

GETTING THE LAW RIGHT ON PHYSICIAN-ASSISTED DEATH

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Introduction

My aim with this paper is to focus on how the law could be improved to better respect and protect patients seeking assistance at the end-of-life, as well as protecting the doctors who assist them. This paper takes as its starting premise the fact that there are currently a number of deficiencies in the law relating to physician-assisted death. I want to argue that these deficiencies have the cumulative effect of rendering the operation of the law inconsistent, discriminatory and hypocritical, and that as a consequence of this dysfunctionality, the law is brought into disrepute.

In exploring ways in which the law could be improved, I will be examining different legislative models for change: direct assistance at the request of a patient, based on the Netherlands model where the doctor administers the lethal dose, as well as the Oregon model of physician-assisted suicide where the doctor provides the lethal dose but the patient self-administers it, and I will be looking at the pros and cons of both of these models. Essentially, I argue that more functional, objectively realistic and transparent laws are needed to deal with end-of-life concerns.

I. Deficiencies in the Law Relating to Physician-Assisted Death

Despite the strict legal prohibition of the practice, with the threat of the most serious criminal liability (i.e. murder), the reality of the matter is that, not infrequently, requests for active voluntary euthanasia are made by patients. In surveys of doctors, approximately half report receiving such requests,¹ and a significant proportion of doctors are responding to such requests.² So, it is abundantly clear that the criminal law prohibition of active voluntary euthanasia and doctor-assisted suicide does not prevent the occurrence of these practices.

However, because of their present illegality, these practices are largely covert and rarely come to the attention of others or are exposed to scrutiny. There are serious problems with a hidden and unregulated practice.³ It is unsatisfactory to have a situation where it is commonly known that the law

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¹ See: H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', *Medical Journal of Australia* 1998-148, pp. 623-627; P. Baume and E. O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners', *Medical Journal of Australia* 1994-161, pp. 137-144, reporting on data from Victoria and New South Wales respectively.

² *Ibid.* See also: B. Ward and P. Tate, 'Attitudes Among NHS Doctors to Requests for Euthanasia', *British Medical Journal* 1994-308, pp. 1332-1334; C. Douglas et al, 'The Intention to Hasten Death: A Survey of Attitudes and Practice of Surgeons in Australia', *Medical Journal of Australia* 2001-175, pp. 511-515; D. Neil et al, 'End-of Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)', *Journal of Medical Ethics* 2007-33, pp. 721-725.

³ M. Otlowski, *Voluntary Euthanasia and the Common Law*, Oxford: Oxford University Press 1997, pp. 148-152. See also: R. Magnusson, *Angels of Death: Exploring the Euthanasia Underground*, Melbourne: Melbourne University Press 2002.

is being breached by the medical profession, yet breaches are usually ignored or pass unpunished. Such discrepancies between the law on the books and the law as applied are likely to undermine public confidence in the law and bring it into disrepute. Further, as a result of these serious discrepancies, there is no established legal precedent with reference to which medical decisions in respect of terminal patients can be made and evaluated. Because of the illegality of these practices, doctors will feel inhibited in discussing these issues with their colleagues in an open way, and consequently will not be able to benefit from constructive critique or support from their professional peers. In turn, this jeopardises the quality of medical decision-making in this area.

The gap between the law in theory and the law in practice creates enormous problems.⁴ Although legally, motive is irrelevant, in practice it is often decisive in determining the outcome of cases. Further, because the administration of the law depends to such a large extent on intangible considerations of sympathy, there is no guaranteed consistency of application, thus raising serious questions regarding justice and equality before the law. Due to the fact that the present criminal law principles, which treat motive as irrelevant, are widely perceived as being inappropriate, devious means are frequently used to circumvent the full rigour of the criminal law. The motive of the offender is in fact being incorporated into decision-making, but only surreptitiously through the use of certain fictions or tactics. This can result in serious distortion of legal principles and widespread connivance to defeat the application of the criminal law. The use of fictions (for example in relation to causation or intention) represents a blatant abuse of the law, and when occurring on a regular basis, suggests that the current criminal prohibitions do not reflect common views of reprehensibility.⁵

One matter causing particular disquiet is that the present situation threatens to undermine the rights and interests of patients. A very significant concern is that there is a very real risk of abuse if the law condones what is an unregulated practice. Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism, and in the belief that they are acting in the patient's best interests. There is survey evidence to suggest that active euthanasia is not always administered at the patient's request. For example, one Australian study found that 20% of doctor respondents, who had reported that they had administered drugs for the purpose of hastening a patient's death, had not received an unambiguous request for a lethal dose of medication.⁶ Extrapolating out and comparing that data with data from other jurisdictions such as the Netherlands where voluntary active euthanasia is allowed but strictly regulated, it appears that there is a higher incidence in Australia of ending the life of patients by active means without the patient's explicit consent than in the Netherlands where these issues are addressed more openly. Notably, analogies can be drawn between Australian data and data from Belgium (Flanders) taken prior to the legalisation of voluntary active euthanasia in Belgium: both jurisdictions reported a higher incidence of unrequested killing than for voluntary active euthanasia (3.2% of all deaths in Flanders, Belgium compared with 3.5% of all deaths in Australia, both of which are significantly higher than the comparable figure for the Netherlands

⁴ Otlowski 1997 *supra*, note 3.

⁵ *Idem*, p. 150.

⁶ Douglas *et al*, 2001 *supra*, note 2.

(0.7%)).⁷ There is, therefore, the possibility that the present state of the law, whilst ostensibly protecting patients, may in effect be sanctioning such killings without providing adequate protection to unwilling victims. If active euthanasia is in fact being practised, it is imperative that these decisions are based upon the patient's choice rather than the idiosyncratic views of individual doctors.

There are also a number of unacceptable inconsistencies and anomalies in the law. One example of the inconsistencies in the law relates to passive euthanasia and the law on suicide.⁸ A person who effectively commits suicide (slowly) by refusing food, water and/or medical treatment with the specific intention of ending their life is not considered in law to be committing suicide. This is illustrated by recent Australian cases where a patient's right to refuse any interventions has been upheld, including the much publicised 2009 *Rossiter* case⁹ involving a quadriplegic patient dependent on others for his daily needs including nutrition and hydration, but not terminally ill. This interpretation has been legally justified on the basis of principles of autonomy, self-determination, and the right to bodily integrity. The courts have not been prepared to characterise self-starvation as suicide; in the case of *H LTD v J*¹⁰, which followed the approach in *Rossiter*, Justice Kourakis of the South Australian Supreme Court accepted that an individual refusing nutrition and hydration was merely speeding up the natural and inevitable process of death.¹¹ Furthermore, it is clear from these cases that health professionals and the organisations responsible for the care of these patients who actively co-operate with such regimens (and perhaps assist in the process by providing palliative medication) are not regarded as assisting suicide.¹²

In contrast, however, a person in an identical situation who takes positive action to hasten their death (e.g. by taking an overdose) is regarded in law as committing suicide, and a doctor who provides the drugs to assist will be regarded in law as assisting suicide. The principles of autonomy and self-determination are only seen in law as justifying non-intervention (so that health professionals cannot compel unwanted treatment or force food and water on a patient, even though the patient will inevitably die), and cannot be used as lawful justification for a doctor to provide direct assistance to a patient. Yet, it seems inconsistent and illogical that the provision of palliative drugs in connection with a person's refusal of medical interventions to extend their life is acceptable and indeed, legal, yet the provision of drugs to a person who more directly seeks to end their life would be regarded as illegal.

Another inconsistency relates to how the law deals with palliative measures which hasten death, for example, when a doctor induces a permanent comatose state, knowing, possibly even intending, that this will end the life of the patient. In contrast to active voluntary euthanasia, slow euthanasia appears to be acceptable.¹³ This is not necessarily a bad thing but further highlights the inconsistencies in the law, the lack of transparency, and the

⁷ M. Otlowski, 'The Effectiveness of Legal Control of Euthanasia: Lessons from Comparative Law' 2001, *Recht der Werkelijkheid* 2001, Special Issue: 'Regulating Physician-Negotiated Death', pp. 137-155.

⁸ Otlowski 1997 *supra*, note 3, pp. 191-195.

⁹ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229.

¹⁰ *H LTD v J* [2010] SASC 176.

¹¹ A. Lu, 'End of Life Directions and Self-Determination - *H Ltd v J*', *Australian Health Law Bulletin* 2010-18, pp. 94-96.

¹² *Ibid.*

¹³ Otlowski 1997 *supra*, note 3, pp. 170-184.

fact that sometimes doctors may find themselves forced into such practices because more direct assistance is not lawfully an option.

II. Implications of these Deficiencies

This next section seeks to provide a pragmatic assessment of functionality or 'fitness for purpose' of the law, based on the usual measures that one would look to in good laws, namely certainty, predictability of outcome, fairness and transparency.

These deficiencies, in relation to laws about assisted dying, have the cumulative effect of rendering the operation of the law inconsistent, discriminatory and hypocritical.¹⁴ As a society, we are encouraged to turn a blind eye to the practice and pretend that the criminal prohibition is effective to protect patients from the harm of unwanted and inappropriate intervention. Where practices do come to attention, the law is often misapplied or manipulated to avoid difficult outcomes (e.g. the prosecution of a doctor who acted *bona fide*, on compassionate grounds). This may avoid an unjust result in an individual case, reflects badly on the legal principles themselves. There are plenty of examples of doctors being exposed for providing assistance in dying, but escaping the reach of the law either through non-prosecution (prosecutorial discretion and assessment, amongst other things, of likelihood of a conviction); or bizarre legal outcomes such as in the *Sanders* case,¹⁵ or perverse jury outcomes against the weight of the evidence. However, there are also instances where well-respected doctors who have been reported for providing assistance are successfully prosecuted, such as in the UK case of *Cox*¹⁶ where a prison sentence of 12 months (albeit suspended) was imposed. Leniency can therefore not be reckoned on as a certainty, even where doctors are acting *bona fide*, which makes the application of the law unpredictable.

This multi-dimensional dysfunctionality of the present law leads to it being brought into disrepute. Even very public provocations to either enforce the law or change it, for example, by Dr Rodney Syme and six other doctors in their open letter to the Victorian Premier published in *The Age* in March 1995¹⁷ do not lead to any action. I would argue that this dysfunctionality in the operation of the law is a powerful reason for change, and can only be addressed through some kind of legislative reform which overrides current criminal law prohibitions. We need to close the gap and bring the overt culture as expressed by the law in accord with the covert culture, as expressed in what people do. Essentially, there is a need for greater honesty in recognising what already occurs in medical practice, and genuinely endeavouring to regulate these practices.

These problems should be of concern not just to people who believe in the merits of physician-assisted death as an aspect of autonomy and human rights (which is a large majority of the population), but also to those who support a transparent and functional criminal justice system and who believe in providing protection to patients from non-consensual interventions. The law in this area is simply not fit for purpose when measured against

¹⁴ Otlowski 1997 *supra*, note 3, pp. 148-152.

¹⁵ *People v Sander* ((unreported) *N.Y. Times* 10 March, 1950) - the doctor had injected air into the patient's veins then recorded this in the records, noting that the patient died immediately. Notwithstanding this unequivocal documentation of what he had done, the doctor was found not to have caused the patient's death because it could not be shown that his conduct had caused the patient's death.

¹⁶ (1992) 12 BMLR 38.

¹⁷ Dr Rodney Syme *et al*, 'Open Letter to the Premier', *The Age* (Melbourne), 25 March 1995.

expectations of certainty, predictability of outcome, fairness and transparency.

III. How Could the Law be Improved?

As stated at the outset, my main objective with this paper is to argue for reforms that respect and protect patients seeking assistance at the end of life, as well as protecting the doctors who assist them. In my view, this can only be achieved through a more permissive but regulated legal environment.

It needs to be acknowledged that we are dealing with a delicate area involving sick people who are often vulnerable. Careful scrutiny is therefore required of cases where we would want to allow physician assistance in death and unquestionably, there is a need for safeguards to ensure that such assistance is only available in appropriate cases. Above all, it is important that the voluntariness of patient choice is confirmed, and that medical decision-making is undertaken in an environment which is open, and where doctors can benefit from peer review and advice.

Having identified that there are serious deficiencies in the law leading to dysfunctionality, the question becomes what is the best way of addressing these deficiencies? In other words, what are the features of a functional law that we would aspire to? Amongst other things, they would include clarity, transparency, certainty, fairness and predictability of outcomes.

IV. Overview of Legislative Models

A growing number of jurisdictions have legislated to allow some form of medical assistance in death. For the purposes of this paper, I would like to focus on two of the main models: direct assistance in the form of active voluntary euthanasia, and physician-assisted suicide.

Looking first to the issue of active voluntary euthanasia, a country long associated with this practice is the Netherlands, although, as we will see, it is only in more recent years that the more permissive approach in the Netherlands has been formally enacted into law. This same kind of legislative model has since been introduced in Belgium (*Act on Euthanasia* 2002).¹⁸ The other model is the 'Oregon' model for physician-assisted suicide (*Death with Dignity Act* 1994) which has more recently also been adopted in Washington (*Death with Dignity Act* 2009).

IV.1 The Netherlands Model

The Netherlands has for many years adopted a significantly more permissive approach to active voluntary euthanasia than other jurisdictions.¹⁹ Essentially, it has been based on a policy of regulation rather than outright prohibition, as euthanasia has remained a criminal offence under Dutch law²⁰.

The Netherlands' policy on active voluntary euthanasia has evolved over time through a synthesis of factors commencing with the initiative of the

¹⁸ Note there have also been recent legislative developments in Luxembourg: *Palliative Care Euthanasia Act* (2009).

¹⁹ Otlowski 1997 *supra*, note 3, pp. 391-455.

²⁰ Article 293 *Penal Code* which prohibits taking the life of another at that person's express and serious request, and Article 294 which contains a prohibition on assisted suicide.

courts. Through a series of decisions, the Dutch courts developed certain exceptions to this prohibition by defining guidelines for the practice of active voluntary euthanasia. In doing so, the courts drew on input from the Royal Dutch Medical Association which had developed medical guidelines in this area. Also relevant have been prosecutorial policy, institutional protocols, and ministerial decrees.

Combined, these factors gave rise to a situation of legal tolerance or *de facto* legal acceptance of active voluntary euthanasia, performed in accordance with established guidelines. More recently, legislation has been passed to give a more secure legal basis for these arrangements, codifying this convention of not prosecuting doctors who have performed active voluntary euthanasia in accordance with specified criteria by amending the Dutch Penal Code, to give statutory protection to doctors who adhere to the requirements of careful practice now specified in the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2001). Pursuant to these requirements, active euthanasia is legal if it is carried out by a doctor at the request of a patient who is unbearably suffering from a serious medical condition with no prospect for improvement; the doctor must consult a second independent doctor and comply with a variety of other procedural requirements, including reporting what has been done in accordance with the relevant provisions of the *Burial and Cremation Act*.²¹ The doctor's report is reviewed by an interdisciplinary review committee, comprised of a lawyer, a doctor and an ethicist. If the committee finds that the doctor has complied with all the legal requirements, the case ends there. If not, the case is forwarded to the prosecutorial authorities.

Since the introduction of the legislation, there has been a steady increase in reported cases. For example, in 2003, the number of reported cases was approximately 1626 (1.2% of all deaths),²² but for 2009, 2,636 euthanasia deaths were reported (approximately 2% of all deaths). Data suggests that the great majority of active voluntary euthanasia cases in the Netherlands are now being openly reported,²³ even though doctors know that their actions will come under legal scrutiny. One might reasonably ask *why* do doctors report if killing at request is still an offence on the statute books? The answer seems to be that there is widespread recognition by Dutch doctors involved in this practice that it is better to seek to strictly follow the criteria, and then allow their actions to be investigated as a means of protecting themselves from risk of criminal liability, especially after having gained confidence that thousands of cases are being reported each year, but only a few are identified as problematic. This process of investigation and review offers an opportunity for a cycle of feedback which helps all doctors practising in this field to improve the quality of decision-making and practice.

Focusing on the role of the review committees and on reported data from 2008 and 2009, the number of reported active voluntary euthanasia cases in 2008 was 2,300 deaths.²⁴ According to the annual report published by the five regional euthanasia monitoring committees, ten cases of assisted

²¹ <http://www.euthanasiecommissie.nl/en/reporting/> (3 December 2010). See also: H. Buiting *et al*, 'Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study', *BMC Med Ethics* 2009-10, p. 18.

²² http://en.wikipedia.org/wiki/Euthanasia_in_the_Netherlands (3 December 2010)

²³ Buiting 2009 *supra*, note 20.

²⁴ <http://www.rnw.nl/english/article/faq-%E2%80%93-euthanasia-netherlands> (3 December 2010). For information on reporting requirements and the regional review Committees, see: <http://www.euthanasiecommissie.nl/verslaglegging/> (3 December 2010).

suicide in 2008 were found not to have followed official guidelines and were referred to the Public Prosecution Office and Health Inspectorate for their comments.²⁵ In a number of the earlier cases of assisted suicide where the doctors were found not to have fully complied with the carefulness requirements (cases reported in 2003), the doctor was reprimanded for not being present while the patient drank the potion. They said they had not realized that this was required. Reported active voluntary euthanasia figures for 2009 were 2,636 cases.²⁶ Of these cases, the majority (over 80%) were cancer patients, and more than 80% of the deaths occurred in the patient's home.²⁷ From the cases reported in 2009, there were nine cases where the regional review committees found that doctors had not sufficiently complied with the criteria of due care for their patients.²⁸ Doctors that do not comply with the law can be sent to jail for up to 12 years in cases of euthanasia, and up to three years for assisted suicide, or in less serious matters can be subject to medical disciplinary proceedings.

It has been suggested that part of the explanation in relation to the increase of reported cases over the past few years is to do with the characterisation of certain conduct, in particular, clarifying the boundaries between palliative sedation and active voluntary euthanasia. It is thought that the stricter definitions cause doctors to report active voluntary euthanasia more often, instead of reporting the use of palliative sedation. In addition, the review committees think that the doctors' preparedness to report active voluntary euthanasia may have increased because the new law clearly describes the medication that is allowed in the process.²⁹

IV.2 The Oregon Model

In Oregon, physician-assisted suicide has been legalised under the *Death with Dignity Act* 1994. This Act allows terminally ill adult persons, who are Oregon residents with less than six months to live, to request a prescription of a lethal dose of drugs to end unbearable suffering. Two doctors must have assessed the patient's condition as terminal. The patient must have made their request at least three times, and the third time must be in writing before witnesses. The administration of the lethal dose must be by the patient, and not the doctor. The Act specifies that the Oregon Department of Human Services monitors compliance with the legislation, collects data on those who use the Act, and publishes annual reports setting out this information. There is a Task Force ('The Task Force to Improve the Care of Terminally Ill Oregonians') which publishes a guidebook to the Act for health care providers which is updated on a regular basis.³⁰

The evidence emerging from the Oregon experience based upon a study of the deaths occurring since the commencement of the Act's operation should allay many of the concerns that have been raised against such legislation.³¹

²⁵ *Ibid.*

²⁶ B. Berkowitz, 'Dutch Euthanasia Cases Rise 13 Percent in 2009' *Amsterdam* (Reuters) Wed Aug 11, 2010. (Could you please check if this footnote contains all the necessary information?)

²⁷ *Ibid.*

²⁸ *Ibid.*

²⁹ <http://www.rnw.nl/english/article/faq-%E2%80%93-euthanasia-netherlands> (3 December 2010).

³⁰ The Task Force to Improve the Care of Terminally-Ill Oregonians, 'The Oregon death with Dignity Act: A Guidebook for Health Professionals', <http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethicsoutreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf> (3 December 2010).

³¹ International Task Force on Euthanasia and Assisted Suicide:

Many people had feared that if physician-assisted suicide was legalised in the United States, it would be disproportionately chosen by or forced on terminally ill patients who were poor, uneducated, uninsured, or fearful of the financial consequences of their illness. Drawing on the data from the annual reports, since the law was first passed in 1997, in Oregon (which has a population of approximately 4 million), 460 patients have died from ingesting medications prescribed under the *Death with Dignity Act*.³² Significantly, the decision to request and use a prescription for lethal medication was associated with concern about loss of autonomy, loss of dignity and decreasing ability to participate in activities that made life enjoyable, rather than fear of intractable pain or worry about financial loss. Further, it was found that the choice of physician-assisted suicide was not associated with level of education or lack of health insurance coverage: the great majority of person's availing themselves of this option were well-educated, and had some form of health insurance (for example, in the data reported for 2009, 84.7% had private health insurance).³³

This model for legalised physician-assisted suicide has since been adopted in the State of Washington in 2009: *Washington Death with Dignity Act 2009*.³⁴ Under this legislation, a patient (of at least 18 years of age, and permanent resident of the state) must be diagnosed as having less than six months to live, be of sound mind, make a request orally and in writing, have it approved by two different doctors, then wait 15 days and make the request again. A doctor can prescribe a lethal dose, but cannot administer it.

Data from the first report under the Washington Act (for 2009) has confirmed similar outcomes as reported under the Oregon legislation.³⁵ According to this Washington Report, medication was dispensed to 63 individuals and prescriptions were written by 53 different physicians. Of the 63 people to whom medication was dispensed, 36 died after ingesting the medication. The After Death Reporting Forms (received for 44 out of the 47 patients) set out the end-of-life concerns for these individuals. All were concerned about loss of autonomy, 82% about loss of dignity, and 91% about losing the ability to participate in activities that made life enjoyable. These reporting requirements under the Oregon and Washington physician-assisted suicide legislation have ensured high visibility of the practice. Further, they allow for quality control, but also for collection of data regarding people's reasons for requesting physician-assisted death. Such empirical data is particularly useful to inform policy, and permits evidence-based decision making about such practices.

<http://www.internationaltaskforce.org/orstats.htm> (3 December 2010). For an early report, see: A. Chin *et al*, 'Legalised Physician-Assisted Suicide in Oregon – The First Year's Experience', *New England Journal of Medicine* 1999-340, pp. 577-583.

³² International Task Force on Euthanasia and Assisted Suicide, *supra*, note 30.

³³ Summary of Oregon's *Death with Dignity Act* (2009):

<http://oregon.gov/DHS/ph/pas/docs/year12.pdf> (3 December 2010). For critique of the data from Oregon, see M. Battin *et al*, 'Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups', *J Med Ethics* 2007-33, pp. 591-597.

³⁴ J. Goldstein, 'Washington's Physician-Assisted Suicide Law Takes Effect', <http://blogs.wsj.com/health/2009/03/05/washingtons-physician-assisted-suicide-law-takes-effect/> (3 December 2010).

³⁵ Death with Dignity Report, Washington State Department of Health, Washington State Department of Health 2009
<http://www.deathwithdignity.org/media/uploads/Washington2009Report.pdf> (3 December 2010).

V. Evaluation of these Models?

Before examining the pros and cons of these two different models, some initial observations can be made about what these models have in common. Through legislation, these jurisdictions have created a lawful pathway for medical assistance in death, subject to carefulness criteria. It does come at some price, however, in terms of accessibility for patients. These models only come into play in circumstances where a patient has had time to explore options with their doctor; they need time for reflection, and there are considerable due process requirements which limit the availability of active voluntary euthanasia or physician-assisted suicide. It is, of course, important to safeguard against hasty decisions and ensure voluntariness, but inclusion of extensive substantive and procedural safeguards means that such legislation will not be available where death is imminent and there is not time to complete all the requirements.

There is undoubtedly greater transparency of practice in jurisdictions which have processes which keep doctors practising in this area accountable, than in jurisdictions such as Australia which prohibit active voluntary euthanasia or physician-assisted suicide. Furthermore, through a process of reporting we can gather data that informs our understanding of the practice, including circumstances of those people who seek to access these options and their motivations for doing so. This has in fact proved helpful to debunk many of the assumptions and objections raised in respect of the practice, for example, regarding the category of persons who would seek such assistance. Additionally, processes for the review of these practices can perform an educative function for the doctors involved, with feedback to them of how end-of-life practices can be further improved.

It should also be noted that these models of legalised active voluntary euthanasia and physician-assisted suicide are not necessarily mutually exclusive: for example, the Netherlands makes both available. Indeed, it would be strange for a jurisdiction to make it lawful for a doctor to take direct steps to end the life of a patient but prevent the doctor, in the same circumstances, to provide the patient with the means of taking their own life. However, the main focus for the purposes of this paper is to consider active voluntary euthanasia and physician-assisted suicide as alternative options.

VI. Directions for Australia?

The Netherlands model of active voluntary euthanasia (but patients also having the option of physician-assisted suicide) clearly offers a more comprehensive solution. One way of evaluating the two models is to compare the level of complexity of safeguards required for each. Of its nature, active voluntary euthanasia being the more interventionist of the models, involving the doctor in the administration of the lethal dose typically by injection, requires more rigorous requirements. When this sort of model is sought to be adopted in other jurisdictions, the proposed legislation sometimes contains extremely demanding procedures in an attempt to demonstrate safety and the integrity of the process. For example, the most recent *Tasmanian Dying with Dignity Bill* introduced in 2009,³⁶ which was heavily based on the Northern Territory of Australia model which has been in

³⁶ Dying with Dignity Bill 37 of 2009, , <http://www.austlii.edu.au/au/legis/tas/bill/dwdb37o2009241/> (3 December 2010). For discussion, see L. Bartels and M. Otlowski, 'A Right to Die? Euthanasia and the Law in Australia', *Journal of Law and Medicine* 2010-17, pp. 532-555.

force for a short time,³⁷ ended up being criticised (seemingly by all sides) as being too cumbersome and complex. Ironically, it was the stringency of the safeguards that contributed to the equivocal report from the Parliamentary Standing Committee,³⁸ and the lack of support for the legislation in the parliament.

Looking at the alternative, there are a number of arguments one could put forward to support a model based on physician-assisted suicide rather than active voluntary euthanasia:

- It requires less complex and cumbersome legislation because it is the patient who administers the lethal dose; compared with legalising active voluntary euthanasia, physician-assisted suicide would inevitably be less complicated to introduce;
- It would provide some guarantee of the voluntariness of the patient's decision by virtue of the death being at the patient's own hand;
- It minimises third party involvement in the patient's death: it is reasoned that where the patient is capable of performing the death inducing act, there is no justification for another to do what the patient can do themselves;
- By minimising the involvement of doctors, one avoids placing the responsibility of killing on others, and reduces the risk of emotional trauma to the person who is involved in bringing about death;
- As it is a less drastic option than active voluntary euthanasia, it is likely to gain wider acceptability amongst doctors and the community generally.

There is certainly some substance to these arguments. These considerations may justify a cautious approach to the legalisation of active voluntary euthanasia and could arguably justify a requirement that active voluntary euthanasia is only to be available in circumstances where the patient is physically unable to commit suicide.

For my own part, however, I am on the record for recommending reform of the law by legalising active voluntary euthanasia.³⁹ Although I can see the advantages of a physician-assisted suicide model, I am not convinced that it is, on its own, a satisfactory legal response to the present problems. Whilst this option may be appropriate and adequate in many cases, it does not represent a complete solution to the existing difficulties in this area. There will always be a proportion of patients who are physically unable to commit suicide. For others, the concept of suicide may be objectionable, yet they may willingly seek active voluntary euthanasia. If the legal reform response were limited to physician-assisted suicide, these categories of people would not be provided for. There could also potentially be human rights arguments raised against a model limited to physician-assisted suicide based on the

³⁷ *Rights of the Terminally Ill Act 1995 (NT)*. For analysis of the operation of the legislation before it was overturned by the Commonwealth Parliament (*Euthanasia Laws Act 1997 (Cth)*), see: D. Kissane, A. Street and P. Nitschke, 'Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act, Northern Territory, Australia', *Lancet* 1998-352, pp. 1097-1102.

³⁸ Parliament of Tasmania, Joint Standing Committee on Community Development, Report on the Dying with Dignity Bill 2009, <http://www.parliament.tas.gov.au/ctee/REPORTS/Dying%20with%20Dignity%20Final%20Report.pdf> (3 December 2010).

³⁹ Otlowski 1997 *supra*, note 3, pp. 494-501.

sort of reasoning as was argued in *Rodriguez v British Columbia (Attorney General)*⁴⁰ before the Supreme Court of Canada and which was accepted by the dissenting minority in that case: essentially an argument that the criminal law prohibition on assistance in suicide discriminates against Mrs Rodriguez who was physically unable to commit suicide, and was therefore in violation of her rights under the *Canadian Charter of Rights and Freedoms*.⁴¹

Those who are campaigning for reform may need, however, to make a pragmatic assessment of which model they wish to endorse. This would entail a realistic evaluation of the likelihood of securing either legalisation of active voluntary euthanasia and/or physician-assisted suicide. Given the many obstacles to achieving reform in Australia witnessed over the past decade or so, it could be argued that expectations need to be modified, and efforts should focus on what may be currently achievable, albeit less comprehensive legislation. Realistically, it may be better to secure some reforms at this time, even though this is at the price of limiting availability to those who are physically capable of committing suicide. Certainly, from the evaluations that have been undertaken of this physician-assisted suicide model, for example, in Oregon, annual reporting required under the legislation suggests that it has been an effective practice for those who have sought to use it and have satisfied the eligibility criteria. Although there is more limited scope for its use, in comparison with an active voluntary euthanasia model, it is likely to be easier to achieve in Australia because it may be seen as safer from abuse due to the required self-administration by the patient.

This is not to say that there might not be potential problems if only physician-assisted suicide is available. In the Netherlands (where, by far the great majority of cases involve active voluntary euthanasia rather than physician-assisted suicide), a study in 2000 found that Dutch physicians who intend to provide assistance with suicide sometimes end up administering a lethal medication themselves because of the patient's inability to take the medication, or because of problems with the completion of physician-assisted suicide.⁴² Such additional assistance to complete the task would not appear to be possible under the Oregon model, and one can imagine nothing more disturbing for a patient than to awaken from a failed attempt. This may warrant an exception permitting additional intervention in circumstances where the patient is physically unable to commit suicide.

The question always remains, to what extent are practices in one country exportable to another? Obviously, this cannot be taken for granted, but there is nothing to suggest that the circumstances of those jurisdictions where the physician-assisted suicide model has been adopted (Oregon and Washington) are so different to the states and territories in Australia; indeed, Australia, as a nation, could be argued to have a safer starting premise because of our national health care system, underpinned by Medicare, guaranteeing access to health care for all, whereas this has only been a more recent development in the United States.⁴³

The other reality that needs to be stressed is that even if such a model were adopted in Australia, it would be very unlikely to result in a large uptake.

⁴⁰ *Rodriguez v British Columbia (Attorney General)* [1993] 3 S.C.R. 519.

⁴¹ Otowski 1997 *supra*, note 3, pp. 86-94.

⁴² J.H. Groenewoud *et al*, 'Clinical Problems with the Performance of Euthanasia and Physician-assisted Suicide in The Netherlands', *N Engl J Med* 2000-342, pp. 551-556.

⁴³ <http://www.healthreform.gov/> (3 December 2010).

Data from these United States jurisdictions does not suggest that the numbers would be significant (and arguably not more in number than would already occur surreptitiously in practice, notwithstanding current prohibitions). However, the lawful and transparent availability of this option will be of significant symbolic importance, bringing peace of mind to many people through a process of empowerment in decision-making, even if many of these individuals ultimately never need to avail themselves of such assistance.

Conclusion

We simply cannot ignore the problems inherent in the present law. More realistic, functional and transparent laws are needed to deal with end-of-life issues. The law should deliver clarity, certainty, predictability and fairness. We need to be realistic and accept that we are not facing a choice of whether the activity of assistance in dying should commence, as there is incontrovertible evidence that this it already occurs. Rather, the question is: should we continue to turn a blind eye to the practice, and pretend that the prohibition of the practice is effective to protect patients from the harm of unwanted or inappropriate intervention? Alternatively, is it preferable to be more honest and open, recognising that such activities occur, and endeavour to regulate this area to make this practice as safe as possible? Adopting the latter approach, measures could be taken to ensure that physician-assisted death is only utilised where other options, including palliative care, have been attempted, as well as imposing safeguards and restrictions on the practice, such as limiting its availability to patients who have reached the terminal stage of their illness.

Although in principle, I remain a strong supporter of active voluntary euthanasia and believe legalisation of this model can be readily justified; perhaps a more feasible approach for Australian jurisdictions at this point is to adopt the Oregon model which addresses many of the objections to physician-assisted death, and has a more realistic chance of support by the Australian legislatures.