welfare, and Sport (2007) 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act', The Hague, Ministry of Health, Welfare and Sport.

A key feature to note when looking at the Netherlands data is the distinction between voluntary euthanasia, non-voluntary euthanasia, and PAS. Voluntary euthanasia is defined as the administration of drugs with the explicit intention of ending the patient's life at the patient's explicit request.¹⁰⁰ Non-voluntary euthanasia is understood as the administration of drugs with the explicit intention of ending the patient's life without an explicit request by the patient.¹⁰¹ Physician-assisted suicide (PAS) is defined as the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life.¹⁰²

Taking these distinctions into consideration, there are several key trends that emerge (see Figure 1.2a). Firstly, the percentage of deaths as a result of voluntary euthanasia increased from 1.7 per cent to 2.6 per cent from 1990 to 2001 but this was followed by a reduction from 2.6 per cent in 2001 to 1.7 per cent in 2005.¹⁰³ Secondly, the percentage of total deaths as a result of non-voluntary euthanasia has been reduced by half from 0.8 per cent in 1990 to 0.4 per cent in 2005.¹⁰⁴ Thirdly, the percentage of deaths as a result of PAS has remained stable across the reporting period except for a reduction in 2005 from 0.2 per cent to 0.1 per cent of all deaths.¹⁰⁵

Figure 1.2a



Source: A. van der Heide et al. (2007) op. cit., pp.1962.

In terms of actual numbers over the reporting period, there has been an average of 3,131 deaths as a result of voluntary euthanasia and PAS with the peak being in 2001 with a total of 3,800 deaths or 3.5 per cent of the total deaths in that year.¹⁰⁶ Over the four studies from 1990 to 2005 there has been an average of 135,125 deaths per year, with euthanasia and PAS accounting for an average of 2.9 per cent of the total deaths per annum.

¹⁰⁰ B.D. Onwuteaka-Philipsen et al. (2005) 'Dutch experience of monitoring euthanasia', *BMJ*, vol.331, pp.691.

¹⁰¹ *ibid.*

¹⁰² *ibid.*

¹⁰³ van der Heide et al. (2007) op. cit., p. 1962.

¹⁰⁴ *ibid.*

¹⁰⁵ *ibid.*

¹⁰⁶ Ministry of Health, Welfare, and Sport (2007) op. cit., p. 8.

According to the 2007 Dutch government review, the decrease in euthanasia cases from 2001 to 2005 is attributable to several factors. Firstly, there was a growing trend over this period of pursuing alternative care for patients in the final stages of their life, such as terminal deep sedation.¹⁰⁷ Terminal deep sedation refers in the Dutch context specifically to rendering a patient unconscious through medication until death.¹⁰⁸ There were 11,200 cases of terminal deep sedation in 2005 accounting for 8.2 per cent of the total deaths in that year.¹⁰⁹ In addition to an increase in alternative care, the 2007 Dutch review reported that doctors see a direct correlation between improved palliative care and the decrease in euthanasia cases from 2001 to 2005.¹¹⁰

The second key factor that the 2007 review attributes to the decrease from 2001-2005 is the changed attitude of physicians regarding the use and effect of morphine. Physicians were less likely to classify death by morphine overdose to euthanasia and more likely to cite the 'double effect' in these cases. What this means is physicians are more likely to attribute the cause of death to the underlying terminal illness.¹¹¹ It must be stressed however that this brings the Netherlands more in line with other countries where physicians accept this as common practice.¹¹²

In 2005 the percentage of the total male and female cases of euthanasia (voluntary and non-voluntary) and PAS was 56 per cent and 44 per cent respectively. The most represented age group in 2005 was the 65-79 age group with 39 per cent of the total cases of euthanasia and PAS. In the same year, 0-64 year olds constituted 38 per cent and 80+ year olds accounted for 23 per cent of the total cases.¹¹³ These characteristics are consistent with the other reporting periods.¹¹⁴

In the Dutch system of reporting the regional review committees refer cases to the Assembly of Prosecutors General only if there is doubt about whether the prudent practice requirements have been met. In 2001 the review committee sought further information in five per cent of the cases; only seven cases (0.1 per cent of the total) resulted in a negative judgment from the regional committee.¹¹⁵ Only four of these cases were discussed by the Assembly of Prosecutors with the other three being dismissed.¹¹⁶ In 2003, 2004, and 2005 the verdict of 'non-compliance' was given by the committee in a total of 15 cases.¹¹⁷

¹⁰⁷ *ibid.*

¹⁰⁸ Rietjens et al. (2008) 'Continuous deep sedation for patients nearing death in the Netherlands: descriptive study', *BMJ*, vol.336, iss.7468, p. 810.

¹⁰⁹ Ministry of Health, Welfare, and Sport (2007) *op. cit.*, p. 8

¹¹⁰ *ibid.*

¹¹¹ *ibid.*

¹¹² G. Bosshard (2008) 'A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries', *Journal of Medical Ethics*, vol.34, pp. 27-32.

¹¹³ van der Heide et al. (2007) *op. cit.*, pp. 1957-1965.

¹¹⁴ van der Maas (1991) *op. cit.*; van der Maas et al. (1996) *op. cit.*; Onwuteaka-Philipsen et al. (2003) *op. cit.*

¹¹⁵ Onwuteaka-Philipsen et al. (2005) *op. cit.* p. 692.

¹¹⁶ In these three cases the concern was that the doctor had not sought consultation from another doctor. However, the committee took into account that these doctors were from remote areas and seeking consultation was difficult.

¹¹⁷ Ministry of Health, Welfare, and Sport (2007) *op. cit.*

References

Books, Journal Articles and Reports

Anderson J. (2005) *The Medical Treatment Act 1988 (Vic): Its History, Applications, and Comparative Analysis*, Parliamentary Internship Report, Melbourne, Parliament of Victoria.

Australian Christian Lobby (2008) Submission to the Senate Legal and Constitutional Committee's Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008, ACL.

Australian Medical Association (2007) The Role of the Medical Practitioner in End of Life Care – Position Statement, viewed 17 June 2008, <<http://www.ama.com.au>>.

Battin, M. (2005) *Ending Life: Ethics and the Way We Die*, Oxford, Oxford University Press.

Beauchamp T. (2008) 'Euthanasia', MSN Encarta, On-Line Encyclopedia, viewed 18 June 2008, <<http://encarta.msn.com>>.

Bellamy, P. (2003) 'Voluntary Euthanasia and New Zealand' *Background Note 2003/07* Wellington, New Zealand Parliamentary Library.

Bosshard, G. (2008) 'A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries', *Journal of Medical Ethics*, vol.34, pp. 27-32.

Bradbury, L. (2003) 'Euthanasia in the Netherlands: Recognizing Mature Minors in Euthanasia Legislation' *New England Journal of International and Comparative Law*, vol. 9, pp. 209-257.

Bregje, D. et al. (2005) 'Dutch experience of monitoring euthanasia', *BMJ*, vol.331, pp. 691-693.

Burns, L. and I. Hunt (ed.) *The Quality of Death: Euthanasia in Australia*, Adelaide, Flinders University Press.

Cica, Natasha (1996) 'Euthanasia- the Australian Law in an International Context: Part 1 Passive Voluntary Euthanasia' *Research Paper No. 3 1997-97*, Canberra, Parliamentary Library.

Cica, Natasha (1996) 'Euthanasia- the Australian Law in an International Context: Part 2 Active Voluntary Euthanasia' *Research Paper No. 4 1997-97*, Canberra, Parliamentary Library.

Cosic, M. (2003) *The Right to Die? An Examination of the Euthanasia Debate*, Sydney, New Holland.

De Graeff, A. and Dean, M. (2007) 'Palliative Sedation Therapy in the Last Weeks of Life: A Literature Review and Recommendations for Standards', in *Journal of Palliative Medicine*, February, 10(1), pp. 67 - 85.

Dunsmuir, M. & Tiedemann, M. (2007) 'Euthanasia and Assisted Suicide: International Experiences' *PRB 07-03E*, Ontario, Canadian Parliamentary Library.

Dworkin, R. (1993) *Life's Dominion*, London, Harper Collins.

Dying With Dignity Victoria (2008) 'FAQS', viewed 20 June 2008, <<http://www.dwdv.org.au>>.

Francke, A. (2003) 'Palliative Care for Terminally Ill Patients in the Netherlands: Dutch Government Policy' *International Publication series Health, Welfare and Sport no 16*, The Hague, Netherlands Institute for Health Services Research.

Gevers, S. (1996) 'Euthanasia: law and practice in The Netherlands' *British Medical Bulletin* vol. 52 pp.326-333.

Gott, R. & R. Linden (1993) *No Easy Way Out: The Euthanasia Debate*, Carlton, CIS Publishers, pp. 6 - 9.

Griffith, G. (2001) 'Euthanasia: An Update' *Briefing Paper no 3/2001* Sydney, New South Wales Parliamentary Library.

House of Lords (1994) in Report of the Select Committee on Medical Ethics, House of Lords Paper, viewed 5 June 2008, < <http://www.parliament.the-stationery-office.co.uk>>.

Hudson, P. L., S. Aranda, M. Ashby, R. Hudson, B. Kelly, L. J. Kristjanson, M. O'Connor, P. Schofield, A. Street (2006) 'Desire for Hastened Death in Patients with Advanced Disease and the Evidence Base of Clinical Guidelines: a Systematic Review', in *Palliative Medicine*, October, 20 (7), pp. 693 - 701.

Ireland, I. (2001) 'The Netherlands Euthanasia Legislation' *Research Note 31 2000 - 2001* Canberra, Parliamentary Library.

Keown, J. (ed.) (1995) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge, Cambridge University Press.

Kissane, D., A. Street & P. Nitschke (1998) 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' *The Lancet*, vol 352, pp. 1097 - 1102.

Kuhse, H. (1994) *Willing to Listen, Wanting to Die*, Ringwood, Penguin Books.

McGee A. (2004) 'Double Effect in the Criminal Code 1899 (QLD): A Critical Appraisal', *QUT Law & Justice Journal*, AustLII, viewed 18 June 2008, <<http://austlii.edu.au>>.

Norberry, J. & N. Cica (1996) 'Euthanasia Laws Bill 1996' *Bills Digest no. 45 1996 - 97*, Canberra, Parliamentary Library.

Onwuteaka-Philipsen, B.D., A van der Heide, D. Koper, I. Keij-Deerenberg, J.A.C. Rietjens, M.L. Rurup, A.M. Vrakking, J.J. Georges, M.T. Muller, G. van der Wal & P.J. van der Maas (2003) 'Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001', *Lancet*, vol.362, pp. 395 – 399.

Parker, M. H., C. M. Cartwright, G. M. Williams (2008) 'Impact of Speciality Attitudes of Australian Medical Practitioners to End-of-Life Decisions', in *Medical Journal of Australia*, April 21, 188(8), pp. 450 - 456.

Rietjens, J., J. van Delden, B.D. Onwuteaka-Philipsen, H. Buiting, P. van der Maas & A. van der Heide (2008) 'Continuous deep sedation for patients nearing death in the Netherlands: descriptive study', *BMJ*, vol. 336, is. 7468, pp. 1 - 7.

Singer, P. (1994) *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, Melbourne, Text Publishing.

Smith, K. (2007) 'Dying with Dignity', Speech, Death With Dignity Victoria, viewed 11 June 2008, <<http://www.dwdv.org.au>>.

Smith, K. (2008) 'Investigative visit to Portland Oregon USA 17 May 2008 - 25 May 2008', Travel Report to the Speaker of the Legislative Assembly and the President of the Legislative Council, Melbourne.

Stewart, C. (1999) 'Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions', *Melbourne University Law Review*, MULR 6, viewed 18 June 2008, <<http://www.austlii.edu.au>>.

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

Van der Heide, A., B.D. Onwuteaka-Philipsen, M.L. Rurup, H.M. Buiting, J.J.M. van Delden, J.E. Hanssen-de Wolf, A.G.J.M. Janssen, H.R.W. Pasman, J.A.C. Rietjens, J.M.C. Prins, I.M. Deerenberg, J.K.M. Gevers, P.J. van der Maas & G. van der Wal (2007) 'End-of-Life Practices in the Netherlands under the Euthanasia Act', *The New England Journal of Medicine*, vol. 356, pp. 1957 - 1965.

Van der Maas, P.J. & J.J.M. van Delden (1991) 'Euthanasia and other medical decisions concerning the end of life', *Lancet*, vol. 338, is. 8768, pp. 669 – 674.

Van der Maas, P.J. G. van der Wal, I. Haverkate (1996) 'Euthanasia, physician-assisted suicide, and other medical practices involving end of life in the Netherlands 1990-1995', *The New England Journal of Medicine*, vol. 335, pp. 16.

Verhagen, E. & P Sauer (2005) 'The Groningen Protocol – Euthanasia in Severely Ill Newborns' *New England Journal of Medicine* vol 352 pp. 959-962, viewed 18 June 2008, <<http://content.nejm.org>>.

Victorian Greens (2008) Current Campaigns, viewed 6 June 2008, <<http://www.electedgreensvictoria.org.au>>.

Willmott L., B. White & M. Howard (2006) 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment', *Melbourne University Law Review*, Vol.30, pp.211-243.

Government Publications

Department of Human Services (2002) *Fourth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division.

Department of Human Services (2003) *Fifth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division.

Department of Human Services (2004) *Sixth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division.

Department of Human Services (2005) *Seventh Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division.

Department of Human Services (2006) *Eighth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon's Health Division.

Ministry of Health, Welfare, and Sport (2007) 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act', The Hague, Ministry of Health, Welfare and Sport.

Netherlands Department of Foreign Affairs (date unknown) 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act' viewed 13 June 2008, <<http://www.minbuza.nl>>.

Netherlands Ministry of Foreign Affairs (2008) 'Q&A Euthanasia 2008: A guide to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act', viewed 18 June 2008, <<http://www.minbuza.nl>>.

Netherlands Ministry of Health, Welfare and Sport (2007) 'Euthanasia' viewed 12 June 2008, <<http://www.minvws.nl>>.

Netherlands Ministry of Health, Welfare and Sport (2005) 'Termination of Life (Neonates)' viewed 13 June 2008, <<http://www.minvws.nl>>.

Oregon Department of Human Services (2008), Centre for Health Statistics, viewed 10 June 2008, <<http://www.oregon.gov>>.

Oregon Department of Human Services (date unknown) 'Death with Dignity Act' viewed June 11 2008, <<http://www.oregon.gov>>.

Oregon Department of Human Services (date unknown) 'Death with Dignity Act History' viewed June 11 2008, <<http://www.oregon.gov>>.

Oregon Department of Human Services (date unknown) 'Death with Dignity Act Requirements' viewed June 11 2008, <<http://www.oregon.gov>>.

Oregon Health Division (1999) *Oregon's Death with Dignity Act: the First Year's Experience*, Portland, Oregon Health Division.

Oregon Health Division (2000) *Oregon's Death with Dignity Act: the Second Year's Experience*, Portland, Oregon Health Division.

Oregon Health Division (2001) *Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide*, Portland, Oregon Health Division.

Oregon Health Division (2007) *Summary of Oregon's Death with Dignity Act – 2006*, Portland, Oregon Health Division.

Oregon Health Division (2008) *Summary of Oregon's Death with Dignity Act – 2007*, Portland, Oregon Health Division.

Regionale toetsingdommissies euthanasia (2005) 'Legislation' viewed June 11 2008, <http://www.toetsingscommissies euthanasie.nl/en/legislation/ducarecriteria/>

Senate Legal and Constitutional Committee (2008) 'Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008', viewed 11 June 2008, <<http://www.aph.gov.au>>.

Victoria, Social Development Committee (1987) *Report upon the Inquiry into Options for Dying with Dignity: Second and Final Report*, Melbourne, F. D. Atkinson.

Media

Alcorn, G. (1996) 'The fight to end a life'. *Sydney Morning Herald*, September 27.

Lateline (2002) 'Euthanasia Debate', ABC Television, online transcript, viewed 10 June 2008, <<http://www.abc.net.au>>.

Leidig, M. and P. Sherwell (2004) 'Swiss to crack down on suicide tourism', *Telegraph*, 14 March.

Ife, H. (2007) 'Eight Out of 10 Support Euthanasia', *Herald Sun*, 5 March.

Maley, J. (2007) 'The troubling question of life or death', *Sydney Morning Herald*, 29 January.

Legislation

Consent to Medical Treatment and Palliative Care Act 1995 (SA)

Crimes Act 1958 (Vic)

Criminal Code Amendment (Suicide Related Material Offences) Act 2005 (Cth)

Euthanasia Laws Act 1997 (Cth)

Medical Treatment Act 1988 (Vic)

Medical Treatment (Health Directions) Act 2006 (ACT)

Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic)

Natural Death Act 1976 (California)

Natural Death Act 1988 (NT)

The Rights of the Terminally Ill Act 1995 (NT)

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

Voluntary Euthanasia Bill 2002 (WA)

Voluntary Euthanasia Bill 2007 (SA)

Voluntary Euthanasia Trial (Referendum) Bill 2003 (NSW)

Cases

R v Hood [2002] VSC 123

R v Maxwell [2003] VSC 278

Appendix - A Comparative Overview

What is included.	Victoria's Bill	Northern Territory	Oregon	Netherlands
Physician Assisted Dying Euthanasia	Yes No	Yes Yes	Yes (PAS) No	Yes Yes
Age restrictions	18 years plus	18 years plus	18 years plus	18 years plus; minors 16-18 with parental consultation; minors 12-16 with parental consent; neonates - not under the Act, but case law has provided guidelines
Preconditions: Terminal illness	Yes. Also physician assisted dying for an incurable illness.	Yes	Yes with 6 months to live	Yes and the illness may be chronic or in exceptional cases, mental suffering (case law).
Cooling off period	Yes: 48 hours for terminal illness. Two cooling off periods of 48 hours plus 14 days for incurable illness	Yes: 7 days following verbal request & 2 days following written request	Yes: 15 days after verbal request & 2 days after written request	Not a specified period of time, but one of the criteria that must be applied is that the request by a patient must be well considered, i.e. an enduring repeated request.
Pain or suffering	Yes Intolerable suffering physical, psychological or existential	Yes experiencing pain, suffering, and distress to an extent deemed unacceptable	Not mentioned	Yes suffering is unbearable with no prospect of improvement; suffering may be mental
Resident	Yes – minimum of 12 months	No	Yes	Yes - in practice. Not specified in the Act - but close association with physician would exclude non-residents

What is included.	Victoria's Bill	Northern Territory	Oregon	Netherlands
Mental Assessment	Mandatory for incurably ill. Only required for terminally ill if there is reason to believe patient has a mental illness.	Yes - mandatory	Not mandatory; If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination	Not mandatory, only if consulting physician thinks it's necessary where there is a mental condition
Palliative care offered	Yes - mandatory 'advice' for terminally ill. Palliative care 'advice' plus 'consultation' for incurably ill	Yes - mandatory	Yes - mandatory	One of the criteria that doctors must follow is: ' to become convinced together with the patient that there is no other reasonable solution for the situation that the patient is in'. According to Dutch Govt. policy, this requirement of due care means that it has to be ascertained whether there are further possibilities for palliative care to reduce the suffering. It has been reported in the literature however, that this may not always happen in practice
Mandatory Second opinion from another Doctor	Yes	Yes - 3 doctors	Yes - 2 doctors	Yes - 2 doctors, but can consult more
Mandatory participation by Doctors/ Institutions	No	No	No	No

© 2008 Library, Department of Parliamentary Services, Parliament of Victoria

Except to the extent of the uses permitted under the Copyright Act 1968, no part of this document may be reproduced or transmitted in any form or by any means including information storage and retrieval systems, without the prior written consent of the Department of Parliamentary Services, other than by Members of the Victorian Parliament in the course of their official duties.

Research Service

This paper has been prepared by the Research Service for use by Members of the Victorian Parliament. The Service prepares briefings and publications for Parliament in response to Members, and in anticipation of the requirements, undertaking research in areas of contemporary concern to the Victorian legislature. While it is intended that all information provided is accurate, it does not represent professional legal opinion.

Research publications present current information as at the time of printing. They should not be considered as complete guides to the particular subject or legislation covered. The views expressed are those of the author(s).

Enquiries

Enquiries should be addressed to:
Dr Greg Gardiner
Senior Research Officer
Victorian Parliamentary Library
Parliament House
Spring St, Melbourne
Victoria 3002

T: (03) 9651 8640

F: (03) 9654 1339

Information about Research Publications is available on the Internet at:

<http://www.parliament.vic.gov.au>