In Pursuit of a Good Death: Responding to Changing Sensibilities in the Context of the Right to Die Debate

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Juridical Studies at the University of Sydney

VICTORIA HILEY

The Faculty of Law University of Sydney

January 2008
ABSTRACT

This thesis challenges a number of claims that are made in the context of the euthanasia debate: that there is only one version of the good death; that rights discourse is the most appropriate vehicle by which to secure legal recognition of a right to die; that the Netherlands is either a model for reform or the epitome of a slippery slope in its regulation of euthanasia; and that a key argument in the euthanasia debate, the sanctity of life doctrine, is a fixed, immutable concept.

In this thesis I use process sociology, developed by Norbert Elias, in order to capture changing sensibilities toward death and dying in the common law jurisdictions (Australia, England, the United States of America, Canada and New Zealand) and in the Netherlands. At the same time I analyse changing attitudes among key groups whose work impacts upon the euthanasia debate namely, parliamentarians, law reform bodies, the judiciary and medical associations.

My aim in adopting this approach is threefold. First of all, to examine evolving attitudes to death and dying in order to determine whether the institutions of law and medicine are responding in an adequate manner to changing sensibilities in the common law countries and in the Netherlands. Secondly, to highlight shifting balances of power within the euthanasia debate. Thirdly, to assess whether the various options for reform that I discuss are workable or not.

In this thesis I show that there appears to be a sensibility of support in the common law countries for euthanasia to be legally available when an adult is terminally ill, is experiencing pain that he or she cannot bear and has expressed a wish to die (the typical euthanasia scenario). However, the situation is far from clear cut. The methods adopted by one of the ways of measuring sensibilities, opinion polls, suggest that sensibilities may not always be well-informed. Further, attitudes within and between key groups are not uniform or settled.

In the context of this unsettled state of affairs, I show that responses to changing sensibilities from law and medicine in the common law jurisdictions are far from
satisfactory. So far as legal responses are concerned, case law outcomes in right
to die applications suggest a lack of flexibility. Outcomes in prosecutions following
active voluntary euthanasia or assisted suicide reveal a non-application of
established legal principles and suggest that the courts do not focus, squarely,
upon the real issues at stake in the euthanasia debate. Medical responses are
similarly less than optimal due to a tendency to de-emphasise existential
(emotional) pain which, research shows, is the prime motivating factor in requests
to be assisted to die sooner. Responses to changing sensibilities to death and
dying in the Netherlands are also unsatisfactory because of the disorganised
manner in which euthanasia was legalised and because regulation is inadequate.

I come to the conclusion that there are three ways in which we could possibly
resolve these problems and increase the flexibility of responses to changing
sensibilities toward death and dying. They are as follows: by legalising euthanasia;
by permitting a defence of necessity; or, by liberalising the use of terminal sedation
in end-of-life care. Of these three, I conclude, in light of shifting sensibilities and
overall negative attitudes among key groups to euthanasia, that the last is the
most appropriate option at the present time. In closing, I address some of the
larger issues at stake in the euthanasia debate. In particular, I deal with the effect
that changing sensibilities toward the process of dying have had upon human
social life, leading to the problematic situation that Elias referred to as the
‘loneliness of the dying’.
ACKNOWLEDGEMENTS

Thank you to my supervisors, Professor Julie Stubbs and Dr Isabel Karpin and, for commenting on earlier drafts, Judicial Registrar Catherine McDonald and Associate Professor Anne Duggan.

This thesis was written in loving memory of Dorothy Beatrice Hiley
25 September 1923 – 3 December 2002

And then the rain stops. Gradually, the room is filled with light; the bare criss-crossing branches of the tree are hung with drops and as the sun comes out it catches the drops and they flash with colour – blue, yellow, green, pink. The branches are black against a golden orange sky, black and brilliant. Claudia gazes at this; it is as though the spectacle has been laid on for her pleasure and she is filled with elation, a surge of joy, of well-being, of wonder.

The sun shrinks and the glittering tree is extinguished. The room darkens again. Presently it is quite dim; the window is violet now, showing the black tracery of branches and a line of houses packed with squares of light. And within the room a change has taken place.

It is empty.¹

Victoria Hiley, 2008

# TABLE OF CONTENTS

**ABSTRACT**

1

**ACKNOWLEDGEMENTS**

III

**TABLE OF CONTENTS**

IV

**LIST OF ABBREVIATIONS**

VIII

**CHAPTER ONE – DEATH IN THE 21ST CENTURY: DOING IT MY WAY?**

1

1. Introduction

1

2. Terminology

3

3. The Scope of the Research

4


5

A. Australia

5

B. England

7

C. The United States of America

10

D. Canada

12

E. New Zealand

13

F. The Netherlands

13

5. The Analytical Framework

15

6. The Thesis

17

7. Changing Sensibilities in relation to Death and Dying in the Common Law Jurisdictions

18

8. Defence of the Analytical Framework

24

**CHAPTER TWO – MURDER? CAN YOU PROVE IT? SOME TERMINAL PROBLEMS WITH END-OF-LIFE LAW MAKING IN THE COMMON LAW JURISDICTIONS**

29

1. Introduction

29

2. The DDE

32

3. AVE – Established Legal Principles

38

A. Australia

39

B. England

46

C. The United States of America

49
i. American States whose Approach is Based on the English Common Law 49

ii. American States whose Approach is Based on the Model Criminal Code 50

D. Canada 51
E. New Zealand 53

4. AVE – the Law in Practice 54
A. Australia 56
B. England 57
C. The United States of America 64
D. Canada 67
E. New Zealand 70

5. AS – Established Legal Principles 73
A. Australia 74
B. England, Canada, New Zealand and the United States of America 75

6. AS – The Law in Practice 79
A. Australia 79
B. England 82
C. The United States of America 83
D. Canada 85

7. Conclusion 87

CHAPTER THREE – IN PURSUIT OF A GOOD DEATH: THE MISTAKEN RESORT TO RIGHTS TALK 90
1. Introduction 90
2. Rights Talk – Changing Sensibilities 94
3. What’s Wrong with Rights? 99
4. The Mistaken Resort to Rights Talk 101
A. Canada 103
B. The United States of America 105
C. England 110
D. A De Facto Right to Die? 114
E. The Defence of Necessity 116
F. Contrary Cases 119
5. Some Alternative Approaches 128
6. Conclusion 132
CHAPTER FOUR – THE PALLIATED (? GOOD) DEATH 134
1. Introduction 134
2. Pain and Suffering – Changing Sensibilities 137
3. The Palliated (? Good) Death 150
   A. Previous Research 152
   B. Research Question 154
   C. Research Methodology 154
   D. Subjects’ Responses 156
   E. Discussion of the Subjects’ Responses 164
   F. Palliative Care Experts and the Good Death 169
4. A better way forward? 170
5. Conclusion 173

CHAPTER FIVE – GOING DUTCH: A MODEL FOR REFORM OR THE EPITOME OF A SLIPPERY SLOPE? 175
1. Introduction 175
   A. The Dutch Judiciary 181
   B. The RDMA 196
   C. The Dutch Government 202
3. Dutch Society – Changing Sensibilities 207
4. The Netherlands: the Epitome of a Slippery Slope? 212
   A. The Remmelink Report 213
      i. The Interview Study 215
      ii. The Death Certificate Study 217
   B. The 1995 Study 218
   C. The 2001 Study 219
   D. The 2005 Study 221
   E. Reporting Since the Remmelink Report 222
5. Conclusion 224

CHAPTER SIX – RESPONDING TO CHANGING SENSIBILITIES IN THE CONTEXT OF THE RIGHT TO DIE DEBATE 225
1. Introduction 225
2. Options for Reform 228
   A. Legalising Euthanasia via Legislation 228
i. Limiting the Potential for Abuse 229
ii. The Problem of Instituting a Precondition that Death Occur within a Specified Time 231
iii. The Need to Debate the Issue of Existential Pain 232
iv. Recognising the Limits of Personal Autonomy 233
v. Ensuring that the Process of Human Dying is Dignified 234

B. Permitting the Defence of Necessity to be Raised 235
C. Extending Existing Practices in Palliative Care 238

3. The Larger Issues at Stake in the Euthanasia Debate 244

BIBLIOGRAPHY 248

APPENDICES

1. Health care workers’ attitudes to active voluntary euthanasia
2. Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002
3. Physical and fault elements of murder in Australia
4. Incidence of assisted suicide in Oregon
5. Summary of case law in Australia, England, the United States of America, Canada and New Zealand in relation to murder (and related offences) and assisted suicide
6. Letter to research subjects
7. Consent to take part in research
8. Interview questions
9. Table of results
10. Due Care Guidelines, 1973-2002
12. Chronology of major events in relation to euthanasia in the Netherlands, 1953-2005
13. Reported non-leading cases of voluntary and involuntary euthanasia and DAS, 1986-2004
15. Frequency of end-of-life decisions for non-sudden deaths in European countries
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>the Australian Medical Association</td>
</tr>
<tr>
<td>AS</td>
<td>assisted suicide</td>
</tr>
<tr>
<td>AVE</td>
<td>active voluntary euthanasia</td>
</tr>
<tr>
<td>BMA</td>
<td>The British Medical Association</td>
</tr>
<tr>
<td>CSA</td>
<td><em>The Controlled Substances Act</em></td>
</tr>
<tr>
<td>DAS</td>
<td>doctor-assisted suicide</td>
</tr>
<tr>
<td>DDE</td>
<td>the doctrine of double effect</td>
</tr>
<tr>
<td>DPP</td>
<td>the Director of Public Prosecutions</td>
</tr>
<tr>
<td>ECHR</td>
<td>the European Court of Human Rights</td>
</tr>
<tr>
<td>ERGO</td>
<td>Euthanasia Guidance and Research Organisation</td>
</tr>
<tr>
<td>GMC</td>
<td>the General Medical Council</td>
</tr>
<tr>
<td>ICCPR</td>
<td>the International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>the International Covenant on Economic Social and Cultural Rights</td>
</tr>
<tr>
<td>LAWER</td>
<td>life terminating acts without explicit request</td>
</tr>
<tr>
<td>MDEL</td>
<td>medical decision to end life</td>
</tr>
<tr>
<td>ODDA</td>
<td>the <em>Oregon Death with Dignity Act</em></td>
</tr>
<tr>
<td>PPS</td>
<td>the Public Prosecution Service</td>
</tr>
<tr>
<td>RDMA</td>
<td>the Royal Dutch Medical Association</td>
</tr>
<tr>
<td>ROTIA</td>
<td><em>the Rights of the Terminally Ill Act</em></td>
</tr>
<tr>
<td>SCEA</td>
<td>support and consultation for euthanasia</td>
</tr>
<tr>
<td>SCEN</td>
<td>support and consultation for euthanasia in the Netherlands</td>
</tr>
<tr>
<td>SLD</td>
<td>the sanctity of life doctrine</td>
</tr>
<tr>
<td>TLRASA</td>
<td><em>the Termination of Life on Request and Assisted Suicide (Review Procedures) Act</em></td>
</tr>
<tr>
<td>UDHR</td>
<td>the Universal Declaration of Human Rights</td>
</tr>
</tbody>
</table>
CHAPTER ONE
DEATH IN THE 21ST CENTURY: DOING IT MY WAY?

Mr Joyboy was waiting for Dennis at the side entrance of the mortuary. Whispering Glades was ideally equipped for the smooth movement of bodies … They drove to the Happier Hunting Ground where things were even more makeshift, but between them without great difficulty they man-handled their load to the crematorium, and stowed it in the oven. Dennis turned on the gas and lit it. Flame shot from all sides of the brickwork. He closed the iron door.

‘I reckon she’ll take an hour and a half’ he said. ‘Do you want to stay?’

‘I can’t bear to think of her going out like this – she loved to see things done right.’

1. Introduction

Walter claims that the good death in the 21st Century from the perspective of those who seek legal recognition of a right to die as well as from the perspective of those who oppose it, is all about making one’s own choices about one’s last days. That may be a reasonable conclusion in light of the many attempts that have been made in recent times to legalise assisted suicide and active voluntary euthanasia and the belief held by many, captured in the quote immediately above, that one’s death ought to be a fitting end to one’s life and in keeping with one’s own values. But is Walter’s analysis of the situation correct? If it is, should this attitude be officially accommodated in some way? If it is not, then what is the actual situation with regard to the shape of death in the 21st Century and, are our institutions responding in an adequate manner to contemporary views of death and dying? If not, should we change our approach? Those are the questions that lie at the heart of this thesis.

The answers to these questions are of pressing importance in light of predictions that, by 2056, the number of old people in the world (65 or older) will exceed the

1 E Waugh, The Loved One (1948) at 126.
3 Assisted suicide and active voluntary euthanasia are defined in Part 2, below.
number of young people (16 years and younger) for the first time in history and, among the old, the fastest growing number will be the ‘old, old’ (people aged 85 or older). These changing demographics arguably suggest that the pressure for greater control over the process of dying, which finds expression in the right to die movement, will increase in the future as more people are terminally ill at any one time.

Accordingly, in this thesis, I focus on changing sensibilities to death and dying in the context of contemporary debates as to whether active voluntary euthanasia and/or assisted suicide should be legalised. I am predominantly concerned with the adequacy of the legal regulation of, and the medical response to, these changing sensibilities. However, in examining the legal regulation of euthanasia and the medical response to the right to die movement, one must recognise that these discourses are limited in their ability to provide a clear resolution to the debate. Further, community sentiment in relation to death and dying has shifted over time and remains unsettled. So, there is no clear consensus on whether either or both of these practices should be legalised. And as we shall see in Chapters Two to Five, the debates play out differently in different contexts.

In domestic criminal law in the common law jurisdictions, which is dealt with in the next chapter, debate revolves around the adequacy of the law’s response to cases of assisted suicide and unlawful killing in the form of active voluntary euthanasia. In right to die applications in the common law countries, a matter which is dealt with in Chapter Three, debate focuses upon whether there should be legal recognition of a right to be assisted to die. In the medical arena, which is the focus of Chapter Four, debate concerns medicine’s ability to be able to facilitate a good death. In the Netherlands, a topic which is dealt with in Chapter Five, debate concentrates upon whether the Netherlands is a model for reform or whether it is the epitome of a slippery slope so far as its regulation of euthanasia is concerned.

---

5 This term is defined in Part 5, below.
6 This phrase is defined in Part 2, below.
Having set out the issues that lie at the heart of this thesis, I now turn to define the key terms that are used throughout it. Definitions of other less frequently used terms are provided by way of footnotes.

2. Terminology

I use the phrase active voluntary euthanasia\(^7\) to mean the situation whereby a third party ends the life of another person, by active means, at that other person’s request. AVE is often achieved by injecting another person with a lethal substance such as potassium chloride or a large dose of morphine.\(^8\)

I use the phrase ‘assisted suicide’\(^9\) to mean the situation whereby a third party assists another person to end his or her life. When the third party is a layperson AS may be achieved by the provision of means that are easily obtained such as Panadol tablets.\(^10\) When a medical practitioner provides the assistance his or her actions are commonly categorised as doctor-assisted suicide.\(^11\) DAS is often achieved by the provision of a script for a lethal medication.\(^12\)

It is important to note that there is no bright dividing line between AVE, DAS and AS. However, according to commonly held views, in the case of AVE the third party actually carries out the act that causes the person’s death whereas in DAS and AS the third party merely provides the means of death and then leaves it to the other person to use the means provided to achieve the desired result.

I use the word ‘euthanasia’ throughout this thesis to mean AVE and DAS (but not AS) because this thesis focuses upon the provision of assisted dying by medical practitioners. I use the phrases ‘the euthanasia debate’ and ‘the right to die

---

\(^7\) Hereafter AVE.
\(^8\) See the cases discussed in Chapter Two.
\(^9\) Hereafter AS.
\(^10\) See the cases discussed in Chapter Two.
\(^11\) Hereafter DAS.
\(^12\) See discussion in relation to the *Oregon Death with Dignity Act* in Chapter Two.
debate’ interchangeably to mean the debate over whether AVE and/or DAS should be legalised in the common law jurisdictions.

I use the phrases ‘the common law jurisdictions’ and ‘the common law countries’ interchangeably to mean Australia, England, the United States of America, Canada and New Zealand.

Having defined the key terms that I use in this thesis, I now turn to outline the parameters of the research upon which it is based.

3. The Scope of the Research

I adopt the view that we can achieve a more comprehensive understanding of the shape of death in the 21st century by examining changes in sensibilities and attitudes toward death and dying in a number of jurisdictions rather than by limiting the analysis to just one jurisdiction. I consider a broader approach to be important because it assists us to challenge attitudes in relation to death and dying which tend to regard local practices as normal and beyond question. Accordingly, I consider and contrast the shape of death between the common law jurisdictions, and in addition, with the Netherlands. Reporting the shape of death in the Netherlands provides a unique example because a codified exception was created to the criminalisation of euthanasia in the Netherlands in 2002.

Having outlined the scope of the research, I now turn to orientate the reader to the shape of death in the common law jurisdictions and in the Netherlands at the present time. My aim in doing so is to show that the shape of death and dying today is complex and contradictory. At the same time, I provide a snapshot of the legal regulation of euthanasia in each of those jurisdictions in order to provide the basis for more detailed analysis that occurs in subsequent chapters.13

I undertake a detailed consideration of the legal regulation of euthanasia in Chapter Two, a detailed consideration of right to die applications in Chapter Three and a detailed consideration of the response of the Dutch courts to cases of euthanasia in Chapter Five.

A. Australia

On 25 March 1996, the Northern Territory of Australia became the first jurisdiction in the world to legalise both AVE and DAS when the *Rights of the Terminally Ill Act*[^14] was passed[^15]. The ROTIA, which legalised euthanasia provided certain procedural and substantive guidelines were met[^16], was enacted following 30 years of increasing support for the legalisation of AVE among the Australian public[^17].

The ROTIA came into effect on 1 July 1996. Just nine months later, in March 1997, four Australians had committed suicide with the assistance of Australia’s ‘Doctor Death,’ as he came to be known, Philip Nitschke. The four were Janet Mills, Bob Dent and two unidentified individuals[^18]. On each occasion, Dr Nitschke connected each person to an intravenous drip attached to a computerised system which asked whether the person wished to proceed or not and stated that if the response was ‘yes’ the person would die. On pressing the key corresponding to ‘yes’, an intravenous drip delivered a lethal combination of drugs, 30 seconds later[^19].

In December 1996, the ROTIA was overturned when the Commonwealth Euthanasia Laws Act[^20] was enacted[^21]. Notwithstanding the demise of the ROTIA,

[^14]: The Rights of the Terminally Ill Act 1996 (Cth) (hereafter the ROTIA).
[^16]: See Chapter Two of this thesis for discussion of the events leading up to the enactment of the ROTIA and the criteria which had to be met before a person could be euthanased or assisted to commit suicide pursuant to it.
[^17]: K Walsh, ‘Vote … 1 Choice’, The Bulletin (17 September 1996) 18 at 19. These statistics are based on a special Bulletin Morgan Poll which was carried out on 7 September 1996 by telephoning 611 Australian respondents aged 14 and over as well as the results of 13 other Morgan polls carried out since 1962. In September 1996, 76% of those surveyed believed that ‘a hopelessly ill patient who asks for a lethal injection should be given one.’
Dr Nitschke continues to advocate AVE and AS in conjunction with his organisation, Exit International. Since 2003, he has held workshops on how to make a ‘peaceful pill’; a pill that leads to death within an hour of ingestion. Participants in the workshops do not have to be terminally ill.

In contrast to the position adopted by Dr Nitschke, the former Federal Liberal/National Coalition Government was opposed to the legalisation of euthanasia. In January 2006, it enacted the Federal Criminal Code Amendment (Suicide and Related Material Offences) Act which criminalises the provision of information, by telephone, fax, internet and email on how to commit suicide. Yet, in September 2006, the then Federal Liberal Minister for Immigration, Amanda Vanstone, stated in a speech to mark the ten-year anniversary of the first death pursuant to the ROTIA, ‘I strongly support the development of effective laws to allow people who are approaching the end of their lives to choose to die with dignity’. And, in August 2006, Democrat Party member Sandra Kanck, offered advice on how to commit suicide in the South Australian Parliament in a move calculated to defy the Criminal Code Amendment Act. The newly-elected Federal Labor Government, led by Prime Minister Kevin Rudd, has not yet indicated whether or not it supports legalised euthanasia.

---

21 The Bill was remarkable from the perspective of Australian constitutional law because it was the first time that a law that had been validly enacted by a Territory was defeated pursuant to the powers contained in the Australian Constitution: L Bunney, ‘Decision on the Northern Territory Rights of the Terminally Ill Act’ (1997) 5 Australian Health Law Bulletin 72.
22 See <http://www.exitinternational.net/>.
24 Ibid.
28 P Debelo, ‘MP Defiant on Suicide’, The Age (31 August 2006) 3. This was still the case as at 13 January 2008.
Notwithstanding the criminalisation of euthanasia in Australia, cases of alleged euthanasia that come before the courts are generally dealt with in a more lenient manner than one might expect on the basis of Australian criminal law principles. There is evidence that some health care workers in Australia engage in euthanasia, that some Australian doctors support its legalisation and some have openly admitted to having provided euthanasia. In contrast to this, the Australian Medical Association does not support the legalisation of euthanasia.

There is presently no draft legislation at the State or Federal level seeking to legalise euthanasia. However, the situation is far from settled. Independent Minister of the South Australian Parliament, Bob Such, is reportedly finalising a draft Euthanasia Bill to be submitted to the Parliament in the sixth attempt to legalise euthanasia in that State. The Green Party in Queensland has indicated an interest in introducing draft euthanasia legislation in the near future. In addition Ken Smith, a member of the Parliament of Victoria, intends to move a private member’s Bill that will allow doctors to provide lethal medication to patients who are terminally ill.

B. England

The situation with regard to assisted dying, in England, is also complex and contradictory. The question of legalised euthanasia was re-visited in England during 2005 as a consequence of the introduction into the House of Lords of the

---

30 See Chapter Two for discussion of how cases of AS and AVE are dealt with by the courts in Australia.
33 See, for example, M Cooper, 'I Helped Cancer Man Die: Doctor', *Geelong Advertiser* (21 June 2007) 1.
37 C Nader, 'State Liberal MP to Push Death Law', *The Age* (21 June 2007) 11. As at 25 January 2008, the draft *Medical Treatment (Physician Assisted Dying)* Act was expected to be introduced within six months: E Whinnett, 'Mercy Kill Debate to Go Ahead' *Herald Sun* (25 January 2008) 23.
Assistance with Dying for the Terminally Ill Bill, a Bill which sought to legalise AVE and DAS. In 1994, the House of Lords rejected the possibility of legalising euthanasia on the basis that it would breach the sanctity of life doctrine.

The House of Lords’ Committee consulted broadly in 1994 but not as broadly as it did in 2005 when the Select Committee travelled to Switzerland, Belgium and the Netherlands where AVE and/or AS have been legalised or de-criminalised, to investigate the risks and the benefits of legalisation. The Assisted Dying Bill was ultimately defeated but this occurred in the context of a recommendation that it be re-submitted with clearer definitions of key terms such as ‘pain and suffering’ and with a focus on DAS instead of AVE. Notably, by 2005, the SLD was no longer a self-evident reason to reject draft euthanasia legislation.

The stance of the House of Lords to issues in relation to death and dying is far from settled. In an unusual development in 2001, the House of Lords (among many other complex and contradictory reasons) utilised the SLD to justify the killing of a newborn baby when it permitted the separation of conjoined twins, ‘Mary’ and ‘Jodie,’ in the knowledge that this would result in Mary’s death. The

---

38 The Assisted Dying for the Terminally Ill Bill (UK). Hereafter Assisted Dying Bill.
39 In 1994 the Committee stated that: ‘The prohibition against killing is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may seem appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover, dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interests of the individual cannot be separated from the interests of society as a whole’: House of Lords Select Committee on Medical Ethics, Report of the Select Committee on Medical Ethics (1994) at 91.
40 (Hereafter SLD). The SLD is a moral claim with religious underpinnings that holds that all human life is a divine gift from God and therefore cannot be terminated except by God. The doctrine is also expressed in a secular form: it is morally wrong to kill another human being: J Mason & G Laurie, Mason & McCall Smith’s Law and Medical Ethics (7th ed, 2005) at 3.
41 In 2005, the Committee stated that: ‘There is clearly the need to balance the interests of terminally-ill people who wish for assistance to end their lives as against those of patients who do not. But this cannot be seen as a simple matter of weighing a certainty against a doubt and coming down in favour of the former. In any cost-benefit analysis … the balance of advantage needs to take into account the different weightings on each side of the scales. In this case, it is necessary to know, for example, how many people are being deprived of benefit on one side of the equation and how many others might be endangered on the other side. We need also to take a view of the size of the benefits to the one group as against the magnitude of the damage to the other … it is necessary to look at how the balance would look in practice if the law were to be changed’: House of Lords Select Committee, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) at 28.
judges reasoned that separating the twins was in keeping with the SLD because it permitted each twin to maintain her bodily integrity.\footnote{Re A Children (Conjoined Twins: Surgical Separation) [2001] 147 (Fam), discussed in Chapter Three.}

By comparison, a year later, the House of Lords utilised the SLD to justify denying Dianne Pretty’s appeal\footnote{R (on the application of Pretty) v DPP [2002] 1 All ER 1. See Chapter Three.} for her husband to be permitted to assist her to commit suicide in the future, when she was no longer able to care for herself. Yet, at about the same time, the House of Lords granted an order permitting the removal of a ventilator that was keeping Ms B\footnote{Ms B v An NHS Hospital Trust [2002] 2 All ER 449, discussed in Chapter Three.} alive and also upheld the right of English citizens to travel to Switzerland to obtain AS.\footnote{Re Z [2004] EWHC 2917 (Fam).}

This unsettled state of affairs is not confined to the judiciary. In 2004, the English Law Commission conceded that English criminal law is ‘a rickety structure set upon shaky foundations’ and called for reform.\footnote{The Law Commission, Partial Defences to Murder: Report No. 290 (2004) at paragraph 1.4, page 2.} In a consultation paper released in 2005, the Commission suggested that this could be achieved by creating a new homicide statute. Among the many changes proposed by the Commission, AS would remain a criminal offence in its own right but AVE would be categorised as first-degree murder.\footnote{The Law Commission, A New Homicide Law for England and Wales? (2005) at 2-7, 346.}

one might expect on the basis of English criminal law principles, as are others who are convicted of AS.\textsuperscript{50}

Contrary to the stance of the BMA, in November 2006, the Royal College of Obstetricians and Gynaecologists called upon the English health profession to debate the issue of permitting AVE for seriously disabled newborns.\textsuperscript{51} And recent polls reveal growing support for the legal availability of euthanasia in England. In 2005, 86 per cent of the English public were in support of legalising euthanasia.\textsuperscript{52}

C. The United States of America

Attitudes toward euthanasia in the United States of America are also in a state of flux. During 1996, the American Court of Appeal, in \textit{Compassion in Dying v State of Washington}\textsuperscript{53} and in \textit{Quill v Vacco},\textsuperscript{54} held that the provisions of two separate statutes which criminalised AS in New York and in Washington were invalid. In each case the court stated that the statute amounted to a denial of a liberty interest in the manner and timing of one’s own death thus opening the door to legalised euthanasia. However, a year later, the Supreme Court reversed each decision, holding that there is no precedent for such a liberty interest and that to find otherwise would amount to a breach of the SLD.\textsuperscript{55}

The American Medical Association is opposed to the legalisation of euthanasia\textsuperscript{56} but there is evidence that some American doctors support its legalisation.\textsuperscript{57} And

\textsuperscript{50} See Chapter Two for discussion of how the courts in England deal with cases of AS and murder (AVE).
\textsuperscript{53} 79 F 3d 790 (1996) en banc. See Chapter Three.
\textsuperscript{54} 80 F 3d 790 (9th Circuit, 1996). See Chapter Three.
\textsuperscript{55} \textit{Washington v Glucksberg} 117 S Ct 2258 (1997) and \textit{Vacco v Quill} 521 US 793 (1997) respectively. Both cases are discussed in Chapter Three.
medical practitioners who come before the courts in America charged with AS or murder, in circumstances where their actions fall within the definition of AVE, are treated more leniently than one might expect on the basis of American criminal law principles. The exception is America’s ‘Doctor Death,’ Jack Kevorkian, who was convicted of second-degree murder in 1999 and sentenced to up to 25 years in gaol. However, this only occurred after he sent a videotape to 60 Minutes showing him killing a person and, after he had boasted that he had provided AS to approximately 130 people. Kevorkian was released from gaol on 2 June 2007.

Opinion polls show that the majority of Americans support the legalisation of AVE. Indeed many Americans did not believe that Jack Kevorkian should have been gaolied for his activities. However, during 2007, Vermont’s draft Death with Dignity Act and California’s draft Compassionate Care Act, both of which sought to legalise AS, were defeated. In the case of California, this was in spite of a show of support from Governor Arnold Schwarzenegger who commented: ‘I

58 See Chapter Two for discussion of how the courts in America deal with cases of AS and murder (AVE).
60 Under the terms of Kevorkian’s parole, he is not to be present at any suicide or euthanasia and is not to give advice to anyone on how to commit suicide. He has stated that he will devote his time to promoting legislation designed to legalise euthanasia, instead: E Pilkington & A Arbor, ‘International Dr Death’ Swaps Prison for Lecture Circuit: Euthanasia Champion Released after Eight Years: Block Placed on Advising on, or Attending, Suicides’, Guardian (1 June 2007) 21; K Barks Hoffman, ‘Assisted Suicide still Illegal in 49 States: Kevorkian Leaving Prison after Eight Years, but his Cause has made Little Progress’, The Grand Rapids Press (27 May 2007) B3.
61 Editorial, ‘Majority of US Adults Favour Euthanasia and Assisted Suicide by more than Two-to-One Most People with Living Wills do not want to go on Life-Support Systems’ <http://www.prnewswire.com/> accessed 20 November 2006. See also, D Crary, Americans Divided on Whether Doctors should Help Terminally Ill Patients Die <http://www.factiva.com.au> accessed 30 May 2007 regarding an AP-Ipsos poll of 1,000 randomly chosen adults from 22-24 May 2007. The sampling error was plus or minus three percentage points. The poll revealed that Americans less clear on AS. Fifty nine per cent of Northeasterners believe that AS should be legal compared with 52 per cent in the West, 45 per cent in the Midwest and 43 per cent in the South.
62 Fifty three per cent of 1,000 Americans who were surveyed in May 2007, just before Dr Kevorkian was released from gaol, did not believe that he should have been gaolied in the first place: Crary, above n61.
63 From 1994 until 2007, 89 legislative measures to legalise euthanasia failed in 22 states of the United States of America. In addition to California and Vermont, draft euthanasia legislation was defeated in: Alaska; Arizona; Colorado; Connecticut; Hawaii; Illinois; Iowa; Louisiana; Maine; Maryland; Massachusetts; Michigan; Mississippi; Nebraska; New Hampshire; New Mexico; New York; Rhode Island; Washington; and, Wisconsin: K Hamlon, ‘Failed Attempts to Legalise Euthanasia/ Assisted Suicide in the United States’ <http://www.internationaltaskforce.org/> accessed 24 September 2007.
64 Editorial, ‘Suicide: Californians against Assisted Suicide: For the Third Time in Three Years, Assisted Suicide Fails to get Support in the Assembly’, Biotech Week (27 June 2007) 976. Further measures cannot be taken in Vermont until the expiry of this biennial legislative session in 2009: Email from B Orr (Head, Advisory Board of the Vermont Alliance for Ethical Healthcare) to V Hiley (22 March 2007).
don’t think 120 legislators and I should make the decision. I think the people should make the decision, and whatever that is, that is what it ought to be.’65

In contrast to developments in California and Vermont, in January 2006 the Supreme Court of America confirmed the validity of the Oregon Death with Dignity Act,66 which allows Oregon residents to obtain DAS in certain circumstances. The Supreme Court went so far as to admonish the Federal Attorney General, who had challenged the ODDA, for interfering in state matters even though he had the full backing of the Bush Administration in doing so.67

D. Canada

Attitudes to euthanasia are also unsettled in Canada. During 2006, Bill C-407, which sought to amend the Criminal Code in order to de-criminalise euthanasia, was defeated in the Canadian Parliament. However, there are plans to reintroduce it in the future.68

The Minister for Health, Phillipe Couillard, does not support the legalisation of euthanasia,69 nor does the Canadian Medical Association.70 However, when AVE or AS are provided by a medical practitioner, case law outcomes are more lenient than one might expect on the basis of Canadian criminal law principles.71 In addition, there is evidence to suggest that some Canadian health care workers

68 Email from L Juneau (Executive Assistant to Ms F Lalonde, the Federal Member of Parliament who introduced Bill C-407) to V Hiley (29 November 2006). The Bill had not been reintroduced as at 13 January 2008.
69 K Dougherty, 'Legalized Euthanasia has Potential for ‘Ethical Slips’ Couillard Warns; Most Quebecers Advocate Assisted Suicide', The Gazette (11 June 2007) A9.
71 See Chapter Two for discussion of the way in which the courts in Canada have dealt with cases of AS and murder (AVE).
engage in euthanasia\textsuperscript{72} and that the majority of the Canadian public support its legalisation.\textsuperscript{73}

E. New Zealand

The situation in New Zealand is similar to that in the other common law jurisdictions discussed in this Part. In 2003, the Prime Minister of New Zealand, Helen Clark, voted in favour of the Death with Dignity Bill, a Bill which sought to legalise euthanasia. The Bill failed to win Parliamentary support but has since been re-submitted and is awaiting selection from the Ballot.\textsuperscript{74}

On the other hand, in August 2005, the New Zealand Medical Association, after having adopted a neutral stance to euthanasia, voted to oppose it.\textsuperscript{75} Yet a recent opinion poll shows a high level of support among the public in New Zealand for the legalisation of euthanasia.\textsuperscript{76}

F. The Netherlands

Attitudes toward euthanasia in the Netherlands are more settled than they are in the common law countries. In April 2002, the government of the Netherlands created a codified exception to the criminalisation of euthanasia when it proclaimed the \textit{Termination of Life on Request and Assisted Suicide (Review Procedures) Act}.\textsuperscript{77} According to the TLRASA,\textsuperscript{78} doctors who provide euthanasia

\textsuperscript{72} Magnusson, above n31.

\textsuperscript{73} 75.5 per cent of 1,507 Canadians surveyed by Leger Marketing in 2001 believed that a person who ends the life of a loved one who is suffering from an incurable and painful illness should not be prosecuted: Editorial, ‘Strong Support for Euthanasia, Poll Shows – High Profile Cases have Changed Attitudes: Pollster’, \textit{The Toronto Star} (2 July 2001) A06. In an Ipsos Reid telephone survey of 1,005 Canadian adults carried out from 5-7 June 2007, 71 per cent agreed that DAS should be legalised. Support was highest in Quebec at 84 per cent and lowest in Alberta at 61 per cent: Dougherty, above n69.

\textsuperscript{74} H Bain, 'Euthanasia Campaigner Joins Labor Ranks', \textit{Sunday Star-Times} (29 January 2006) 9. The Bill had not been selected as at 13 January 2008.


\textsuperscript{76} D Henzell, 'Martin Case Boosts Support for Euthanasia', \textit{Sunday Star-Times} (2 May 2004) 5: 69 per cent of 500 respondents to a \textit{Sunday Star-Times} poll supported legalised euthanasia to help terminally ill people to end life.

\textsuperscript{77} The \textit{Termination of Life on Request and Assisted Suicide (Review Procedures) Act} 2002 (hereafter TLRASA).
will not be prosecuted provided that they comply with certain procedural
guidelines.\textsuperscript{79}

In contrast to the situation in the common law jurisdictions, the TLRASA was
supported by the Royal Dutch Medical Association.\textsuperscript{80} It was enacted after 30 years
of judge-made law permitting the provision of euthanasia in certain circumstances
and in the context of a sensibility of support for euthanasia.\textsuperscript{81}

However, Dutch attitudes toward euthanasia continue to evolve and have arguably
become more permissive since the TLRASA was enacted.\textsuperscript{82} During 2005, a
protocol was established for providing AVE to newborn children\textsuperscript{83} and a man
suffering from Alzheimer’s disease who had requested AVE by advance directive
was euthanased.\textsuperscript{84}

Having provided a snapshot of the shape of death and its legal regulation in the
common law jurisdictions and in the Netherlands at the present time, I now turn to
outline the analytical framework that I utilise in this thesis before moving on to
outline my main arguments.

\textsuperscript{78} See Appendix 2 for the text of the TLRASA.
\textsuperscript{79} The Dutch procedural guidelines are discussed in detail in Chapter Five of this thesis.
\textsuperscript{80} H ten Have & J Welie, \textit{Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice}
\textsuperscript{81} See Chapter Five.
\textsuperscript{82} By comparison, attitudes toward other legalised practices such as abortion, prostitution and the sale
of soft drugs have reportedly become less tolerant, possibly as a result of the orthodox Christian political
party (CDA) making up part of the government for the first time and also as a result of widespread anxiety
about the potential effects of a high level of immigration on the Dutch national identity: M Moore, ‘In
Netherlands, it’s no Longer ‘Anything Goes”, \textit{The Washington Post} (24 June 2007) A5. See also, D
\textsuperscript{83} T Sheldon, ‘Dutch Doctors Adopt Guidelines on Mercy Killing of Newborns’ (2005) 331 \textit{British Medical
Journal} 126
\textsuperscript{84} T Sheldon, ‘Dutch Approve Euthanasia for a Patient with Alzheimer’s Disease’ (2005) 330 \textit{British Medical
Journal} 1041.
5. The Analytical Framework

In this thesis I utilise an analytical framework called process sociology that was developed by German sociologist Norbert Elias. In determining whether legal and medical responses to the call for legalised euthanasia are satisfactory, I draw upon four propositions that are central to process sociology:85

1. if we are to better understand developments in human social life such as the call for legal recognition of a right to die we must analyse and explain changes in people’s attitudes and beliefs in that domain;86

2. we can only respond to these developments in a satisfactory manner if we view human beings as interdependent rather than as separate, autonomous individuals;87

3. in order to comprehend such developments we need to view power as a dynamic phenomenon that attaches to all human social relationships and not as an object that is possessed by some and not by others;88 and

4. we can only gain a full understanding of such developments in human social life if we analyse changes in attitudes and beliefs over a significant period of time, preferably over at least three generations.89

In order to capture changing views of death and dying in the context of the euthanasia debate, I utilise the notion of ‘sensibilities’ which refers to attitudes and beliefs that fall between reason and emotion and that are held at a collective level among people in society.90 I use the term ‘attitudes’ to refer to what I infer to be

85 In this Part, I rely upon the work of the esteemed sociologist R van Krieken who has distilled Elias’ principles in his excellent book, Key Sociologists (1998) at 50-71.
86 Id at 50-54.
87 Id at 55, 56.
88 Id at 61-65.
89 Id at 65-71.
90 R Williams, Keywords: A Vocabulary of Culture and Society (1987) at 282, 283.
views that are held by groups or by individuals from, inter alia, actions, policies, statements and reports.

The use of these ideas is crucial to this thesis for a number of reasons. First of all, it permits me to explain how law and medicine struggle to respond to changing approaches to death and dying. Secondly, it allows me to show that a technical legal or medical approach does not provide adequate answers to the complex issues that are at stake in the euthanasia debate. Thirdly, it permits me to examine inconsistencies in attitudes among key groups and individuals in the euthanasia debate as an expression of a struggle on the part of those groups and individuals to respond to changing sensibilities. Fourthly, it allows me to draw out the implications of unreported and reported case law in relation to unlawful killing, AS and right to die applications. Last of all, it facilitates a more nuanced interpretation of the original research that I carried out among palliative care experts in 2000.91

The importance and the utility of the notion of sensibilities as an analytical tool can be seen in a number of key works. In *Punishment and Modern Society: A Study in Social Theory*, Garland used the notion of sensibilities to show how penal processes have come to exist in their present form and with what kinds of consequences.92 In ‘Humanitarianism and the Pornography of Pain in Anglo-American Culture’, Halttunen used the idea of sensibilities to trace the emergence of a new negative sensibility toward suffering at the turn of the 18th and 19th centuries which led to the development of a yet another sensibility – a fascination with pain; a ‘pornography of pain’.93 In *The Civilizing Process*, Norbert Elias used sensibilities to demonstrate how, in the process of Western societies becoming more ‘civilised’, certain types of behaviour that were once tolerated in public such as eating with one’s hands have become less acceptable and are no longer considered to be appropriate in the public domain.94

91 See Chapter Four.
Dying, Elias used the notion of sensibilities to show how, as the process of dying has become less acceptable to contemporary sensibilities, it has been increasingly removed behind the scenes of human social life with the result that dying has become a lonely experience.95 In The Hour of Our Death Ariès used the concept of sensibilities to argue that death has become a topic that is denied because we have come to view the process of dying as dirty and shameful.96

6. The Thesis

I advance four main arguments:

1. the shape of death and dying in the 21st century is the result of changes in human sensibilities over time which we need to understand and to explain if we are to better respond to emerging developments in our world such as the call for a right to die;

2. in order to comprehend the issues at stake in the euthanasia debate we need to examine changes in human social life over a significant period of time;

3. we can only respond to these changing sensibilities in an adequate manner if we understand human beings as interdependent rather than as separate and autonomous; and

4. we can only apprehend the issues at stake in the euthanasia debate if we understand relationships between individuals and between groups as being based on shifting balances of power.

Having outlined the main arguments in this thesis, I now turn to examine changing sensibilities toward death and dying, in the common law jurisdictions, from the Middle Ages to the present. My aim in doing so is as follows: to locate the thesis within a broader context; to highlight some of the dominant themes in the

euthanasia debate; and to challenge assumptions that local responses to death and dying are settled or beyond question.

7. Changing Sensibilities in relation to Death and Dying in the Common Law Jurisdictions

Contemporary sensibilities toward death and dying are highly dynamic. Factors such as age, gender, social and economic status, education and spiritual orientation all play a role in producing notions of the good death. However, looking back over time suggests that factors such as the medicalisation and secularisation of human social life and a widespread belief in the importance of personal autonomy have also influenced sensibilities in relation to death and dying.

According to Ariès, from the 5th century until the 18th century there was a dominant theme of acceptance and tranquillity toward death. Early in this period, a good death was one that could be anticipated thus allowing the dying person time to prepare and his or her community time to gather and offer support.

---

98 Ariès examined changing sensibilities and attitudes toward death from the early Middle Ages to the 20th century by studying literary, liturgical, testamentary, epigraphic and iconographic documents. He identified five key themes: the tame death; the death of the self; remote and imminent death; the death of the other; and invisible death. The period of tame death lasted from the early Middle Ages to the 17th century and is characterised by death being viewed as a communal event. The period of the death of the self has its roots in the rise of individuality from the 11th century but had become ascendant by the 17th century. By the end of the 16th century, with the rise of science and technology, there was a gradual movement away from viewing death as a communal event. He refers to this period, which lasted until the 19th century, as the period of remote and imminent death. During the 19th century a sensibility emerged which permitted freer expression of emotion. This coincided with the advent of the nuclear family and as a result, people began to feel more intensely about those to whom they were closest leading to a focus on the death of the other. The medicalisation of death and a new view of it as dirty and shameful resulted, by the 20th century, in death becoming invisible and taboo. Whereas death was once a part of the life of the community, secularisation broke the link between death and evil in religious thought. Consequently, death is now wild whereas it was once tame: Ariès, above n96 at 602-624.
99 According to Kselman only one other historian has attempted to provide as comprehensive an examination of changing sensibilities in relation to death and dying in Western countries as Ariès; Michel Vovelle. Vovelle’s work, *La Mort et L’Occident de 1300 à nos Jours* (Death in the West from 1300 to Today) has not been translated into English. Vovelle’s account is reportedly a more nuanced and complex history of attitudes toward death and dying than is Ariès’ account. By and large, Vovelle agreed with the account provided by Ariès but he did not agree that there was ever a period of calm acceptance of death: T Kselman, ‘Death in the Western World: Michel Vovelle’s Ambivalent Epic *La Mort et L’Occident de 1300 à nos Jours*’ (2004) 9 *Mortality* at 168, 170, 175.
100 Ariès, above n96 at 15, 16, 27, 28.
Rituals and prayers were there to help ease the distress of losing a loved one.\textsuperscript{101} Death was a spiritual and a communal event.\textsuperscript{102} It was usual for a person’s entire family and members of his or her community to be involved in the process of his or her death.\textsuperscript{103}

Society’s acceptance of death was reportedly so total and complete that, by the 12\textsuperscript{th} century, the cemetery had become what the modern shopping mall is to people today. People ate, cooked, made merry and even courted in the graveyard.\textsuperscript{104} However, this does not mean that death was never a painful, miserable or violent experience.\textsuperscript{105} Rather, the point is that death was seen as a communal event.\textsuperscript{106} This attitude of seeing death as an intrinsic part of life is reflected in the poetry, paintings, art, drama and stories from the 14\textsuperscript{th} to the 16\textsuperscript{th} centuries which often depicted corpses, rotting skin and dead bodies – in much the same way as sexy, scantily clad women predominate on magazine covers today.\textsuperscript{107}

The communal view of death began to decline at the beginning of the 11\textsuperscript{th} century when the notion of a collective destiny disappeared and the notion of the individual began to emerge.\textsuperscript{108} A good death was still a religious death involving prayer, an act of contrition and a confession on one’s deathbed but people had become afraid of the possibility of eternal damnation if they did not embrace God before

\textsuperscript{101} Ariès, above n96 at 17, 19.
\textsuperscript{102} Ibid.
\textsuperscript{103} Id at 18, 19.
\textsuperscript{106} Ariès, above n96 at 18,19.
\textsuperscript{107} Wendell Moller, above n104 at 9.
\textsuperscript{108} Ariès, above n96 at 104, 605.
they died.\textsuperscript{109} Consequently, books were published on the art of how to die well in the same way that books are published today on how to have a good love life.\textsuperscript{110}

During the 16\textsuperscript{th} and 17\textsuperscript{th} centuries the focus shifted from dying a good death to living as good a life as possible as people began to believe that this would lead to salvation.\textsuperscript{111} This is arguably still a theme in notions of the good death today. However, one important difference is that the dead body was sensualised because people thought that dying heightened the intensity of love and passion. In addition, people started to view the body as an important source of scientific knowledge.\textsuperscript{112} Ariès argues that whilst death became more remote from human social life during this time, it also became more fascinating.\textsuperscript{113} This may explain why necrophilia became a prevalent theme in the plays and books of the time and why dissections were held in people’s homes much as we would host a cocktail party today.\textsuperscript{114}

During the Victorian era, the shape of death changed again. From the early to mid-Victorian period, a good death involved the dying person exhibiting intense piety, spiritual fervour and courage in the face of suffering.\textsuperscript{115} The use of opium was frowned upon during this time because it undermined notions of the good death.\textsuperscript{116} According to Wendell Moller, Victorian society ‘embraced suffering and dying with idyllic romanticism and excessive emotionalism.’\textsuperscript{117} Consequently, death became sentimental instead of sensual and was beautified.\textsuperscript{118}

During the late Victorian period, from 1870 onwards, religious issues such as the state of one’s soul prior to death, were no longer as important as before. Themes

\begin{thebibliography}{99}
\bibitem{109} Wendell Moller, above n104 at 7.
\bibitem{110} Id at 17-19.
\bibitem{111} Id at 10.
\bibitem{112} Ibid.
\bibitem{113} Ariès, above n96 at 608.
\bibitem{114} Wendell Moller, above n104 at 11.
\bibitem{115} P Jalland, \textit{Death in the Victorian Family} (1996) at 51, 52.
\bibitem{116} Id at 87.
\bibitem{117} Wendell Moller, above n104 at 12.
\bibitem{118} Ibid.
\end{thebibliography}
of uncertainty, uneasiness, fear and avoidance became more dominant among responses to death and dying.\textsuperscript{119}

There is disagreement among scholars as to how sensibilities toward death and dying changed after the Victorian period. Commentators such as Gorer and Ariès posit that death became taboo.\textsuperscript{120} Gorer claims that this occurred after World War I with the decline of mourning rituals.\textsuperscript{121} Ariès links death’s alleged disappearance to the spread of individualism, romanticism and secularism after the Victorian period, all of which he says undermined the rituals associated with death so that the modern individual is heir to a Victorian romanticism which made the loss of a significant other unbearable and to a 20\textsuperscript{th} century sensibility that forbad or at least hid death.\textsuperscript{122}

The taboo theory has been challenged\textsuperscript{123} and, in my view, is not correct because death has been widely discussed, researched and depicted in contemporary life since the Victorian era. Armstrong suggests that death became more of a public concern after the mid-19\textsuperscript{th} century due to a new requirement that deaths be recorded in a central register.\textsuperscript{124} Walter notes that, by 1979, there were over 1,700 books in print dealing with the topic of death.\textsuperscript{125} Further evidence against the taboo theory can be gleaned from popular culture. Consider death at the cinema (from \textit{Love Story} to \textit{Nightmare on Elm Street}), death in music (from \textit{Candle in the Wind} to Ice-T’s \textit{Cop Killer}), and, death in print (from \textit{The Loved One} to the graphic newspaper coverage of 9/11 during 2001).\textsuperscript{126}

\textsuperscript{119} Jalland, above n115 at 52, 54, 58.
\textsuperscript{120} Hereafter taboo theory.
\textsuperscript{121} G Gorer, ‘The Pornography of Death’ in G Gorer, \textit{Death, Grief and Mourning in Contemporary Britain} (1965) 169-175.
\textsuperscript{122} Ariès, above n96 at 579-583.
If the topic of death did not become taboo, then how did the shape of death change after the Victorian period? The answer is that the process of dying became more likely to be an experience that is medicalised, prolonged, secular in nature and sequestrated from the community.

Prior to the 1900s, people in the common law jurisdictions probably did not expect to live to advanced old age because of the prevalence of diseases and infections that could not be cured. This changed in the early 1900s with the introduction of sanitation and antibiotics both of which increased longevity and changed the way in which people died. Whereas before people generally died at home from an incurable infection or disease, they now began to die in hospital of diseases that are commonly associated with old age such as cancer, heart disease and stroke – all of which are frequently accompanied by a longer period of pain, suffering and loss of function before death.

The medicalisation of the process of dying accelerated after the 1950s, when medical practitioners became the custodians of a whole host of new medications designed to reduce pain and prolong life. The medical practitioner replaced the priest at the deathbed in most cases and home became an inappropriate place in which to die.

---

127 It is generally agreed in the literature that life in Western society has been medicalised but there is disagreement on how this has occurred: R Cox, 'The Medicalization and Demedicalization of American Society' in J Knowles (ed), Doing Better and Feeling Worse: Health Care in the United States of America (1977) at 11. Zola considers that technology is the cause: I Zola, 'Medicine as an Institution of Social Control' in Cox & Mead (eds), A Sociology of Medical Practice (1975) at 171. Illich claims it is due to industrialisation and bureaucratisation: I Illich, Limits to Medicine: Medical Nemesis, the Expropriation of Health (1990). Navarro claims it is due to medicine having become a means of social control that serves the interests of the capitalist class: V Navarro, Crisis, Health and Medicine: A Social Critique (1986). Ariès links the medicalisation of death to its transfer to the hospital setting: above n96 at 612.

128 M Mannes, Last Rights (1977) at 7.


130 The correct medical term is cerebrovascular accident.


132 J Hockey, Experiences of Death: An Anthropological Account (1990) at 36, 56; T Walter, The Revival of Death (1994) at 12. These developments were facilitated by increasing urbanisation as a result of the industrial revolution and the advent of the nuclear family with fewer family members available to look after the sick and the elderly as more and more women, who have traditionally carried out the work of caring,
The sequestration of death is associated with the development, during the 1960s, of a new attitude within medicine. Medical practitioners such as Dr Cicely Saunders and Dr Elisabeth Kübler-Ross stepped into what they perceived to be a void in the care of the dying. Saunders argued that the dying should be cared for in a separate facility where the focus would be on palliative care rather than cure. Kübler-Ross developed a theory of the five stages of dying which was relied upon by health care workers in assisting dying patients to work through the stages of: denial; anger; bargaining; depression; and acceptance. However, these developments did not change the fact that the application of palliative care and delivery of care at the end of life still medicalises the process of dying and sequestrates it from the community.

During the 1970s, a new sensibility of fear of a prolonged death developed due to a proliferation of new technologies designed to extend life such as respirators and by-pass machines. The initial, widespread use of this new technology led the public and many medical practitioners and parliamentarians to conclude that high technology medicine can result in a bad death. Relatives, medical practitioners and patients began to approach the courts seeking permission to remove life support measures that were perceived to no longer be of any demonstrable benefit. Permission was granted in each of the common law jurisdictions.

Notwithstanding these developments, fears of being subjected to a high technology, prolonged death persisted. Consequently, during the 1980s, a number of the common law jurisdictions enacted statutes shoring up the right at common

---


134 E Kübler-Ross, Death: The Final Stage of Growth (1st Touchstone ed, 1986) at 34-121.

135 Mellor & Shilling, above n105 at 423.

136 See the cases discussed in Chapter Two.
law to refuse unwanted medical treatment. In responding to this emerging sensibility, courts and legislators made inroads into the SLD; it was no longer the case that human life had to be preserved at all costs.

During the 1990s, sensibilities toward death and dying shifted again as a result of concerns regarding perceived inequities in the options available to the terminally ill. Petitioners who were suffering from progressive, debilitating diseases began to approach the courts seeking legal recognition of a right to be assisted to die. They alleged that, whereas the able-bodied can bring about their own death by committing suicide and others can bring about their own death by refusing unwanted medical treatment, the disabled are unable to achieve the same result because AS is criminalised. This alleged inconsistency remains a hotly contested issue in the euthanasia debate today.

Having provided a contextual background to the shape of death in the 21st century and having highlighted some of the dominant themes at the present time, I now turn to defend the analytical framework that I utilise in the thesis. I conclude the chapter by outlining what the reader can expect to find in the remaining chapters.

8. Defence of the Analytical Framework

I consider process sociology to be an appropriate analytical tool in this thesis. However, I acknowledge that four major criticisms have been made of Elias’ approach: it is not distinctive enough; he places too little emphasis on human agency (the human capacity for choice and evaluation); he ignores discontinuities

---

137 See Chapter Two for discussion of the Statutes that were enacted and the leading cases on withdrawal of treatment.
138 See Chapter Three for discussion of right to die applications.
140 For a recent article which demonstrates the enduring relevance of Elias as a theorist and compares him favourably to Foucault see P Spierenburg, ‘Punishment, Power and History' (2004) 28 Social Science History 607-636.
and breaks in long-term trends; and he believed, erroneously, that knowledge can be de-mythologised. 141

It is true that Elias’ approach is not completely distinctive but theories do not have to be distinctive to be useful. Elias also did, erroneously, think that knowledge can always be de-mythologised. I avoid this pitfall by critically analysing the claims of those on both sides of the euthanasia debate. It is correct that Elias did not emphasise the actions of individuals in his analysis of social change. This was largely because his approach involved analysing changes over a significant period of time, usually over at least three generations. 142 I avoid this downfall by recognising the important role that individuals have played in the development of the euthanasia debate in addition to key groups and organisations. It is true that, earlier in his career, Elias did not focus on discontinuities in long-term trends. However, according to van Krieken, Elias became more sensitive to serious discontinuities later in his career and came to acknowledge ‘counter-trends’ and bi-polar character of social processes’. 143 In this thesis, I avoid this limitation by including counter-trends in my discussion of changing sensibilities toward death and dying in the context of the euthanasia debate.

This thesis is divided into five chapters, the ultimate concern of which is to determine whether law and medicine, in the common law countries, and in the Netherlands are responding in an adequate manner to changing sensibilities in relation to death and dying as expressed in the euthanasia debate.

In Chapter Two, I question whether the response of the judicial systems in the common law countries to changing sensibilities in relation to death and dying is adequate in the context of prosecutions for unlawful killing and AS. I answer this question by examining outcomes in end-of-life lawmaking following AS and AVE. I find that those who come before the courts in the common law jurisdictions

---

141 Van Krieken, above n85 at 78.
142 Id at 79, 80.
charged with AS or murder (in circumstances that fall within the definition of AVE) are dealt with more leniently than one might expect on the basis of applicable criminal law principles. I argue that case law outcomes suggest that there is a community sensibility of support for euthanasia to be available in a particular set of circumstances: when it is provided by a medical practitioner to an adult who is terminally ill, who is suffering and who has asked for AVE or AS. I argue that, in order to keep pace with changing sensibilities, the courts have employed mechanisms which allow matters that are not formally relevant such as the deceased’s diagnosis, prognosis, level of suffering and stated wishes about death to be taken into account. I find judicial responses to be unsatisfactory because end-of-life law making does not openly address changing community sensibilities and is not cognisant of contextual factors and clinical reality. I suggest ways in which legal process could be made more transparent and more responsive to these matters. However, I conclude, on the basis of my discussion of the attitudes of key groups toward euthanasia, that such changes are unlikely to be made via case law.

In Chapter Three, I continue to focus on the law’s response to changing sensibilities in relation to death and dying but I question its efficacy in the context of right to die applications under the umbrella of constitutional and international law. I answer this question by examining changes in the notion of rights discourse from the Middle Ages to the present and by examining outcomes in right to die applications. In the process, I find that rights discourse is not well-suited to the task of securing legal recognition of a right to die. Rights discourse provides no guidance when there are competing rights at stake and does not recognise the many competing sensibilities that typically exist at the end of life. I show that, in the absence of such guidance, appellate courts have invariably resorted to established moral claims such as the SLD to justify denying the application and maintaining the status quo. I examine contrary case law in order to challenge assumptions that the SLD is a fixed, immutable concept. I find that the approach of

the law is unsatisfactory and I suggest changes that could be made to facilitate a
process by which a broader range of factors could be taken into account in
determining case outcomes. However my conclusion, as in Chapter Two, is that
such changes are unlikely to be made via case law.

In Chapter Four, I relocate my analysis to the domain of medicine. Upon noting
that pain and suffering are key contested issues in the right to die debate, I
question whether the current medical model of pain and suffering is sufficiently
nuanced to permit an adequate response to changing sensibilities around the
notion of a good death. I answer this question by examining changes in attitudes in
mainstream medicine in relation to pain and suffering from the Middle Ages to the
present and by analysing the results of original research that I carried out among
palliative care experts in Sydney in 2000. I find that mainstream medicine and
palliative care experts privilege the physical aspect of pain and tend to
de-emphasise the existential\textsuperscript{144} aspect of the pain experience. I show that it is
existential pain that generates requests to be assisted to die and I go on to
theorise the likely effect that this has upon the ability of palliative care specialists
to facilitate a good death. I conclude that medicine must develop a more nuanced
understanding of pain and suffering if medical practitioners are to respond to
changing sensibilities in relation to the good death in a more satisfactory manner.

In Chapter Five, I alter my focus to the Netherlands where euthanasia was
decriminalised in 2002. I note that two opposing claims are typically made about
the Netherlands: that it is a model for reform for how to go about legalising
euthanasia; and, that it is the epitome of a slippery slope because the practice of
euthanasia is out of control. I question whether either claim can be substantiated. I
assess the first claim by examining changing sensibilities toward death and dying
among the Dutch public and changing attitudes among the judiciary, medical
practitioners and successive governments from the 1950s to date. I assess the
second claim by analysing the results of the leading studies in relation to medical

\textsuperscript{144} This term is defined in Chapter Four.
end-of-life decision-making. I find that neither claim can be substantiated. However, I conclude that there is still much that we in the common law jurisdictions can learn from the Dutch response to changing sensibilities toward death and dying in the context of the right to die debate, a theme to which I return in the final chapter of the thesis.

In Chapter Six, having found the response of the judiciary and the medical profession in the common law countries to be wanting, I canvass three options for reform: legalising euthanasia by way of legislation; permitting a doctor to raise the defence of necessity after providing euthanasia; and allowing palliative sedation\(^{145}\) to be used in a greater number of contexts. I reject legislation as an option because key issues such as the role of existential pain in requests to be assisted to die are yet to be adequately debated. In the context of the defence of necessity I highlight a contextual issue that, in my view, prevents the use of the defence after euthanasia. I argue that the third option is the better option at the present time. I conclude the chapter by considering some of the larger issues at stake in the euthanasia debate.

\(^{145}\) This phrase is defined in Chapter Four.
CHAPTER TWO
MURDER? CAN YOU PROVE IT? SOME TERMINAL PROBLEMS WITH END-OF-LIFE LAW MAKING IN THE COMMON LAW JURISDICTIONS

Beneath the façade of equality lurks partiality, which is arguably explicable on policy grounds: the conscientious doctor is not to fall foul of the criminal law. General principles, therefore, yield to – often, unarticulated – exceptions.¹

… a major goal of the criminal law – to deter others by punishing the convicted criminal – would not be substantially served where the penalty is so seldom invoked that it ceases to be the credible threat essential to influence the conduct of others.²

1. Introduction

In the previous chapter, I explained that the aim of this thesis is to capture and to apprehend changing attitudes toward death and dying in the 21st century in the context of the euthanasia debate. In doing so, my goal is to determine whether we are responding to changing sensibilities in an acceptable manner. In this chapter, I focus my line of enquiry on the appropriateness of legal responses to changing sensibilities in the common law countries as expressed in cases of unlawful killing (AVE) and AS.

At first blush, established legal principles in relation to assisted dying suggest that the situation is clear-cut; intentionally ending or assisting to end another person’s life is a criminal act and one who does so will likely be convicted and incarcerated. However, as I show, when the ending of life occurs in the form of AVE or AS the non-application of legal principles in practice makes the law uncertain and unpredictable. The situation is complex and multidimensional and contextual factors are crucial.

This chapter is divided into seven parts. In Part 2, I define and explain the doctrine of double effect, its status in end-of-life lawmaking in the common law jurisdictions and the problems associated with it. I explain that, in England, the doctrine has often played a crucial role in case outcomes in prosecutions of medical practitioners following unlawful killing. In the other common law jurisdictions, there is the potential for the doctrine to play a greater role in the future which is why I deal with the DDE as a topic in its own right.

In Part 3, I outline established legal principles in relation to the taking of human life (AVE) in each of the common law jurisdictions. At the end of each section in Part 3, I enlarge upon the preliminary comments that I made in Chapter One regarding changing attitudes among key groups such as law reform bodies, the judiciary, medical associations and parliamentarians as well as changing community sensibilities toward death and dying. My aim in doing so is to provide a more complete picture of the shape of death and dying at the present time.

In Part 4, I contrast how the law says it will respond to assisted dying with how it commonly treats doctors who are prosecuted for homicide in the context of AVE. Due to difficulties in gathering evidence, many cases of alleged AVE are not prosecuted. As we shall see, prosecutions that are commenced are often abandoned due to insufficient evidence. When prosecutions do proceed, it is typically difficult to establish that the accused intended to, or in fact caused, the deceased’s death. In addition, in many cases, reliance upon the DDE and/or a sympathetic attitude on the part of the judge or the jury have led to more lenient

---

3 Hereafter DDE.

4 The phrase 'established legal principles' is defined at the beginning of Parts 3 and 5 of this chapter.

5 I also consider a number of cases involving other health care providers such as nurses but, for reasons of relevance, I do not for the most part consider cases involving the provision of AVE or AS by family members and friends ('mercy killing' cases). For information about mercy killing cases see: M Ottowski, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17 Criminal Law Journal 10; Braugham et al, above n2 at 1213-1215; D Weisstub, 'Ethical and Legal Reflections on Euthanasia' (1997) 18 Health Law in Canada 20-30; J Downie, Dying Justice: A Case for Decriminalising Euthanasia and Assisted Suicide in Canada (2004) at 41, 42; S Rosenblatt, Murder of Mercy: Euthanasia on Trial (1992) regarding Dr Peter Rosier who euthanased his wife in 1986.

30
outcomes than one might expect on the basis of established legal principles in relation to unlawful killing.

In Part 5, I turn to outline established legal principles with regard to AS. Whilst suicide is no longer a criminal offence in any of the common law jurisdictions, it is illegal (with the exception of Oregon\(^6\) in the United States of America) to help another person to commit suicide. In accordance with established legal principles, a conviction for AS may result in a significant gaol term.

In Part 6, having outlined how the law says it will respond to cases of AS, I contrast this with how the law tends to respond to such cases. I show that, whilst the law provides for harsh penalties for AS, convictions and custodial sentences are rare. In general, it is difficult to establish causation in cases of AS because the deceased often dies alone.\(^7\) In addition, in many cases, there is a tendency to require a high degree of involvement on the part of the accused in order to prove AS. This, and a tendency for the judge or the jury to feel sympathy toward the accused, can lead to more lenient outcomes than one might expect on the basis of applicable legal principles.

In the final Part, I conclude that the courts in the common law jurisdictions are not responding to changing sensibilities in relation to death and dying in a satisfactory manner in the context of prosecutions for homicide (AVE) and AS. I argue that a gap has developed between what the law says it will do in response to an unlawful ending of life and what it actually tends to do when this involves AVE or AS. Paradoxically, this gap arises from attempts to respond, more flexibly, to changing sensibilities in relation to death and dying. However, the end result is that the law in this area is not transparent and intellectually coherent. Accordingly, I suggest changes that could be made to end-of-life lawmaking to render it more transparent, more responsive to clinical reality and more intellectually coherent.

---

\(^6\) The situation in Oregon is discussed in greater detail below.

\(^7\) Evidentiary problems may also be exacerbated by the confidentiality requirement of the doctor/patient relationship.
However, for reasons that will become apparent, I conclude that such changes are unlikely to be made via domestic case law.

Having outlined the contents of the remaining parts of the chapter, I now turn to define the DDE, to explain its standing at law and to outline the problems associated with it.

2. The DDE

The DDE is a principle with religious underpinnings which holds that it is acceptable to carry out an act that has bad consequences so long as one’s motive in carrying out the act is good and so long as there is proportionality between the good and bad effects so that the latter do not outweigh the former.\(^8\) Thus, according to the DDE, it is acceptable for a medical practitioner to give a patient successively larger doses of pain relief medication, such as morphine (a practice that is known as pyramid pain relief), knowing that this might cause the patient to die sooner, provided that the doctor’s intention in doing so is to reduce the patient’s pain and not to kill him or her.\(^9\)

The DDE is relevant to varying degrees in the common law jurisdictions. It was adopted into English law in 1957 in *R v Adams*,\(^10\) discussed in Part 5, below. However, the situation with regard to the DDE has become more complicated in England since 1999, when *R v Woollin*\(^11\) was decided. In *Woollin*, a case that did not involve AVE,\(^12\) the court held that an intent to kill will be established when the accused foresees death as a virtual certainty as a result of his or her actions.\(^13\)

---

8. Huxtable, above n1 at 66.
9. Ibid.
12. *Woollin* concerned a father who killed his infant son by throwing the child onto a hard surface.
13. “Where the charge is murder and in the rare cases where the simple direction is not enough, the jury should be directed that they are not entitled to find the necessary intention, unless they feel sure that death or serious bodily harm was a virtual certainty (barring some unforeseen intervention) as a result of the defendant’s actions and that the defendant appreciated that such was the case.” *Woollin* at 96 (Lord Steyn).
This does not sit comfortably with the DDE because the DDE permits doctors to
give pain relief at the end of life in the knowledge that the patient’s death is a
virtually certain outcome.

The DDE has been referred to with approval in American case law in Vacco v Quill\textsuperscript{14} and in Washington v Glucksberg.\textsuperscript{15} In Canada, the DDE was referred to
with approval in AS case law in Rodriguez v Attorney General of British Columbia.\textsuperscript{16} All of these cases are discussed in the next chapter. The DDE was
accepted into New Zealand law in 2004 in R v Martin\textsuperscript{17} a case that is discussed in
Part 5, below.

The DDE has not been addressed in Australian case law and so its status is not
entirely clear. Principles consistent with it have been adopted in section 17 (1) of
the Consent to Medical Treatment and Palliative Care Act in South Australia\textsuperscript{18} and
in section 282A of the Criminal Code Act in Queensland.\textsuperscript{19} The formulation of the

\begin{footnotesize}
\begin{enumerate}
\item [A physician who provides palliative care acts lawfully since their] ‘purpose and intent is, or may be, only
\item ‘There is no dispute that dying patients in Washington and New York can obtain palliative care, even
when doing so would hasten their deaths:’ 521 US 702 (1997) at 737, 738 (O’Connor J).
\item (1993) 107 DLR (4th) 342.
\item 3 NZLR [2004] 69.
\item Consent to Medical Treatment and Palliative Care Act 1995 (SA). ‘A medical practitioner responsible for
the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in
the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal
liability by administering medical treatment with the intention of relieving pain or distress:
(a) with the consent of the patient or the patient's representative; and
(b) in good faith and without negligence; and
(c) in accordance with proper professional standards of palliative care,
even though an incidental effect of the treatment is to hasten the death of the patient.’
\item Criminal Code Act 1899 (Qld).
‘(1) A person is not criminally responsible for providing palliative care to another person if –
(a) the person provides the palliative care in good faith and with reasonable care and skill; and
(b) the provision of the palliative care is reasonable, having regard to the other person's state at
the time and all the circumstances of the case; and
(c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor
who confirms the order in writing.
(2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the
other person's death.
(3) However, nothing in this section authorises, justifies or excuses –
(a) an act done or omission made with intent to kill another person; or
(b) aiding another person to kill himself or herself.
\end{enumerate}
\end{footnotesize}
DDE in each of these Acts differs. The former excludes liability altogether for doctors who comply with principles consistent with the DDE when providing pain relief whereas the latter Act only protects from liability those who administer pain relief when the provision of pain relief was part of good medical practice and was provided by a doctor or was confirmed in writing by a doctor.\(^{20}\)

Notwithstanding these differing interpretations of the DDE, there is the potential for it to play a greater role in the future in Australian, American and Canadian case law in prosecutions for murder following AVE. Yet there are numerous problems associated with its use in this context.

Dr Richard Huxtable, a lecturer in medical law at the University of Bristol, has pointed out that it remains unclear exactly how the DDE operates: whether it negates criminal intent; whether it neutralises causation in certain limited circumstances; or whether it constitutes a defence in its own right to a charge of murder in certain circumstances.\(^{21}\)

According to the English Law Commission, the most appropriate analysis of the DDE is that it negates intent:

\[
\text{… the doctor by his act } \textit{intends} \text{ (on any proper understanding of the term) the death of his patient and by his act } \textit{causes} \text{ (on any proper understanding of the term) the death of his patient, but the intention is not culpable and the cause is}
\]

---

(4) To remove any doubt, it is declared that the provision of the palliative care is reasonable only if it is reasonable in the context of good medical practice.

(5) In this section –

*good medical practice* means good medical practice for the medical profession in Australia having regard to:

(a) the recognised medical standards, practices and procedures of the medical profession in Australia; and

(b) the recognised ethical standards of the medical profession in Australia.

*palliative care* means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.'


\(^{21}\) Huxtable, above n1 at 66.
not blameworthy because the law permits the doctor to do the act in question.22

Unfortunately, the Commission has not considered how the DDE, which involves foreseeing a patient’s death, sits with the principle in Woollin that criminal intent will be made out when an accused foresees death as a ‘virtual certainty’ as a result of his or her actions. It has only said that the DDE should be categorised as a criminal defence.23

Glanville Williams claims that even if the DDE is a theory about intent, it is problematic because it may allow a person to avoid criminal liability by keeping his or her mind off the consequences of his or her actions.24 Finnis rejects Williams’ view and insists that the DDE is confined to an analysis of intention and does not extend to keeping one’s mind off unintended but foreseen consequences.25

However, research carried out by Douglas et al in 1999 suggests that the DDE can in fact be used to shield an intent to kill.26

---


23 The Law Commission, above n22 at 117.

24 G Williams, The Sanctity of Life and the Criminal Law (1958) at 286.


26 During 1999, Douglas et al surveyed 683 general surgeons in Australia and found that 247 (36.2 per cent, with a confidence interval of 95 per cent) had given drugs in dosages that they perceived to be greater than those required to relieve symptoms with the intention of hastening death: C Douglas, I Kerridge, K Rainbird, L Hancock & A Spigelman, ‘The Intention to Hasten Death: A Survey of Attitudes and Practices of Surgeons in Australia’ (2001) 175 The Medical Journal of Australia 511. See also: W Wilson, N Smedira, C Fink, J McDowell & J Luce, ‘Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients’ (1992) 267 Journal of the American Medical Association 53; P Barr, ‘Relation of Neonatologists’ End-of-Life Decisions to their Personal Fear of Death’ (2007) 1 Archives of Disease in Childhood F1. Whilst Barr’s study dealt with the effect of attitudes to death in making treatment decisions, it also revealed that 73 of the 78 neonatologists surveyed admitted to intentionally hastening death in the case of newborns who were severely disabled or for whom treatment was non-beneficial or overly burdensome; P Cotton, ‘Medicine’s Position is both Pivotal and Precarious in the Assisted-Suicide Debate’ 273 (1995) Journal of the American Medical Association 363-364 at 363: ‘We talk about the ‘double effect’ and know jolly well we are sedating them into oblivion, providing pain relief but also providing permanent pain relief, and we don’t tell them’ cited in R Magnusson, ‘The Devil’s Choice: Re-Thinking Law, Ethics and Symptom Relief in Palliative Care’ (2006) Journal of Law, Medicine & Ethics 559 at 13 (footnote 38); D Neil, C Coady, J Thompson & H Kuhse, ‘End-of-Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)’ (2007) 33 Journal of Medical Ethics 721. Thirty-five per cent of 854 doctors surveyed in Victoria admitted to having administered drugs with the intent of hastening death. See generally, R Hunt, ‘Intention, the Law, and Clinical Decision-Making in Terminal Care’ (2001) 175 Medical Journal of Australia 516.
Magnusson, whilst conducting fieldwork in California and Australia, came to the same conclusion; the DDE can make euthanasia easier to accomplish:

This stuff goes on in hospitals all the time, you know’ one palliative care nurse told me in interview: ‘give the little old lady with the ‘fracky neck’ who is going to die in a week a little bit extra Brompton’s cocktail.27

In Canada, the status of the DDE is also unclear. According to Downie,28 actions that fall within the scope of the DDE may breach the Federal Criminal Code by amounting to criminally negligent homicide or culpable homicide. However there is, as yet, no commentary as to how the doctrine intersects with key concepts such as ‘wanton disregard for human life’29 or ‘meaning to cause death.’30

In a similar vein, there has been scant explication of how the DDE sits in relation to the principle in America,31 Tasmania,32 Western Australia,33 Queensland,34 Canada35 and New Zealand36 that hastening death is a form of unlawful killing regardless of the deceased’s diagnosis or prognosis.

Another problem associated with the DDE is that it may not reflect clinical reality. Emerging evidence suggests that it may not be possible to hasten death in the case of patients who have become habituated (tolerant) to the effects of painkilling

28 Downie, above n5 at 32.
29 S219(1) Every one is criminally negligent who
(a) in doing anything; or
(b) in omitting to do anything that it is his or her duty to do, shows wanton or reckless disregard for the life or safety or another person.
30 S222(5) A person commits culpable homicide when he causes the death of a human being.
(a) …
(b) by criminal negligence.
31 State v Francis 152 SC 17 (1929) cited in Margaret Otlowski, Voluntary Euthanasia and the Common Law (1997) at 19.
32 Criminal Code Act 1924 (Tas) s154 (d).
33 Criminal Code 1913 (WA) s273.
34 Criminal Code Act 1899 (Qld) s296.
35 Federal Criminal Code (Can) s226.
36 Crimes Act 1961 (NZ) s164.
medication such as morphine because it is not possible to overdose them.\textsuperscript{37} Indeed, some commentators claim that the provision of large doses of pain relief at the end of life may actually prolong rather than shorten life.\textsuperscript{38}

Quill et al and Stewart highlight additional issues with the DDE. Quill et al note that the DDE fails to acknowledge that human intent is ‘multilayered, ambiguous, subjective, and often contradictory’,\textsuperscript{39} it ignores patient autonomy in the administration of pain relief at the end of life and it may lead some doctors to provide inadequate pain relief at the end of life for fear of prosecution.\textsuperscript{40} Stewart posits that the DDE conflates matters that go to establishing an intent to kill with the separate category of motive. In this way the doctrine breaches established criminal law principles. In cases of alleged unlawful killing the prosecution must prove that the accused intended to kill the deceased and that his or her act was a cause of the deceased’s death. Motive (reflected in the DDE as primary and secondary intent) is not a relevant factor in proving the accused’s guilt.\textsuperscript{41}

Notwithstanding the many shortcomings of the DDE, each of the leading medical associations\textsuperscript{42} in the common law jurisdictions has adopted principles consistent


\textsuperscript{40} Id at 1769.

\textsuperscript{41} Stewart, above n38 at 319.

with it. Yet, none supports the legalisation of AVE and AS. At first blush, this appears to be contradictory but it is likely that these associations are keen to secure maximum flexibility for doctors in clinical decision-making whilst not wanting to be seen to endorse the provision of what some would view as medical euthanasia.

Having defined and explained the DDE and the many problems associated with it, I now turn to outline established legal principles with regard to unlawful killing in the form of AVE, in each of the common law jurisdictions.

3. AVE – Established Legal Principles

AVE is not directly addressed in statute or case law as an offence in its own right. Rather, it falls within the law of homicide (murder or manslaughter). According to established legal principles, the deliberate taking of life, other than in certain limited circumstances such as killing in self-defence, in time of war and, in some American jurisdictions, by capital punishment, is categorised as an act which is always unlawful and unjustifiable and which amounts to murder. Thus AVE, which involves a deliberate taking of life is, or would be where the question has not been directly addressed, categorised as murder or manslaughter in each of the common law jurisdictions. According to established legal principles, matters such as the accused’s motive in providing AVE, the deceased’s diagnosis, prognosis, level of suffering and stated wishes about dying are not formally relevant.

---


44 In this part, ‘established legal principles’ means the case law and statute law in relation to murder and manslaughter in the common law jurisdictions.
A. Australia

In Australia, an act that is deliberately undertaken and which causes the death of another person is defined as murder.\(^{45}\) Where an intent to kill\(^ {46}\) cannot be proven or, where there are mitigating circumstances,\(^ {47}\) a charge of manslaughter\(^ {48}\) may be substituted for a murder charge.\(^ {49}\) In Queensland,\(^ {50}\) Tasmania,\(^ {51}\) and Western Australia,\(^ {52}\) deliberately accelerating death is categorised as homicide. Whilst these legislative provisions were not drafted specifically with AVE in mind,\(^ {53}\) AVE can lead to a conviction for murder or manslaughter in Australia.

In New South Wales\(^ {54}\) and Victoria,\(^ {55}\) the term of imprisonment for murder is discretionary, with a maximum term of life imprisonment. In the Northern Territory,\(^ {56}\) Queensland,\(^ {57}\) Tasmania,\(^ {58}\) Western Australia,\(^ {59}\) the Australian Capital Territory\(^ {60}\) and South Australia,\(^ {61}\) life imprisonment is mandatory for murder. By

\(^{45}\) See Crimes Act 1900 (ACT) s12(1)(a) & (b); Crimes Act 1900 (NSW) s18(1)(a); Criminal Code 1983 (NT) s161,162; Criminal Code 1899 (Qld) ss291, 293, 300 & 302(1)(a); Criminal Law Consolidation Act 1935 (SA) s12A and common law; Criminal Code Act 1924 (Tas) ss156,157; Crimes Act 1958 (Vic) s3A and common law; Criminal Code 1913 (WA) s279(1).

\(^{46}\) See Appendix 3 for a summary of the intent requirements for murder in each jurisdiction in Australia.

\(^{47}\) In Australia, certain defences, such as provocation (all jurisdictions except Tasmania) and diminished responsibility (Northern Territory, Queensland and Australian Capital Territory) and in New South Wales substantial impairment by reason of abnormality of mind (Crimes Act 1900 s23A) can reduce a murder charge to manslaughter: S Bronitt & B McSherry, Principles of Criminal Law (2nd ed, 2005) at 261.

\(^{48}\) For the definition of manslaughter in the various jurisdictions see: Crimes Act 1900 (ACT) s15; Criminal Code 1913 (WA) s280; Criminal Code 1899 (Qld) s303; Crimes Act 1958 (Vic) s421(1)(a); Crimes Act 1900 (NSW) s18(1); Criminal Code Act 1924 (Tas) s159; Criminal Code Act 1983 (NT) s163.

\(^{49}\) Bronitt & McSherry, above n47 at 261.

\(^{50}\) Criminal Code 1899 (Qld) s296: ‘A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that person.’

\(^{51}\) Criminal Code Act 1924 (Tas) s154 (d): ‘A person is deemed to have killed another in the following cases … where by any act or omission he hastens the death of another who is suffering under any disease or injury which would itself have caused death.’

\(^{52}\) Criminal Code 1913 (WA) s273: ‘A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.’


\(^{54}\) Crimes (Sentencing Procedure) Act 1999 (NT) s21(1).

\(^{55}\) Crimes Act 1958 (Vic) s3.

\(^{56}\) Sentencing (Crime of Murder) and Parole Reform Act 2003 (NT) s4.

\(^{57}\) Criminal Code 1899 (Qld) s305.

\(^{58}\) Sentencing Act 1997 (Tas) s19(3).

\(^{59}\) Criminal Code 1983 (WA) s282.

\(^{60}\) Crimes Act 1900 (ACT) s12.
comparison, sentences for manslaughter in these jurisdictions are discretionary but maximum penalties are typically substantial.62 Thus, a conviction following AVE can result in a punishment of up to life in prison.

Whilst Australian community sensibilities are in support of euthanasia for those who 'are hopelessly ill' and who ask for euthanasia,63 attitudes among key groups are in a state of flux. Reviews of the law in relation to death and dying were carried out by the relevant Law Reform Commissions in 1987 in Victoria, in 1992 in South Australia, in 1994 in the Australian Capital Territory and in 1998 in Tasmania.64 None recommended that AVE or AS be legalised. However, in recent times, Bills seeking to legalise AVE and AS were introduced in South Australia in 2001, 2003 and 2005, in Western Australia65 in 1997, 1998, 2000 and 2002, in the Northern Territory66 in 1996, 1997 and 1998 and in New South Wales67 in 2001, 2002 and 2003. One of those Bills was passed, becoming the Rights of the Terminally Ill Act.68

On 25 March 1996, the Northern Territory of Australia became the first jurisdiction in the world to legalise AVE and AS with the passing of the ROTIA. The ROTIA was introduced into the Northern Territory parliament as a Private Member’s Bill by the then Chief Minister of the Northern Territory, Marshall Peron. Mr Peron, the

61 Criminal Law Consolidation Act 1935 (SA) s11.
62 The penalties for manslaughter are: a maximum of 20 years imprisonment in Western Australia: Criminal Code 1983 s287; up to life imprisonment and/or a fine in South Australia: Criminal Law Consolidation Act 1935 s13; up to 20 years imprisonment and/or a fine in Victoria: Crimes Act 1958 s5; 20-26 years imprisonment in the Australian Capital Territory: Crimes Act 1900 s15(2) & (3); up to life imprisonment in Queensland: Criminal Code 1899 s310; a nominal punishment to life imprisonment in New South Wales: Crimes Act 1900 s24; a discretionary punishment in the Northern Territory: Sentencing Act s5; up to 21 years imprisonment in Tasmania: Criminal Code Act 1924 s389(1).
67 Rights of the Terminally Ill Bill 2001/2003; The Voluntary Euthanasia Trial (Referendum) Bill 2002/2003 which sought to provide for a referendum in relation to a legally and medically supervised trial of AVE for a period of 18 months.
68 The Rights of the Terminally Ill Act 1996 (NT) hereafter ROTIA.
individual who was the catalyst for the passing of the ROTIA, reportedly became a supporter of legalised euthanasia after the death of a person who was close to him.\footnote{N Cica, \textit{The Euthanasia Debate in Australia – Legal and Political Issues} (The Australian Institute of Health, Law and Ethics, 1997) at 1.}

For nine months, from 1 July 1996 until 25 March 1997, it was legal for doctors in the Northern Territory to provide AVE and/or AS as long as the following criteria were met:

1. The person requesting AVE (or AS) had to be terminally ill and experiencing pain, suffering and/or distress to an extent unacceptable to him or her;\footnote{ROTIA s4.}

2. A medical practitioner (the first medical practitioner) after receiving a request for AVE or AS had to satisfy him or herself that:
   (a) the person was at least 18 years of age;
   (b) the person was terminally ill, would die without treatment and the only treatment that was available was palliative care; and
   (c) a specialist (the second medical practitioner) and a psychiatrist had to have examined the person and confirmed that the person was terminally ill and would not recover without treatment. The psychiatrist also had to confirm that the person was not suffering from a treatable depression;

3. The first medical practitioner had to inform the patient of any alternative treatment options such as palliative care;

4. The person, after being told of the prognosis and diagnosis, had to adhere to the desire to end his or her life;

5. The person had to discuss his or her decision with his or her family;

6. The person’s decision had to have been made voluntarily and freely and after due consideration;

7. The person had to have signed a certificate of request after thinking the matter over for at least a week;

8. The certificate of request had to be signed by a second medical practitioner in the presence of the person and the first and second medical practitioner

---

\footnote{59 N Cica, \textit{The Euthanasia Debate in Australia – Legal and Political Issues} (The Australian Institute of Health, Law and Ethics, 1997) at 1.}
had to be satisfied that the request was voluntary and the person requesting AVE or AS was of sound mind;

9. A further 48 hours had to elapse after the signing of the certificate of request;\textsuperscript{71} and

10. There had to be no palliative care treatment options reasonably open to the person.\textsuperscript{72}

On 28 June 1996, requirements in addition to those outlined above were introduced with the passing of the \textit{Rights of the Terminally Ill Regulations}.\textsuperscript{73} Pursuant to the Regulations, the second medical practitioner had to hold a qualification in a medical specialty related to the terminal illness from which the patient was suffering and the qualification had to be recognised by a medical specialist college in Australia. The second medical practitioner also had to be a fellow of the College governing his or her area of medical expertise and the patient had to consult a specialist in palliative care prior to being assisted to die.\textsuperscript{74}

Notwithstanding the passing of the ROTIA, attitudes were far from united amongst medical practitioners. At the time that the ROTIA was enacted, all of the 42 specialists in the Northern Territory were reportedly opposed to euthanasia.\textsuperscript{75} And there was no resident oncologist to give a second opinion in the case of patients who were in the terminal stage of cancer.\textsuperscript{76} In contrast to this, a prominent Sydney-based psychiatrist was prepared to provide the necessary signature to establish that patients were not suffering from depression, if appropriate.\textsuperscript{77}

Whilst according to media accounts as many as 60 patients wanted assistance to die,\textsuperscript{78} only four patients satisfied the stringent criteria contained in the ROTIA and

\begin{footnotes}
\footnotetext[71]{ROTIA s7.}
\footnotetext[72]{ROTIA s8.}
\footnotetext[73]{The Rights of the Terminally Ill Regulations 1996 (NT) (hereafter \textit{Regulations}).}
\footnotetext[74]{The Regulations, 3 & 5.}
\footnotetext[75]{G Alcorn, ‘How the Northern Territory Act Came to Life’ \textit{The Sydney Morning Herald} (26 March 1997) 6.}
\footnotetext[77]{R Guilliatt, ‘Signature that Signed Away a Life’, \textit{The Sydney Morning Herald} (27 September 1996) 11.}
\footnotetext[78]{G Alcorn, ‘Sixty Wanted to Join the Queue for Euthanasia’ \textit{The Sydney Morning Herald} (26 March 1997) 1.}
\end{footnotes}
the Regulations and were able to find a doctor willing to assist them namely, Dr Phillip Nitschke.

The Northern Territory branch of the AMA was opposed to the ROTIA. In this it was supported by Australian Aborigines residing in the Northern Territory. During debate, prior to the passing of the ROTIA, evidence was put before the Northern Territory Senate Legal and Constitutional Committee that Aboriginal people were afraid to attend a clinic or go to a hospital because of the ROTIA. This response is understandable in light of the eugenics movement in Australia which targeted Aborigines.

On 24 July 1996, Dr Chris Wake, the then president of the Northern Territory branch of the AMA, and Dr Djiniyini Gondwarra, an Aboriginal leader, argued in the Northern Territory Supreme Court that the ROTIA was invalid because it was ultra vires the power of the Northern Territory Legislative Assembly to make such laws under section 9 of the Northern Territory’s Self-Government Act and because it breached an inalienable right to life which underlies the common law.

The Supreme Court of the Northern Territory upheld the ability of the Parliament of the Northern Territory to enact the ROTIA but the applicants sought, and were granted, leave to appeal to the High Court. On 9 September 1996, the appeal was stayed due to the introduction into Federal Parliament of a Private Members Bill, the Euthanasia Laws Bill, by Kevin Andrews, a member of the Federal Liberal

81 Compare the stance of the Doctors’ Reform Society, a smaller, less powerful professional association which supports legalisation of AVE in circumstances similar to the ROTIA: see <http://drs.org.au>.
82 Senate Legal and Constitutional Committee, Consideration of Legislation Referred to the Committee: The Euthanasia Laws Bill (AGPS, 1996) at 50.
84 The Self-Government Act 1978 (NT).
85 In the alternative, they argued that the ROTIA had not received proper assent from the Administrator of the Northern Territory: Bunney, above n79.
86 The Euthanasia Laws Bill 1997 (Cth).
Party who is reportedly a devout Roman Catholic. In contrast to the situation in the Netherlands, which is discussed in Chapter Five, the opposition to legalised euthanasia expressed by the AMA and the Federal Government was supported by the Catholic Church.

The Euthanasia Laws Bill was designed to invalidate the ROTIA by removing the power of the governments of the Australian Territories (the Northern Territory, the Australian Capital Territory and Norfolk Island) to pass legislation legalising AVE and/or AS:

... the power of the Legislative Assembly conferred by section 4 [of the Australian Constitution] in relation to the making of laws does not extend to the making of laws which permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life.

The Legislative Assembly does have power to make laws with respect to:

(a) the withdrawal or withholding of medical or surgical measures for prolonging the life of a patient but not so as to permit the intentional killing of the patient; and

(b) medical treatment in the provision of palliative care to a dying patient, but not so as to permit the intentional killing of the patient; and

(c) the appointment of an agent by a patient who is authorised to make decisions about the withdrawal or withholding of treatment; and

(d) the repealing of legal sanctions against attempted suicide.

The Euthanasia Laws Act, as the Bill became, was remarkable because it overturned convention in Australian constitutional law. Section 122 of the Australian Constitution, which allows the Federal Parliament to make laws for
the Australian Territories, is unlimited by subject matter.92 The section had never before been relied upon to invalidate a Territory law in this manner although s122 would permit this to occur.93 The outcome of the case was interpreted as a major victory by opponents of legalised euthanasia.94 However, there is the still the possibility that draft euthanasia legislation could be enacted in the Australian states in the future - the Euthanasia Laws Act only applies to the Territories.

According to media accounts, there was a great deal of moral and emotive debate around the Euthanasia Laws Bill. The debate reflected the positions that are typically adopted by the protagonists in the euthanasia debate. Opponents of legalised euthanasia typically argue that life is sacred and should never be terminated.95 Proponents commonly argue that the crucial issue is not life per se but the need for quality of life which should permit people to have choice in the manner and timing of their own death – particularly in the case of people who are terminally ill and suffering.96 These difficult and likely irreconcilable moral issues were, in the end, neatly sidestepped. The debate was cast in the narrow, legalistic terms of Federal rights versus states’ rights and the former prevailed.

93 Cica, above n69 at 5. Cica has suggested that the introduction of the Bill was ‘managed’ so as to attract as little public scrutiny as possible. A debate in relation to the Bill was carried out in the Main Committee instead of in the Main Chamber yet the Main Committee is the proper forum for non-controversial legislation. In addition, interested persons were only allowed a month in which to prepare their submissions.
The way in which the ROTIA was dealt with left no doubt that majority attitudes within a major power broker in Australian politics at the relevant time, the Federal Liberal/Coalition Government, were firmly against legalised euthanasia. By contrast, the Federal Rudd Labor Government that was elected to power on 26 November 2007⁹⁷ has not yet commented whether it is for or against legalised euthanasia.⁹⁸ However, a 2002 Gallup poll found that 70 per cent of Australians are in favour of ‘giving terminally ill and severely suffering people a choice about the timing and method of their death.’⁹⁹

B. England

In England, murder is committed when a person intends to kill and succeeds in killing another person or kills another person after forming an intent to cause the other person serious harm.¹⁰⁰ Unlike the other common law jurisdictions, AVE was directly addressed in England in 1957 in the case of Adams.¹⁰¹ It was deemed to be murder:

> Murder is an act or series of acts … done with intent to kill … and which in fact kill. It does not matter whether … death was inevitable … If life [is] cut short by weeks or months it would be just as much murder as if it were cut short by years.¹⁰²

A charge of manslaughter may be substituted for a murder charge where a partial defence applies such as provocation, diminished responsibility or death in the pursuit of a suicide pact or where death results due to reckless conduct, grossly
negligent conduct or by way of a dangerous and unlawful act on the part of the accused.\textsuperscript{103} Thus AVE could also be categorised as manslaughter.

The starting point for sentencing for murder is life imprisonment. However Schedule 21 of the \textit{Criminal Justice Act}\textsuperscript{104} contains a list of mitigating factors that can reduce the sentence. For example, a period in gaol may be reduced if the accused believed that the act that caused death was ‘an act of mercy’.\textsuperscript{105} A conviction for manslaughter may also result in a maximum punishment of incarceration for life but convictions for manslaughter generally attract much shorter sentences than do convictions for murder.\textsuperscript{106}

In England there is a sensibility of support for people who are ‘terminally ill … in pain [and who] wish to die’\textsuperscript{107} to be able to obtain euthanasia from a medical practitioner. By contrast, attitudes among key groups, whilst by no means uniform, tend to be against the legalisation of euthanasia. In a 2004 report entitled \textit{Partial Defences to Murder}, the English Law Commission concluded that the English criminal law should be reformed. The main areas of concern to the Commission, of relevance to this thesis, were the starting point of life imprisonment for murder and a lack of clarity in relation to the meaning of intent to kill.\textsuperscript{108}

In July 2005, the English Government announced that the law of homicide would be reviewed. In November that year, the Law Commission released a consultation paper entitled ‘A New Homicide Act for England and Wales?’\textsuperscript{109} The paper called for comments on the Commission’s proposal that the general law of homicide be rationalised and clarified through new legislation and that the categories of

\begin{thebibliography}{99}
\bibitem{103} The Law Commission, above n22 at 3; D Ormerod, \textit{Smith & Hogan's Criminal Law} (11th ed, 2005) at 439, 471; \textit{Homicide Act 1957} (UK) s3.
\bibitem{104} \textit{Criminal Justice Act 2003} (UK) (hereafter \textit{Criminal Justice Act})
\bibitem{105} \textit{Criminal Justice Act} s269, schedule 21.
\bibitem{108} Law Commission, above n106.
\bibitem{109} The Law Commission, above n22.
\end{thebibliography}
homicide be altered to run from manslaughter to second-degree murder to first-degree murder. Under the proposed new Homicide Act, AVE would be categorised as first-degree murder but the mitigating provisions for sentencing contained in the *Criminal Justice Act* would still apply.\(^{110}\) This represented a significant departure from earlier attitudes toward AVE. In 1976, the Criminal Law Revision Committee suggested that a new offence of mercy killing be created for cases of AVE.\(^{111}\)

In contrast to this, during 2005, the Select Committee of the House of Lords became more open in its attitude toward legalised euthanasia. In 2004, the Assisted Dying for the Terminally Ill Bill\(^ {112}\) was introduced into the English Parliament and became the subject of a House of Lords Select Committee Report. The qualifying criteria for assisted dying included: suffering that was unacceptable to the person and due to terminal illness; the provision of adequate information and counselling including the offer of palliative care; repeated informed requests to die; a written declaration to this effect witnessed by two people; a 14-day waiting period; and final verification. The primary aim of the Bill was to legalise euthanasia for those who are not physically able to commit suicide.\(^ {113}\)

The Assisted Dying Bill was defeated in May 2006. However, rather than rejecting it outright, the Select Committee recommended that any future Bill: make a clear distinction between AS and AVE (the inference being that legalising the former might be more acceptable to parliamentarians); better articulate doctors’ powers and duties under the Bill; define ‘terminal illness’ and ‘competence’ to reflect modern medical practice; consider changing ‘unbearable suffering’ to ‘unrelievable’ or ‘intractable’ suffering; and abandon the requirement that a

---

\(^{110}\) The Law Commission, above n22 at 2-7, 346. As at 13 January 2008 there had been no further developments in relation to the report.

\(^{111}\) The suggestion was dropped as it did not have widespread support: *Working Paper on Offences Against the Person*, paragraphs 79-87 cited in The Law Commission, above n22 at 206, 208.

\(^{112}\) The Assisted Dying for the Terminally Ill Bill 2004 (UK). Hereafter Assisted Dying Bill.

\(^{113}\) House of Lords Select Committee, *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill* (2005), see Abstract.
medical practitioner who objects to AVE or AS have to refer the patient to another doctor.114 A further draft of the Bill has not yet been presented.115

C. The United States of America

American criminal law is codified into fifty-one state codes and the District of Columbia. The Federal Criminal Code overlays each of the state criminal codes but only the states have the power to impose criminal liability for crimes such as murder. Broadly speaking, American states can be divided into two groups: those with murder statutes based on the English common law, of which California is typical; and those with murder statutes based on the American Law Institute’s Model Penal Code of which New York is typical.116 Due to the large number of jurisdictions in America, I discuss the situation in California and the situation in New York, below, as typical examples of how American law would respond to AVE.

i. American States whose Approach is Based on the English Common Law

These states, of which California is a typical example, define murder as ‘the unlawful killing of a human being … with malice aforethought’.117 Malice can be implied where there is an intentional act, the consequences of which were dangerous to human life and when the act was performed knowing of the danger.118 Murder is divided into first-degree murder and second-degree murder. First-degree murder comprises all premeditated murders and murders involving special circumstances such as killing a police officer. Second-degree murder comprises all murders in which there is no element of premeditation. The unlawful killing of a human being without malice is manslaughter. Manslaughter is divided into three categories: involuntary (in the heat of passion); voluntary (during the

114 The House of Lords Select Committee, above n113 at 91.
115 Email from the Public Bill Office, House of Lords to V Hiley (23 May 2006). This was still the case as at 13 January 2008.
117 California Penal Code s187.
118 Id s188.
commission of an unlawful act not a felony); or vehicular.\textsuperscript{119} So, in those American states with homicide statutes based on the English common law, AVE would likely be categorised as second-degree murder or voluntary manslaughter.

Second-degree murder carries a penalty of imprisonment from 15 years to life.\textsuperscript{120} Voluntary manslaughter is punishable by imprisonment for three, six or eleven years.\textsuperscript{121} The court determines which of the three possible terms to impose after considering all of the circumstances of the case.\textsuperscript{122} Thus AVE could attract a maximum sentence of life in gaol.

\textbf{ii. American States whose Approach is Based on the Model Criminal Code}

In these states, of which New York is an typical example, homicide is defined as ‘conduct which causes the death of a person under circumstances constituting first or second-degree murder, manslaughter in the first or second-degree, or criminally negligent homicide.’\textsuperscript{123} Criminally negligent homicide is where the accused failed to perceive a substantial and unjustifiable risk that death would occur.\textsuperscript{124} Murder in the first-degree is reserved, broadly speaking, for where there is an intent to kill and a person is killed who falls within a specific category (such as a police officer) or the killing occurs in a specific situation (for example, for financial reward) and the accused is over 18 years of age.\textsuperscript{125} Second-degree murder requires an intent to kill in a situation that involves mitigating circumstances such as extreme emotional disturbance or reckless conduct.\textsuperscript{126} Manslaughter in the first-degree requires an intent to cause serious physical injury and death results but there is a mitigating factor such as extreme emotional disturbance.\textsuperscript{127} Manslaughter in the second-degree involves, inter alia, recklessly causing the death of another

\begin{itemize}
\item \textsuperscript{119} California Penal Code s192.
\item \textsuperscript{120} Id s190(b).
\item \textsuperscript{121} Id s193(a).
\item \textsuperscript{122} Id s1170(3).
\item \textsuperscript{123} New York Penal Law s125.00.
\item \textsuperscript{124} Id s15.05(4).
\item \textsuperscript{125} Id s125.27.
\item \textsuperscript{126} Id s125.25(1)-(3).
\item \textsuperscript{127} Id s125.20(1) & (2).
\end{itemize}
person.\textsuperscript{128} So, in American states that adopt the Model Criminal Code AVE could be categorised as murder in the second-degree, first or second-degree manslaughter or criminally negligent murder.

The penalties for murder in the second-degree, first or second-degree manslaughter and criminally negligent murder respectively are: life imprisonment; up to 25 years imprisonment; up to 15 years imprisonment; and up to four years imprisonment.\textsuperscript{129} So, the maximum punishment for AVE is life imprisonment.

In America there is a sensibility of support for the legal provision of euthanasia to people who are ‘terminally ill’ and experiencing ‘unbearable pain and suffering’.\textsuperscript{130} However, attitudes within two key groups, the Bush Administration\textsuperscript{131} and the American Medical Association\textsuperscript{132} remain opposed to it.

D. Canada

In Canada, all criminal offences except contempt of court have been codified into the Federal Criminal Code which must be read alongside the jurisprudence of the Supreme Court of Canada. A conviction for murder requires the accused to have planned and intended to cause another person’s death or to have intended to cause bodily harm that s/he knew was likely to cause death but was reckless as to whether death ensued or not.\textsuperscript{133} Subjective foresight of the risk of death is a prerequisite for a murder conviction in Canada.\textsuperscript{134}

Murder is divided into first and second-degree murder.\textsuperscript{135} First-degree murder is where a killing is planned and deliberate\textsuperscript{136} or where it involves special

\textsuperscript{128} New York Penal Law s125.15(1).
\textsuperscript{129} Id s70.00(2)(a)-(c).
\textsuperscript{131} See footnote 246, below.
\textsuperscript{132} See footnote 42, above.
\textsuperscript{133} Federal Criminal Code s229(a).
\textsuperscript{134} R v Martineau [1990] 2 SCR 633.
\textsuperscript{135} Federal Criminal Code s231(1).
circumstances such as terrorism\textsuperscript{137} or criminal harassment\textsuperscript{138} among others. Second-degree murder comprises all murders which do not meet the criteria for first-degree murder.\textsuperscript{139} A homicide may be categorised as manslaughter when the accused lacked an intent to kill.\textsuperscript{140} The only mitigating circumstances in Canada that can reduce a murder charge to a charge of manslaughter are provocation sufficient to deprive an ordinary person of the power of self-control or intoxication\textsuperscript{141}

Thus, in Canada, AVE could be categorised as second-degree murder or manslaughter. Indeed, in 2001, an act of mercy killing was categorised as second-degree murder in \textit{R v Latimer},\textsuperscript{142} a case in which a father killed his disabled daughter. \textit{Latimer} is discussed in detail in the following chapter.

AVE could also fall within section 226 of the Federal Criminal Code which forbids accelerating the death of another person.\textsuperscript{143} Whilst the section was not drafted with AVE in mind,\textsuperscript{144} its practical effect is that AVE could lead to a conviction for murder or manslaughter.

A conviction for murder can result in a term of imprisonment from ten to 25 years.\textsuperscript{145} A conviction for manslaughter renders the accused liable to a penalty of up to life imprisonment.\textsuperscript{146} Thus AVE could result in a maximum punishment of life in prison.

\begin{footnotesize}
\begin{itemize}
\item \textit{Federal Criminal Code} s231(2).
\item Id s231(6.01).
\item Id s231(6).
\item Id s231.
\item Id s234.
\item Id s232 & 33.
\item \textit{R v Latimer} [2001] 1 SCR 3.
\item ‘Where a person causes to a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.’
\item Otlowski, above n53 at 20.
\item \textit{Federal Criminal Code} s745.
\item Id 236(b).
\end{itemize}
\end{footnotesize}
Opinion polls\(^{147}\) have shown a sensibility of support in Canada for the legalisation of euthanasia for those who are suffering from ‘an incurable, extremely painful illness’.\(^{148}\) However, attitudes within three key groups, the Canadian Medical Association,\(^{149}\) the Law Reform Commission of Canada\(^{150}\) and the Canadian Parliament\(^{151}\) do not support the legalisation of euthanasia.

E. New Zealand

In New Zealand, murder will be established when an accused meant to cause death or bodily injury knowing the injury would likely result in death, or was reckless as to whether death would ensue or not.\(^{152}\) Manslaughter is defined as any culpable homicide that does not amount to murder.\(^{153}\) So, in New Zealand, AVE could be categorised as murder or manslaughter. However, it could also fall within section 164 of the *Crimes Act*,\(^{154}\) which criminalises the acceleration of another person’s death,\(^{155}\) although the section was not drafted with AVE in mind.\(^{156}\)

A conviction for murder carries a maximum penalty of life imprisonment as does a conviction for manslaughter.\(^{157}\) There is a presumption in favour of life imprisonment for murder unless it would be manifestly unjust. If the court does not

---

\(^{147}\) Opinion polls are central to the euthanasia debate. However, as I discuss in the conclusion to the thesis, there are many problems associated with them. The House of Lords Select Committee, in its review of assisted dying in 2005, concluded that opinion polls ‘tend to produce findings which at best may be considered one-dimensional. Simple, direct questions placed without a proper explanatory context and with limited options for reply can sometimes produce results which in fact may be misleading’: House of Lords, n113 at [217] and see Appendix 7 to the report.


\(^{149}\) The Canadian Medical Association, above n42.


\(^{152}\) *Crimes Act* 1961 (NZ) s167(a) & (b).

\(^{153}\) Id s171.

\(^{154}\) *Crimes Act* 1961 (NZ).

\(^{155}\) ’Every one who by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while laboring under some disorder or disease arising from some other cause.’

\(^{156}\) Otlowski, above n53 at 20.
hand down a sentence of life imprisonment, it must give written reasons for not having done so.\textsuperscript{158} Thus, in New Zealand, AVE could result in a maximum penalty of life in gaol.

There is a sensibility of support in New Zealand for the provision of euthanasia ‘for someone with a painful, incurable disease … provided it is provided by a doctor’.\textsuperscript{159} As noted in Chapter One, the Prime Minister of New Zealand supports the legalisation of euthanasia but the majority of her fellow parliamentarians do not, as evidenced by the failure of the Assisted Dying Bill\textsuperscript{160} in 2003. A similar Bill is presently in the ballot of member’s Bills but selection is yet to occur.\textsuperscript{161}

Having set out established legal principles with regard to unlawful killing (AVE) in each of the common law jurisdictions and having provided a more complete picture of sensibilities and attitudes toward death and dying at the present time, I now turn to show that the law does not always respond to cases of AVE as one would expect in light of the legal principles outlined above.

4. AVE – the Law in Practice

In cases\textsuperscript{162} of AVE that have come before the courts in the jurisdictions examined in this chapter, and in which the accused was a medical practitioner, harsh penalties have seldom been invoked. Prosecutions of doctors are rare, even in ‘confession cases’\textsuperscript{163} when doctors openly acknowledge having assisted patients

\begin{footnotes}
\item[157] Crimes Act 1961 (NZ) ss172 & 177.
\item[158] Sentencing Act 2002 (NZ) s102(1) & (2).
\item[160] The Assisted Dying Bill 2003 (NZ).
\item[161] Email from the New Zealand Parliament Information Service to V Hiley (2 June 2006). As at 13 January 2008, selection had still not occurred.
\item[162] See Appendix 5 for a summary of selected cases discussed in this chapter.
\end{footnotes}
to die. According to Skene, it is likely that this is due not only to evidentiary
difficulties in proving intent and causation but also because prosecutors are
reluctant to prosecute doctors who are perceived to be ‘doing their best in an area
of the law which is unclear (and perhaps, deliberately kept unclear).’ 164

In addition to evidentiary problems establishing causation and intent in cases
involving AVE and decisions not to prosecute, 165 juries are said to be sympathetic
and reluctant to convict where the possible outcome is as serious as incarceration
and, juries are entitled to acquit even if the evidence and the judge’s direction
provide no logical basis upon which to do so. 166 Further, as we shall see, juries are
sometimes presented with a reason to acquit in the form of the DDE. And, whether
or not the DDE is raised, sympathetic attitudes on the part of the judge or the jury
may also play a role in securing a more lenient outcome than one might expect
following AVE.

Of the 12 prosecutions for murder or attempted murder that I discuss below,
causation and/or intent could not be proven in six cases, the DDE was
successfully relied upon by the accused in two cases resulting in an acquittal.
Sympathetic attitudes on the part of the judge or jury appeared to play a role in
bringing about a more lenient outcome than one might expect in five cases. There
were only two convictions, neither of which involved a harsh penalty.

164 L Skene, Law and Medical Practice: Rights, Duties, Claims and Defences (2nd ed, 2004) at 287.
165 The case of de la Rocha, discussed below, provides important insights into the factors that drive
decisions not to prosecute following euthanasia. The prosecutor in de la Rocha admitted that the
following factors played a role in his decision not to prosecute Dr de la Rocha for murder: a concern that
the jury would not view Dr de la Rocha as a ‘real’ killer; difficulty in finding an expert witness who was
willing to testify against him; the fact that Gallup polls showed that eight out of ten Canadians were in
support of Sue Rodriguez’s application for AS which was unfolding at the time (for discussion see
Chapter Three); the fact that Dr de la Rocha was a well-respected doctor from a small community to
which it was difficult to attract doctors; the fact that the doctor’s own community was split about how to
deal with the case; a concern that the jury would acquit him; and a concern that 12 jurors would chart the
course for euthanasia in Canada: Downie, above n5 at 40 citing David Thomas, Crown Attorney’s Office,
Timmins, Ontario, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide:
Special Senate Committee, No. 29 (12 December 1994) at 42, 43.
A. Australia

In Australia, reports suggest that only one doctor has been prosecuted for engaging in AVE. In April 2000, it was alleged that Dr Stephens murdered Freeda Hayes at the Murdoch Community Hospice in Perth by giving her an intravenous injection of atracurium and midazolam. Mrs Hayes was suffering from cancer of the kidneys and had secondary tumours throughout her nervous system. Her pain was reportedly extremely severe. Mrs Hayes’ brother, Warren Hayes, her sister, Lena Vinson and Dr Stephens were present at the time she died.\(^{167}\)

In October 2001, Dr Stephens was tried for both wilful murder\(^{168}\) and the specific crime of assisting the suicide of another (AS)\(^{169}\) in the Supreme Court of Western Australia before Justice White.\(^{170}\) The evidence in the case was not sufficient to establish causation. A nurse gave evidence that she had gone into Freeda Hayes’ room on the evening in question and found that the intravenous drip, which contained morphine, was running very fast. When she tried to slow the drip down Dr Stephens tried to prevent her from doing so. However, she conceded that she had not seen anyone give Mrs Hayes an injection. A second nurse gave evidence that Mrs Hayes was able to administer medication to herself which raised doubts as to whether a third party had been involved in her death. A forensic pathologist and a histopathologist gave evidence that it was impossible to state the precise cause of Mrs Hayes’ death.\(^{171}\)

---

\(^{167}\) R Bowles, *What Happened to Freeda Hayes?* (2002) at xv-xviii, 4. I have relied upon the account of the case provided by journalist Robin Bowles because she was present throughout the trial and her account is likely to be reliable.

\(^{168}\) Wilful murder is defined in section 278 of the Criminal Code 1913 (WA): ‘… a person who unlawfully kills another, intending to cause his death or that of some other person, is guilty of wilful murder.’

\(^{169}\) AS is dealt with in the Criminal Code 1913 (WA) s288: ‘Any person who – (1) procures another to kill himself; or (2) counsels another to kill himself and thereby induces him to do so; or, (3) aids another in killing himself; is guilty of a crime, and is liable to imprisonment for life.’

\(^{170}\) Dr Stephens was acquitted, at first instance, in the Local Magistrate’s Court due to a lack of evidence of causation: Bowles, above n167 at 151.

\(^{171}\) Id at 208-237.
The jury reportedly found, after deliberating for just ten minutes, that there was insufficient evidence to prove, beyond reasonable doubt, that Dr Stephens killed Mrs Hayes or assisted her to commit suicide.172

B. England173

In England, several doctors have been prosecuted for murder after allegedly providing AVE but only one has ever been convicted. The conviction resulted in a relatively lenient outcome, a suspended sentence. The leading, and first, reported English case in relation to AVE, as noted in Part 2 above, is Adams.174 In Adams, Dr Bodkin Adams was charged with the murder of Mrs Morrell who had suffered a stroke two years earlier and had complained of pain ever since.175 It was alleged that Dr Adams killed Mrs Morrell by prescribing successively larger doses of morphine. When Dr Adams was arrested for her murder he reportedly did not deny the charge but instead is said to have exclaimed ‘Murder! Can you prove it?’176

The evidence as to causation and intent appears to have been poorly prepared by the prosecution. Four nurses gave evidence for the prosecution that Mrs Morrell was either unconscious or semi-conscious in the days before her death. Each was impeached when the defence produced contemporaneous medical records which revealed that this was not in fact the case. In addition, the prosecution’s expert medical witness conceded during cross-examination that it was not possible to tell whether the huge doses of morphine allegedly given to Mrs Morrell at Dr Adams’ instruction actually brought about her death or whether her death was due to natural causes.177

172 Bowles, above n167 at 295, 296.
173 Judgments are not available for the unreported decisions discussed in this section. As a result, I have relied upon secondary sources.
175 Compare the account of the case provided by Dr J Leavesley. Dr Leavesley claims that Mrs Morrell was not in any pain at all she was merely very restless: Australian Broadcasting Commission, Radio National, Ockham’s Razor (23 July 2006) <http://www.abc.net.au> accessed 20 November 2006.
177 Ibid.
Mrs Morrell’s solicitor gave evidence that Mrs Morrell had altered her will a number of times in favour of Dr Adams. Whilst this evidence suggested a possible motive on Dr Adams’ part, it was tempered by the fact that Mrs Morrell had removed Dr Adams from her will just before her death. On the other hand, a police superintendent gave evidence that bolstered the suggestion of a motive on Dr Adams’ part. He claimed that Dr Adams had initially stated he had no idea, at any stage, that he was to benefit under Mrs Morrell’s will yet, when questioned again later, he reportedly said ‘It was not done wickedly. We always want a cremation to go off smoothly … If I said I knew [the relatives] might get suspicious.’

At the close of the evidence, Justice Devlin repeated the same question to the jury that Dr Adams had allegedly initially asked the police: ‘Murder? Can you prove it?’ After pronouncing the passage that I have already quoted in Part 3 above in which he said that any act that intentionally shortens a person’s life is murder, Justice Devlin directed the jury as follows:

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

In this manner, Justice Devlin adopted into English criminal law what has since been described by scholars as the DDE. In his memoirs, Justice Devlin explained that the DDE was introduced by the defence and was accepted because the prosecution failed to object to its use in the context of criminal proceedings and because Justice Devlin believed its use was appropriate. He viewed the DDE as a mechanism whereby causation was negated:

---

178 Palmer, above n176 at 374, 375.
179 Id at 375.
This was the direction given to the jury in the case of *R v Adams* in 1957, and the Attorney-General on behalf of the Crown did not challenge the submissions of the defence on this issue ... Before a man can be convicted of murder, it must be proved that his act was the cause of the death. That does not invariably mean the medical cause of death. Medicine is concerned with the … physical cause and the criminal law with the guilty cause … proper medical treatment consequent upon illness … plays no part in legal causation; and to relieve the pains of death is undoubtedly proper medical treatment.\(^{181}\)

Dr Adams was acquitted.\(^{182}\) However, there was reportedly widespread concern at the verdict because it was not clear that Mrs Morrell needed large doses of morphine in the first place and it had become public knowledge that Dr Adams was a beneficiary under a total of 132 of his patients’ wills.\(^{183}\) Yet, the DDE made it conceivable that Dr Adams had only intended to relieve Mrs Morrell’s distress and not to kill her. In November 1957, Dr Adams was struck off the Medical Register for other irregularities in his medical practice but that did not prevent him from continuing to practise medicine.\(^{184}\)

A lack of evidence as to intent and causation was also a problem in the next prosecution for AVE, almost 30 years after *Adams* when, in 1986, Dr Carr\(^{185}\) was charged with attempted murder after he allegedly gave Mr Mawson 1,000 milligrams of phenobarbitone instead of 150 milligrams. Mr Mawson was reportedly terminally ill and in pain at the time that the phenobarbitone was given to him. He died two days later. News reports indicate that Dr Carr pleaded not guilty and stated that the dosage had been given in error\(^{186}\) but this contradicted an earlier statement he had given to the police in which he claimed that he had only given Mr Mawson 150 mgs of phenobarbitone and not 1,000 mgs as alleged.\(^{187}\)

---

181 P Devlin, *Samples of Lawmaking* (1962) at 95.
182 Palmer, above n176.
183 Australian Broadcasting Commission, above n175.
187 Ibid.
Justice Mars-Jones’ summing up to the jury, as reported in the media at the time, was hostile to Dr Carr:

A doctor is not entitled to play God and cut short life because the time has come to end the pain and suffering ... [Mr Mawson] did not want to die, and even if he did, killing him would have been illegal. However gravely ill a man may be, however near his death he is entitled in our law to every hour, nay every minute of life that God has granted him. That hour or hours may be the most precious and most important hours of a man’s life. There may be business to transact, gifts to be given, forgiveness to be said, attitudes to be expressed, farewells to be made, 101 bits of unfinished business which have to be concluded.188

The evidence that Dr Carr had initially lied about the dose of phenobarbitone that he had given to Mr Mawson in conjunction with the judge’s summing up to the jury might have led to a conviction. However, the evidence as to intent and causation was not clear-cut and the jury reportedly returned a verdict of not guilty.189

Evidence of intent was easier to establish in the next prosecution for murder, in 1990, in R v Ludwig,190 but establishing causation was not. According to media accounts, Dr Stephen Lodwig was charged with murder after he allegedly gave Mr Spratley a lethal intravenous dose of potassium chloride and lignocaine. Mr Spratley, who died about one minute after receiving the injection, had cancer of the pancreas and was terminally ill. It was alleged that his pain could not be adequately controlled by morphine. Prior to giving Mr Spratley the intravenous injection, Dr Lodwig reportedly said to one of the nurses ‘I’m going to send someone up’ whilst drawing a finger across his throat and pointing upwards.191

A toxicologist who gave evidence for the prosecution stated that Mr Spratley’s death was due to the potassium chloride injected by Dr Lodwig but, under cross-examination, he conceded that death could equally well have been due to the

---

189 Ibid.
191 Huxtable, above n1 at 65.
morphine Mr Spratley had received to relieve his pain or the secondary cancer that was discovered at autopsy. The prosecution abandoned the case when the defence indicated it had located two expert medical witnesses who were willing to testify about research they were carrying out on the use of potassium chloride in enhancing the pain relieving effects of morphine. Thus, in *Lodwig*, medical expertise was successfully utilised to bolster an existing difficulty in establishing causation in these cases even though Dr Carr’s statement to the nurses went directly to the question of intent and might have led to a conviction. After the case was abandoned, Justice Leonard ordered that a verdict of not guilty be entered.\(^{192}\)

Had the prosecution not abandoned the case in *Carr* and had the next case already been decided, it is likely that Dr Carr would have been convicted of attempted murder. However, the question as to the analgesic properties of potassium chloride was not adjudicated until 1991, in *R v Cox*.\(^{193}\) In *Cox*, Dr Nigel Cox was charged with the attempted murder\(^ {194}\) of Mrs Boyes. Mrs Boyes was reportedly terminally ill. She was in agony notwithstanding massive doses of heroin. She allegedly howled like a dog when anyone touched her and had begged Dr Cox to end her life. Dr Cox stated that he had chosen the least evil for Mrs Boyes in acting to end her life.\(^ {195}\)

Evidence was led at the hearing that Dr Cox injected two, undiluted ampoules of potassium chloride into Mrs Boyes’ intravenous cannula and that she died within seconds to minutes after the injection. The defence conceded that: potassium chloride has no curative properties and is not an analgesic; it is lethal if injected undiluted and any qualified doctor would know this; the injection given to Mrs

---

\(^ {192}\) Huxtable, above n1 at 65.

\(^ {193}\) (1992) 12 BMLR 38.

\(^ {194}\) Dr Cox was not charged with murder because the prosecution was reportedly unsure it could prove that he caused Mrs Boyes death as opposed to her medical condition: Skene, above n161 at 288. However, Grubb claims that the prosecution decided to charge Dr Cox with attempted murder rather than murder because of the severity of the punishment for murder: A Grubb, 'Attempted Murder of Terminally Ill Patient' (1993) 1 *Medical Law Review* 232 at 233.

Boyes would result in death seconds to minutes after it was given; and there was no clinical indication for potassium chloride to be given. It was agreed that: Mrs Boyes was terminally ill and very close to death at the time the injection was given; and the use of potassium chloride by Dr Cox could only have been to hasten her death.196

At the close of the evidence, Justice Ognall accepted the use of the DDE in the proceedings, referring to primary and secondary intent:

There can be no doubt that the use of drugs to reduce pain and suffering will often be justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death … If Dr Cox’s primary purpose was to hasten the moment of death then he is guilty … It matters not by how much or by how little death was hastened or intended to be hastened … Staff Nurse Creasey considered that Lillian Boyes was, at best, only hours from death and possibly only minutes away. Even if that be the case, no doctor can lawfully take any step deliberately designed to hasten that death by however short a period of time.197 [Emphasis added.]

Unlike Dr Adams, Dr Cox was not able to rely upon the DDE because he had conceded an intent to kill.198 He was convicted of attempted murder. According to media accounts, he received a 12-month sentence but it was suspended. He was allowed to return to work subject only to a temporary limitation on his right to prescribe narcotic analgesics and a requirement that he undertake a refresher course in palliative care.199 This relatively lenient sentence may have reflected a sympathetic attitude toward Dr Carr on the part of the judge and/or the jury; a number of the jury were reportedly in tears when the verdict was read out.200

The General Medical Council201 admonished Dr Cox but refused to strike him from the Medical Register.202 The outcome is problematic because, as the quote at the

196 (1992) 12 BMLR 38 at 38-43.
197 Id at 41.
198 Huxtable, above n1 at 63.
200 Sneiderman & Verhoef, above n195 at 183.
201 Hereafter GMC.
beginning of the chapter suggests, the lack of a harsh response to the case may do little to deter others from engaging in AVE.

The most recent English case of AVE illustrates how the DDE can exacerbate existing difficulties in proving intent and also suggests that a sympathetic attitude on the part of the judge may produce a more lenient outcome than one might expect. In 1999, Dr David Moor\textsuperscript{203} was arrested by police after allegedly stating to the media that he did not have a problem with helping patients to die and after admitting to a public health official that he had helped up to 300 patients to die. Following an investigation, Dr Moor was charged with murdering George Liddell, a patient who was dying of bowel cancer.\textsuperscript{204}

Evidence was led at the hearing that Mr Liddell was in a severely weakened state before he died and had told a number of people that he did not want to go on. He was immobile, depressed, in considerable pain and was receiving morphine through a syringe driver. It was alleged that when the morphine ran out, Dr Moor gave Mr Liddell a very large bolus dose of morphine and that Mr Liddell died within 20 minutes of receiving the injection. Dr Moor initially denied administering the additional dose of morphine but, in a subsequent prepared statement, he admitted to it.\textsuperscript{205}

During cross-examination, Dr Moor admitted that he intended to put Mr Liddell ‘to sleep’. Further questioning by the judge revealed that Dr Moor had thought the death of Mr Liddell ‘highly probable’ as a result of the injection that he gave to him.\textsuperscript{206} A post-mortem examination of Mr Liddell’s blood indicated that the dose of morphine he had received was up to six times the amount that Dr Moor admitted.

\textsuperscript{202} Huxtable, above n1. See also, D Brahams, ‘Euthanasia: Doctor Convicted of Attempted Murder’ (1992) 340 The Lancet 782 at 783 who argues that Dr Cox’s punishment was unduly harsh and cites two anaesthetists (details not provided) who were convicted of manslaughter in 1990, each of whom received a suspended sentence of only six months.

\textsuperscript{203} R v Moor (David) (Unreported, Crown Court, Hooper J, 11 May 1999).

\textsuperscript{204} A Arlidge, ‘The Trial of Dr David Moor’ (2000) Criminal Law Review at 31, 32.

\textsuperscript{205} Id at 32.

\textsuperscript{206} See Appendix 5.
to having given in his written statement. However, a definitive cause of death could not be established.207

At the conclusion of the evidence, Justice Hooper stated that in his view Dr Moor had lied to the police about the dose of morphine he had given to Mr Liddell only because he was ‘in a state of panic’.208 Contrary to the principles laid down in Woollin (the intent for murder will be made out where death is virtually certain as a result of one’s actions), a case that was decided before Moor, the judge then directed the jury in relation to the DDE as follows:

A person intends to kill another person if he does an act, in this case giving the injection, for the purpose of killing that person. If Dr Moor thought or may have thought that it was only highly probable that death would follow the injection then the prosecution would not have proved that he intended to kill and he would not be guilty.209 [Emphasis added.]

The jury took less than an hour to acquit Dr Moor of attempted murder.210 As noted above, in Part 2, what at face value appears to be an inconsistency with Woollin regarding criminal intent, may be explicable on two counts: Woollin did not involve AVE; and Woollin did not consider the relationship between the DDE and criminal intent. Additionally, Justice Hooper appears to have adopted a sympathetic attitude toward Dr Moor in the direction that he gave to the jury regarding the DDE.

C. The United States of America211

The situation in the United States of America with regard to doctors who are alleged to have provided AVE is similar to that in England and Australia. The first American prosecution following AVE occurred in 1950 when Dr Herman Sander212

207 Arlidge, above n204 at 32.
208 Huxtable, above n1 at 65.
209 Arlidge, above n204 at 40.
210 Huxtable, above n1.
211 I discuss the case of Dr Jack Kevorkian, who was found guilty of murder in 1999, in Part 6 below because of his much greater involvement in AS than AVE.
was charged with murder after he allegedly gave Mrs Borroto air intravenously. Mrs Borroto was reportedly dying of cancer and in great pain. It was alleged that Dr Sander repeated the injection of ten ccs [mls] of air four times and then wrote in the medical notes:

Patient was given 10cc of air intravenously repeated 4 times. Expired within 10 minutes after this was started.213

Due to Dr Sander having documented the injection and its effect, it is possible that a jury could have convicted him of murder. However, a defence witness reportedly gave evidence that it was not clear what had caused Mrs Borroto’s death: the air that was injected; her known illness; or another illness.214 The defence also led evidence that it was not entirely clear that Mrs Borroto was still alive at the time the injection was given.215

Dr Sander was acquitted, without any sanction, even though there was no medical indication for him to have injected air intravenously. Notwithstanding this, according to media reports, local community sensibilities were sympathetic to Dr Sander – over 90% of the people who lived in the same town as him signed a petition supporting his actions.216 It is possible that this also had some bearing on the outcome in the case.217

A lack of evidence of causation was also a problem in the next American case of AVE in 1972, when Dr Vincent Montemarano was charged with the murder of Mr Bauer, a patient who was dying of cancer of the throat. It was alleged that Dr Montemarano gave Mr Bauer an intravenous injection of potassium chloride. Mr Bauer died soon afterwards. Dr Montemarano claimed that Mr Bauer had died

\[\text{New York Times, above n212.}\]
\[\text{Ibid.}\]
\[\text{New York Times, above n212.}\]
\[\text{See footnote 165 above regarding the factors that influenced the prosecutor in de la Rocha.}\]
before the injection of potassium chloride was given or, if he was alive at the time the injection was given, he had died from cancer. Dr Montemarano was acquitted.\textsuperscript{218} Had the case been decided in England, after \textit{Lodwig} in 1991, Dr Montemarano may have been convicted of murder.

By contrast, in \textit{Hassman} in 1987,\textsuperscript{219} a sympathetic attitude on the part of the judge seems to have led to a relatively light penalty for Dr Joseph Hassman who reportedly pleaded guilty to injecting a lethal dose of Demerol into his mother-in-law’s nasogastric tube. Dr Hassman claimed that his mother-in-law, who was suffering from Alzheimer’s disease and who was being cared for in a nursing home, was ‘in great distress and there was no chance of recovery’ and that he had killed her only in order to relieve her suffering.\textsuperscript{220}

By pleading guilty as part of a plea bargain, Hassman became liable to a possible sentence of five years in gaol. In handing down a sentence of two years probation, 200 hours of community service per year for two years and a fine of $10,000, Judge Porreca reportedly stated that whilst he did not condone what Dr Hassman had done and he needed to send a clear message against such behaviour ‘a serious injustice would be committed’ if Dr Hassman were incarcerated.\textsuperscript{221}

\begin{itemize}
\item \textsuperscript{218} Otlowski, above n53 at 141; Editorial, ‘Mercy Killing’ Trial Opens Tomorrow, \textit{The New York Times} (13 January 1974) 44.
\item \textsuperscript{219} Humphry & Wickett cite an additional case of AVE in 1985 when Dr John Kraii was arrested for the murder of his friend and patient, Frederick Wagner. Mr Wagner was an 81-year-old man who had Alzheimer’s disease and gangrene in one foot. He was reportedly in pain and no longer recognised anyone. It was alleged that Dr Kraii injected three large doses of insulin into Wagner’s chest cavity. There were plans to prosecute Dr Kraii but they did not proceed because Dr Kraii committed suicide. Support for Dr Kraii in his home town of Newport was ‘overwhelming. Friends and neighbours had universally praised Dr Kraii’: D Humphry & A Wickett, \textit{The Right to Die: Understanding Euthanasia} (1986) at 147, 148. Brovins & Oehmke cite, in passing only, the 1988 case of Dr Donald Caraccio who reportedly received a sentence of five years probation after pleading guilty to injecting a patient who was terminally ill with potassium chloride: J Brovins & T Oehmke, \textit{Dr Death} (1993) at 236.
\item \textsuperscript{220} A Navarez, ‘Doctor is Spared Jail Term in Mercy Killing’, \textit{The New York Times} (20 December 1986) 29 at 30.
\item \textsuperscript{221} Id at 29.
\end{itemize}
D. Canada

There is only one reported Canadian case of a doctor engaging in AVE. In addition I discuss two unreported cases because of the insights these cases provide in relation to responses to AVE in Canada. Whilst the reported case, *R v Morrison* illustrates difficulties with proving causation and intent (even though Dr Morrison conceded that she had given a patient a lethal injection of potassium chloride), the two unreported cases suggest that sympathetic attitudes toward the accused can lead to more lenient outcomes than one might expect.

In 1998, Dr Nancy Morrison was charged with first-degree murder in connection with the death of Mr Mills who had died six months earlier. Establishing causation was a significant problem in *Morrison*. An intensive care nurse who looked after Mr Mills during his last days gave evidence that his ventilator was removed when nothing further could be done for him. Afterwards, the nurse informed Dr Morrison that Mr Mills was gasping for breath and seemed to be in distress. Dr Morrison injected nitroglycerin to reduce Mr Mills’ blood pressure so that he would not be conscious of suffocating to death without the ventilator. Later, she returned to the bedside and injected potassium chloride as well. Mr Mills’ heart stopped within a minute of receiving the injection. The nurse reported the matter to the hospital and an internal inquiry was mounted. Dr Morrison admitted she had injected Mr Mills with potassium chloride but said she did not know why she had done so.

A pathologist who gave evidence for the prosecution conceded that there were no pain killing drugs in Mr Mills’ liver at autopsy and that the most likely cause of this

---

222 Downie cites an additional unreported case of alleged AVE which occurred in 1982 in Alberta. Paediatric resident Dr Nachum Gal was reportedly charged with first-degree murder in the death of an infant with severe brain damage after he ordered a lethal dose of morphine which was given to the infant by nursing staff. Dr Gal fled to Israel and could not be extradited thus the case was never brought to trial: Downie, above n5 at 38.

223 *R v Morrison* NSR (2d) 201 (Nova Scotia Supreme Court) (1998).

224 Sneiderman & Verhoef, above n195 at 1, 2.


226 Sneiderman & Verhoef, above n195 at 7, 8.
was that the intravenous line had come out of his vein. This called into question whether Mr Mills had received any of the medication that was given to him near the end of his life, including the potassium chloride that was injected by Dr Morrison.227

Justice Randall discharged Dr Morrison after ruling that a jury could not convict her of the offence with which she was charged due to a lack of evidence of causation. Responses toward Dr Morrison were mixed but were more positive than negative. She was reprimanded by the College of Physicians and Surgeons in 1999 but her colleagues were sympathetic to her. A number of them wrote a letter to the media stating ‘We think it is important for the public to know that we believe your actions were compassionate and motivated only by a desire to help a dying, suffering man’.228 The sensibilities of the Canadian public were similarly placed. The prosecutor reportedly received thousands of cards and letters stating that Dr Morrison should not be prosecuted.229

The outcomes in two unreported Canadian cases of alleged AVE add weight to the claim that sympathetic attitudes can lead to a more lenient outcome than one might expect. In 1990, a Montreal physician referred to as ‘Doctor X’, allegedly administered a lethal dose of potassium chloride to a patient who was dying of AIDS. The patient’s body was reportedly covered with abscesses and he was in agony despite receiving massive doses of morphine. He repeatedly expressed a wish to be helped to die. Dr X allegedly injected the potassium chloride after a nurse said to him in desperation, ‘If you don’t end this, I will.’ The incident came to light when Dr X recorded the dose of potassium chloride in the patient’s notes. The Quebec Ministry of Justice reportedly refused to lay charges against Dr X. Commentary on the case suggests that this was possibly as a result of a recommendation by the Quebec College of Physicians that there be no

228 Sneideman & Verhoef, above n192 at 11.
229 After Dr Morrison was discharged the prosecution appealed to the Supreme Court (R v Morrison NSJ 441, SH No. 147941 (Nova Scotia Supreme Court) (1998)) but the appeal was denied on technical grounds: Sneideman & Verhoef, above n192 at 11.
prosecution.\textsuperscript{230} The College concluded that Dr X had acted in the best interests of his patient and that a jury would not convict him if he were prosecuted. However, he was disciplined.\textsuperscript{231}

In the second unreported Canadian case of AVE, in 1998, Dr Alberto de la Rocha\textsuperscript{232} was reportedly charged with second-degree murder after giving an injection of potassium chloride to a patient who was dying of cancer of the mouth, cheek and lungs. The patient had reportedly expressed a wish to die and had asked that her respirator be turned off. Dr de la Rocha complied with her request and soon afterwards injected her with morphine to prevent her from being aware of suffocating. He then injected potassium chloride which was said to have been the most likely cause of her death. The patient’s family praised his actions.\textsuperscript{233}

Justice Loukidelis stated that the patient had already stopped breathing and death was only moments away when the injection of potassium chloride was given and claimed that Dr de la Rocha had not acted with euthanasia in mind. A plea bargain was arranged whereby the prosecution agreed to drop the charge of second-degree murder in return for Dr de la Rocha pleading guilty to the lesser charge of administering a noxious substance with intent to cause harm, in contravention of section 245 of the Canadian Criminal Code. In spite of the prosecution’s submissions on sentencing that Dr de la Rocha should be incarcerated the judge handed down a three-year suspended sentence with no special conditions attached to it.\textsuperscript{234}

\textsuperscript{231} Downie, above n5 at 39.
\textsuperscript{232} See also, R v Mataya 19 WCB (2d) 118 (Ontario Court, General Division) (1983), a case involving a nurse who injected a dying patient with potassium chloride. Mataya was also permitted to plead guilty to breaching section 245 of the Criminal Code and also received a three-year good behaviour bond but in his case two conditions were attached: that he no longer work as a nurse and that he not apply in the future to be re-registered as a nurse: Id at 39, 40.
\textsuperscript{233} Sneiderman & Verhoef, above n195 at 15.
The Ontario College of Physicians and Surgeons Disciplinary Committee was sympathetic to Dr de la Rocha. It permitted him to choose between a 90-day suspension or writing a guideline on how to withdraw life support from patients who are terminally ill. He was not struck from the Medical Register. Yet, it is arguable that the outcomes in de la Rocha and in Doctor X might not deter others from engaging in AVE.

E. New Zealand

In stark contrast to the other cases discussed in this part, is the case of New Zealand nurse Lesley Martin who was charged with attempted murder when she published To Die Like a Dog; a book in which she stated that she had killed her mother, who was dying of rectal cancer, by giving her an overdose of morphine and then suffocating her with a pillow.

R v Martin came before the High Court of New Zealand in March 2004. Unlike the accused in most of the cases discussed above, Martin admitted an intent to kill and showed no remorse for her actions. Further, she was not a doctor and therefore was subject to legislation in New Zealand, discussed in Part 3 above, that excludes disease as a reason for accelerating another person’s death. Another factor that set Martin apart, making it unlikely the DDE would be available to her, was the fact that she did not confine herself to medically-recognised methods of treatment that might also accelerate death.

Nevertheless, at trial, Martin sought to rely upon the DDE as a defence to the murder charge. Justice Wild ruled that the DDE was not available to Martin but the

235 Otlowski, above n53 at 145, 146.
236 Martin could not be charged with murder because the post mortem examination was inconclusive. It revealed that Martin’s mother had died of respiratory failure which is a common side effect of morphine. There was no evidence of suffocation: The Queen v Lesley Jane Martin, Court of Appeal, CA 199/04, 14 February 2005, at paragraph [23].
judgment suggests that Justice Wild accepted the doctrine as part of New Zealand law on policy grounds without really being certain as to its status at law:

> The doctrine in the medical arena has been applied in New Zealand and in the United Kingdom only to doctors. The accused is not a doctor. Implicit in the doctrine is that it applies only to people who are capable of assessing the effects both good and bad of the painkillers. That effectively confines double effect to doctors: only they can make that assessment …

> I do not accept … that the four conditions of successful reliance upon the doctrine [suggested by the defence] will provide safeguards if the doctrine is extended beyond doctors …

> Nor do I accept that the criminal law would provide any real safeguard. If the criminal law is itself subject to the doctrine, or if the doctrine is itself part of the criminal law then the circularity, or at least the difficulty, in this argument is obvious.239

In sentencing Martin to 15 months in gaol, Justice Wild conceded that Martin’s mother had asked for help to die and stated that he did not doubt the sincerity of Martin’s views or that her actions had been taken out of love and compassion. However, he was not sympathetic to her. He noted that Martin was the foremost advocate of euthanasia in New Zealand and that there were four aggravating factors which suggested the need for deterrence: her actions were premeditated; she failed to seek external help; she breached the trust reposed in her by her mother’s general practitioner who had supplied the morphine; and she failed to consult her family and her mother’s long-standing friends before acting. Further, Martin continued to demonstrate ‘a lack of remorse and arrogance.’240 Attitudes toward Martin within the Nursing Registration Board were similarly placed. In March 2007, Martin was struck off the Nursing Register ‘in the interests of the nursing profession and society.’241

---

239 R v Martin 3 NZLR [2004] at 72.
240 The Queen v Lesley Jane Martin, Court of Appeal of New Zealand CA 199/04, Anderson P, McGrath & O’Regan JJ, 14 February 2005, at [9], [16], [17], [20], [25], [27], [43], [44], [48], [57] & [58].
In November 2004, Martin appealed against her conviction and sentence.\textsuperscript{242} Her appeal was denied. Her intention to kill her mother was said to be so clear-cut that the jury could not have reached any other verdict but guilty:

\begin{quote}
It is difficult to imagine a case where an accused has made so many deliberate, repetitive, detailed, private and public admissions of conduct carried out in the knowledge of its criminality … she did not recant those admissions …\textsuperscript{243}
\end{quote}

To sum up thus far, the cases discussed in this part show that a gap has developed between what the law says it will do in response to a proven case of AVE and what it tends to do in practice. Adams was acquitted even though there was evidence he had lied about being a beneficiary under Mrs Morrell’s will and it was not clear that Mrs Morrell required the high doses of morphine that he had prescribed for her. This was because Dr Adams was able to rely upon the DDE. Cox conceded an intent to kill and was convicted of attempted murder but he was not incarcerated, his sentence was suspended, possibly due to a sympathetic attitude toward him on the part of the judge. Moor was acquitted even though he admitted to having helped numerous patients to die, not just because of evidentiary problems, but also because he too was able to rely upon the DDE which was explained to the jury in a sympathetic manner by the judge. Hassman admitted to having killed his mother-in-law but it is possible that a sympathetic attitude on the part of judge resulted in a relatively lenient sentence following a plea bargain; the judge chose to institute a non-custodial sentence stating that to have incarcerated him would have been ‘a serious injustice’. It is arguable that sympathetic attitudes also played a part in the outcome in Dr X. He was never prosecuted even though he documented giving a patient an injection of potassium chloride which resulted in the patient’s death. Similarly, de la Rocha conceded that he had killed a patient but he was permitted to plead guilty to the lesser charge of

\begin{flushright}
\textsuperscript{242} The Queen v Lesley Jane Martin, Court of Appeal of New Zealand, CA 199/04, Anderson P, McGrath & O’Regan JJ, 14 February 2005.
\textsuperscript{243} The Queen v Lesley Jane Martin, Court of Appeal of New Zealand, CA 199/04, Anderson P, McGrath & O’Regan JJ, 14 February 2005 at [24].
\end{flushright}
administering a noxious substance. And, it is likely that a sympathetic attitude on the part of the judge led to a more lenient punishment than one might expect.

Having discussed legal responses to AVE in the common law countries, I now turn to outline established legal principles in each of those jurisdictions with regard to AS.

5. AS – Established Legal Principles

AS is treated differently to AVE in the common law jurisdictions. As I noted in the previous chapter, AVE requires the accused to have actively brought about the deceased’s death by, for example, administering a lethal injection. By comparison, AS requires the accused only to have assisted in the death by, for example, providing a script for a lethal medication. Thus AVE requires a positive act whilst AS requires what is commonly viewed as a passive measure. A further difference between the two is that AVE is not directly addressed in legislation or case law as an offence in its own right whereas AS is. However, as I noted in the previous chapter, there is no sharp dividing line between AVE and AS. Rather, it is a matter of degree. As is the case with the law around unlawful killing (AVE), matters such as the deceased’s prognosis, diagnosis and stated wishes about death are not formally relevant in prosecutions for AS.

In each of the common law jurisdictions, a refusal of unwanted medical treatment will generally not be interpreted as AS. It is typically viewed as a right. Similarly, withdrawal of medical treatment from insensate patients is typically not categorised as AS where treatment is no longer of any benefit to the patient even

---

244 In this part, ‘established legal principles’ means statute law dealing with AS.

245 For the situation at common law see: Cruzan v Director, Missouri Department of Health 111 L Ed 2d 224 (1990) (America); In re F (mental patient: sterilisation) [1989] 2 WLR 1025 (England); Rodriguez v British Columbia (Attorney General) [1993] 3 SCR 519 (Canada); Secretary, Department of Community Services (NT) v JWB and SMB [1992] 66 ALJR 300 (Australia); Smith v Auckland Hospital Board [1965] NZLR 191 (New Zealand). For the situation pursuant to statute see: Medical Treatment Act 1994 (ACT), Natural Death Act 1988 (Northern Territory), Consent to Medical Treatment and Palliative Care Act 1995 (South Australia); Medical Treatment Act 1988 (Victoria); Civil Code of Lower Canada Art 19.1; Bill of Rights Act 1990 (NZ) s11.
though it is not requested by the patient.\textsuperscript{246} It is commonly justified by the act/omission distinction which holds that: it is acceptable to omit to save life whereas to actively end life is not; the withholding and withdrawal of potentially life-sustaining treatment are omissions whereas AVE and AS are acts; and thus, it is acceptable to withhold or withdraw treatment but it is not acceptable to provide AVE or AS.\textsuperscript{247} However, as we shall see in the next chapter, when the withdrawal of treatment involves an active measure such as removing life support, it is not as easy to accept that the patient’s death was caused by his or her disease.

A. Australia

AS is criminalised throughout Australia.\textsuperscript{248} Section 31C of The Crimes Act\textsuperscript{249} which applies in New South Wales, provides a typical example of the AS provisions in Australia:

A person who aids or abets the suicide or attempted suicide of another person shall be liable to imprisonment.

\textsuperscript{246} The test in England is the ‘best interests’ of the patient: \textit{Airedale NHS Trust v Bland} [1993] 1 All ER 821. The test in America is the expressed wishes of the patient or, if not known, what a surrogate believes that the patient would have wanted: \textit{Cruzan v Director, Missouri Department of Health} 111 L Ed 2d 224 (1990). However, in the recent high profile case of Terri Schiavo, after Terri’s feeding tube was removed pursuant to a court order there were attempts to override the court’s decision. President George Bush’s brother, Governor Jeb Bush, breached the order by directing that Terri’s feeding tube be reinserted. George Bush then attempted to introduce a Bill that would prevent the tube being removed again. He was unsuccessful. Terri died on 31 March 2005 after a ten-year legal battle between her parents and her former husband after the court ordered that the tube be removed, for the last time: W Thompson, ‘Terri’s Law: The Limit of the Florida Legislature to Decide an Individual’s Right to Die’ (2005) 31 \textit{New England Journal on Criminal and Civil Confinement} 485 at 502, 503, 517.

\textsuperscript{247} Downie, above n5 at 89. The act/omission distinction is typically challenged on two grounds: the withdrawal and the withholding of treatment are as much acts as AVE and AS; and there is no moral significance between the two because the outcomes are the same and there is no way of proving that there is no intent to cause death when treatment is withheld or withdrawn: see, for example, J Rachels, \textit{The End of Life: Euthanasia and Morality} (1986). Some commentators use this as a basis for arguing that there is no real difference between withdrawing and withholding treatment and AVE or AS and that therefore AVE and AS should be legalised: see, for example, Downie, above n5 at 89-105.

\textsuperscript{248} In the Australian Capital Territory and New South Wales it is an offence to ‘aid, abet, incite or counsel’ someone to commit suicide: \textit{Crimes Act} 1900 (ACT) s17; \textit{Crimes Act} 1900 (NSW) s31C. In the Northern Territory and Queensland it is an offence to ‘procure, counsel or aid’ another person to commit suicide: \textit{Criminal Code} 1983 (NT) s168; \textit{Criminal Code} (Qld) s311. In South Australia it is an offence to ‘aid, abet, counsel or procure’ another person to commit suicide: \textit{Criminal Law Consolidation Act} 1935 (SA) s13A(5) & (7). In Tasmania it is an offence to ‘instigate or aid’ a suicide where instigate means counsel, procure or command: \textit{Criminal Code} 1924 (Tas) s1 & 163. In Victoria it is an offence to ‘incite, aid or abet’ a suicide: \textit{Crimes Act} 1958 (Vic) s6B(2). In Western Australia it is an offence to ‘procure, counsel or aid’ a suicide: \textit{Criminal Code} 1913 (WA) s288.

\textsuperscript{249} \textit{Crimes Act} 1900 (NSW).
The penalty following a conviction for AS ranges from a discretionary term of imprisonment up to imprisonment for life.\textsuperscript{250}

B. England, Canada, New Zealand and the United States of America

In the England, AS is a crime under section 1 of the Suicide Act\textsuperscript{251} and is punishable by up to 14 years in gaol.\textsuperscript{252} However, in 2004, the House of Lords held that the legal prohibition against AS does not extend to the practice of taking English citizens overseas to obtain AS.\textsuperscript{253}

In Canada\textsuperscript{254} and New Zealand,\textsuperscript{255} a statutory offence of AS has been created. In each of these jurisdictions the law provides for a maximum penalty of 14 years incarceration following a conviction for AS. Thus in England, Canada and New Zealand a conviction for AS can result in a term of imprisonment.

In the United States of America, approximately 49 states have statutes which criminalise AS.\textsuperscript{256} Most of the states that do not have a specific statute that criminalises AS treat AS as murder or manslaughter under a general criminal law.

\textsuperscript{250} The penalties for a conviction for AS in Australia are as follows: ten years imprisonment in New South Wales and the Australian Capital Territory; life imprisonment in the Northern Territory, Queensland and Western Australia; eight years imprisonment for attempt and 14 years if the assistance is successful in South Australia; a discretionery custodial sentence in Tasmania; five years imprisonment in Victoria; see references cited in footnote 245 above except for Tasmania, in which case see: Sentencing Act 1997 (Tas) s3.

\textsuperscript{251} The Suicide Act 1961 (UK).

\textsuperscript{252} 'A person who aids, abets, counsels of procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction to indictment to imprisonment for a term not exceeding fourteen years.'

\textsuperscript{253} Re Z [2004] EWHC 2817 (Fam).

\textsuperscript{254} Criminal Code (Can) s241: 'Every person who (a) counsels a person to commit suicide or, (b) aids or abets a person to commit suicide, whether suicide ensues or not is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.'

\textsuperscript{255} Crimes Act 1961 (NZ) s179: 'Everyone is liable to imprisonment for a term not exceeding 14 years who (a) incites, counsels or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or, (b) aids or abets any person in the commission of suicide.'

\textsuperscript{256} K Hoffman, 'Assisted Suicide still Illegal in 49 States: Kevorkian Leaving Prison after Eight Years, but his Cause has made Little Progress', The Grand Rapids Press (27 May 2007) B3.
statute. A conviction for AS may result in a term of imprisonment. The situation in Oregon, a matter to which I now turn, is a different matter.

The legality of AS was confirmed in Oregon in 1996. The ODDA, filed in 1994 by ERGO (Euthanasia, Research & Guidance Organization) was a state-wide citizens' initiative to legalise AS. The ODDA was supported by 51% of Oregon voters.

The ODDA, unlike the ROTIA, legalised AS but not AVE. It permits a treating doctor to assist a patient who is over 18 years of age to commit suicide by providing a prescription for barbiturates. The patient must make a written request for AS and the treating doctor must carry out the following steps.

1. Determine that the patient has a terminal illness, is capable, has made the request voluntarily, has less than six months to live and is a resident of Oregon.
2. Inform the patient of his or her diagnosis and prognosis and the potential risks as well as probable result of taking the medicine prescribed.
3. Inform the patient of feasible alternatives such as comfort care, hospice care and pain control.
4. Refer the patient to a consulting doctor for confirmation of the diagnosis and for determination that the patient is capable and acting voluntarily.
5. Refer the patient for counselling if appropriate.
6. Recommend that the patient notify his or her next of kin.
7. Counsel the patient that it is better to take the medication with another person present and not to take it in a public place.

For example, in Arkansas where there is no law against AS, a person who is alleged to have engaged in AS can be charged with manslaughter: D King, 'Police Charge Man with Helping NLR Man Commit Suicide', Associated Press Newswires, accessed 30 March 2007 via <http://www.factiva.com>.


Senate of Canada, above n151 at A-156 (including footnote 191).


See Appendix 4 for the incidence of AS in Oregon since the enactment of the ODDA.
8. Inform the patient that he or she has a right to rescind the request and offer to do so at the end of a 15-day waiting period.

9. Verify immediately prior to writing the script that the patient is making an informed decision.

10. Complete all necessary medical documentation and dispense the prescription direct to the patient.

11. Or, obtain the patient’s written request to contact a pharmacist and inform him or her of the prescription and to deliver the prescription by mail or in person to the pharmacist who will dispense the medication to the patient, the attending doctor or an expressly identified agent of the patient.262

As was the case with the ROTIA, the American Government (the Bush Administration) is opposed to the legalisation of euthanasia. Consequently, the ODDA has been under almost constant challenge since it was first enacted. After the ODDA was passed in 1994, the Oregon State legislature obtained an injunction so that the citizens of Oregon could re-consider their decision. In November 1997, State Measure 51, asking Oregon voters to repeal the ODDA was placed on the general election ballot. In the three-year interim period, community sensibilities in support of legalised AS had increased. Oregon voters rejected Measure 51 by 60 per cent to 40 per cent.263

Nevertheless, on 6 November 2001, the then Federal Attorney General, John Ashcroft, issued a direction that the ODDA was contrary to The Controlled Substances Act.264 He reasoned that, since AS is provided in Oregon by way of a prescription for barbiturates and the CSA stipulates that prescriptions must be for a legitimate medical purpose only, AS was unlawful. Ashcroft directed that Oregon medical practitioners who engaged in AS have their registration suspended.265

262 ODDA, ss1-3.
263 The Law Commission, above n22 at 54.
264 The Controlled Substances Act 1970 (USA). Hereafter CSA.
Unlike the ROTIA, there was no question as to the validity of the ODDA. So, on 20 November 2001, a counter suit was filed by the State of Oregon. As a result, the United States District Court issued a temporary restraining order against Ashcroft’s direction, pending a hearing. On 17 April 2002, District Court Judge Robert Jones upheld the ODDA but, on 23 September 2002, Attorney General Ashcroft filed an appeal asking the Ninth Circuit Court of Appeals to overturn Judge Jones’ ruling. Ashcroft’s appeal was denied on 26 May 2004 by a three-judge panel.  However, he was not to be put off. On 9 November 2004, he asked the United States Supreme Court to review the Ninth Circuit Court’s decision. Ashcroft’s successor, Alberto Gonzales, who pursued the appeal, had the backing of the Bush Administration in doing so.

In January 2006, the United States Supreme Court upheld the validity of the ODDA, rejecting the appeal in a 6-3 decision. The Court reportedly held that Ashcroft was claiming ‘an extraordinary authority’ in seeking to impose his view of proper medical care at the end of life on the citizens of Oregon. The Court said that the American States, not the federal authorities, have the power to regulate the practice of medicine and the licensing of doctors. At the conclusion of this extensive challenge to the ODDA it, unlike the ROTIA, had survived.

In Oregon, as was the case in the Northern Territory of Australia, the court did not address the difficult moral and ethical issues around the legalisation of AS as courts sometimes do. Instead, the matter was dealt with as a state’s rights issue. The difference is that, in the case of Oregon, state’s rights were preferred. This was interpreted as a major victory by proponents of legalised euthanasia.

266 State of Oregon & Ors v John Ashcroft & Ors 368 F 3d 1118, United States Court of Appeals Ninth Circuit, No. 02-35587 (2004).
267 Department of Human Services Oregon, above n265 at 6, 7.
269 Gonzales v Oregon, Supreme Court of the United States, No. 04-623, 17 January 2006, at 56, 57.
For the time being, the Bush Administration has been prevented from dictating to the State of Oregon in relation to the legalisation of AS but the fate of the ODDA remains uncertain. It is still possible for Congress to overturn the ODDA by amending Federal drug control laws to state that doctors must not prescribe lethal medications.  

6. AS – The Law in Practice

There have been very few prosecutions of medical practitioners for AS in the common law jurisdictions. As a result, in this part, I extend my discussion to include other health care workers and a few leading cases in relation to AS. In general, as is the case with AVE, it can be difficult to establish causation following AS because the person assisted to die usually dies alone. Similarly, harsh outcomes are rare. Of the 14 cases of AS discussed below, a sympathetic attitude on the part of the judge or jury appeared to play a role in securing a lenient outcome in ten cases, in one of those cases the jury refused to convict the accused. The need for a high degree of involvement on the part of the accused and an intent that the person who was assisted to die would in fact die appears to have facilitated a less harsh outcome in seven cases. Evidentiary difficulties resulted in two investigations being abandoned. Two cases resulted in a conviction but the sentence imposed in each case was relatively lenient in light of established legal principles.

A. Australia

In Australia, a conviction for AS is unlikely to draw a harsh penalty. In _R v Larkin_, in 1983, a nurse pleaded guilty to aiding and abetting a patient who was mentally ill to commit suicide by providing him with insulin and helping him to inject it. The nurse received a three-year good behaviour bond. The Judge hearing the

---

271 Savage & Boseley, above n270.

272 It remains to be seen what effect, if any, the _Criminal Code Amendment Act_ will have on prosecutions for AS in Australia (see Chapter One).

273 (Unreported, Supreme Court of Victoria, Nicholson J, 14 April 1983). Hereafter _Larkin_.

79
matter appeared to be sympathetic toward her, describing her actions as compassionate.

Likewise in 1995, Mr Hoddy,\(^{274}\) who was also a nurse, helped his partner who had AIDS to commit suicide by giving him a glass of orange juice into which, at his partner’s request, he had crushed an overdose of narcotic analgesics. Following his partner’s death, Hoddy was tried for AS. He was convicted but released on a three-year good behaviour bond. It is possible that a sympathetic attitude on the part of the judge (in addition to other matters such as the fact that he did not pose a threat the community) facilitated this outcome.

During 2001, Dr Philip Nitschke was investigated after he allegedly wrote a prescription for sedatives for Mrs Hall who was dying of liver and bone cancer. A lack of evidence proved to be an issue. Dr Nitschke was with Mrs Hall when she died but, according to media accounts, stated he had been careful not to do anything that could be regarded as AS. The investigation into Dr Nitschke’s alleged involvement in Mrs Hall’s death was abandoned due to a lack of evidence. No one else was present at the time she died.\(^ {275}\)

Notwithstanding the presence of 21 people, in May 2002, when Nancy Crick committed suicide, there was insufficient evidence to prove AS. Mrs Crick was suffering from chronic pain due to adhesions that had formed after surgery for an inoperable, twisted bowel. She was not terminally ill, she was suffering from pain from her condition and was tired of living. She provided a statement to the media that she intended to commit suicide and called for there to be no prosecutions of those who would be present.\(^ {276}\) Mrs Crick died after taking a lethal dose of Nembutal, a medication that can only be obtained legally with a prescription. Dr


Nitschke was allegedly implicated in her death but he was not one of those present when she died.  

The police reportedly launched an investigation into Mrs Crick’s death and forwarded the police brief to the coroner to decide if any charges should be laid. The matter was eventually dropped due to a lack of evidence.  

The case of Mr Maxwell, in 2003, supports the suggestion that a sympathetic attitude on the part of the judge may facilitate a less harsh outcome than one might expect. Mr Maxwell pleaded guilty to AS after assisting his wife, who was dying of breast cancer, to kill herself. Mrs Maxwell had obtained a copy of Final Exit, a self-help guide on how to commit suicide. After reading it, she realised she could not commit suicide alone and extracted a promise from her husband to help her. At her request he purchased gas, a plastic bag and a hose. He later sedated her, placed the bag over her head and secured it. He then filled the bag with gas and left it in place until she died. Due to the active nature of his involvement in his wife’s death, Mr Maxwell could have been charged with the more serious crime of murder but he was charged with AS instead.

In handing down an 18-month suspended sentence, Justice Coldrey stated that he had taken all of the circumstances of the case into account. He noted that Mr Maxwell had no prior convictions, had led an unblemished life and there was no evidence that he would re-offend. Further, Mr Maxwell had co-operated fully with

---

277 Editorial, above n276. Dr Nitschke was also reportedly involved in two additional cases of alleged AS but his involvement could not be proven. The first involved Sandy Williamson, in 2002. Ms Williamson was suffering from motor neurone disease and feared that she would end up being trapped in her body. She took an overdose of sleeping tablets which made her slip into a coma. She died a week later: Editorial, ‘Suicide Bid Woman Dies’, The Adelaide Advertiser (30 July 2002) 21. The second involved Lisette Nigot a French academic who committed suicide using Seconal, in 2002. Nigot was not terminally ill. She, like Nancy Crick, was simply tired of living. Dr Nitschke released her suicide note yet claimed to have tried to talk her out of killing herself: M Metherell & R Pollard, ‘News and Features – Handmaiden of Death’, The Sydney Morning Herald (27 November 2002) 13; Editorial, ‘Tired of Living, so Lisette Took her Life’, The Adelaide Advertiser (27 November 2002) 1.


281 Maxwell at paragraphs 21, 26.
the police and had shown great remorse for what he had done. However, Judge Coldrey’s judgment suggests that a sympathetic attitude toward Mr Maxwell was also a factor in the outcome:

The degree of moral blame attributable to a person who assists or encourages an act of suicide may vary greatly from case to case. At one end of the spectrum may be placed a person who assists or encourages a person to commit suicide in order to inherit property or for some other ulterior motive; at the other end, there is the individual who supplies potentially lethal medication to a terminally ill person, perhaps a loved one who is in extreme pain and wishes to end that suffering at the earliest possible opportunity.

B. England

There has been no reported prosecution of a medical practitioner for engaging in AS in England. However, the case of Attorney General v Able & Ors provides some indication of how the courts are likely to respond to AS. In Able, an organisation handed out pamphlets on how to commit suicide and was charged with AS. The court held that a conviction for AS requires a more active degree of involvement in death than merely providing information on how to commit suicide.

The outcome in a more recent case, R v. Chard, is consistent with Able, suggesting that the court will require a high degree of involvement on the part of the accused to establish AS. The outcome also suggests that a sympathetic attitude on the part of the judge can facilitate a softer outcome. In Chard a 19-year-old boy reportedly supplied a friend, who had multiple sclerosis, with Panadol knowing that she intended to use the Panadol to commit suicide. Following her

282 Maxwell at paragraphs 32-34, 36-39.
283 Id at paragraph 31.
285 Able at 277.
287 Note that approaches to AS are not necessarily consistent within or between key groups. In September 2005, a doctor who tried to help a friend commit suicide but who did not actually succeed (the friend died whilst in a coma and not as a result of any assistance rendered by the doctor) was struck off the Medical Register by the GMC: M Hosnell, ‘Doctor is Struck Off for Trying to Help Friend to Die’, The Times (28 September 2007) 1.
death, Chard was prosecuted for AS. Justice Pownall QC of the Old Bailey directed the jury to find Chard not guilty because all Chard had done was provide his friend with ‘the option of taking her own life’.288 [emphasis added.]

C. The United States of America

Between 1990 and 1999, retired pathologist, Dr Jack Kevorkian, reportedly assisted 130 people to commit suicide.289 Kevorkian was tried for AS and acquitted three times. In the first two cases, Kevorkian used a suicide device called Mercitron which delivered a lethal substance, intravenously, at the touch of a button. In the third, he used a mask into which carbon monoxide was released by pulling a string. Dr Kevorkian was acquitted in the first two trials because his actions did not amount to murder and there was no specific law against AS in Michigan at the relevant times.290 It is possible that juror sympathy played a role in the third case because the jury accepted Kevorkian’s argument, consistent with the DDE, that he had intended to relieve the deceased’s suffering and not to bring about death. Further, at the end of the third trial, several jurors asked Dr Kevorkian for his autograph.291

Kevorkian’s last act of euthanasia occurred on 16 September 1998 when he videotaped himself giving a lethal injection to Thomas Youk, a man who was suffering from Lou Gehrig’s disease.292 Kevorkian sent the videotape, which contained clear evidence of his intent to kill Youk, to the producers of 60 Minutes and parts of it were aired. He was subsequently charged with murder.293

289 Vitez, above n286.
292 Lou Gehrig’s disease causes progressive degeneration of the motor cells in the spinal cord and brain so that a person is eventually unable to eat, move or breathe.
The murder trial was heard in 1999 in Oakland County Court, before Judge Jessica Cooper. The trial did not involve a jury. In response to an application by the prosecution, Judge Cooper reportedly refused to allow Youk’s relatives to testify because evidence of Kevorkian’s intent was clear from the videotape and the evidence of Youk’s relatives could only have been intended to support a claim of mercy killing which the judge said was not recognised by American law. However, Kevorkian was allowed to lead evidence that, at the end of his life, Youk was only able to control the thumb and first two fingers of one hand and had almost lost the ability to speak and to metabolise food due to the effects of his disease.

On this occasion Kevorkian, like Martin, had made no secret of the fact that he intended to kill nor did he show any remorse. In acting as he did he, like Martin, seemed to be deliberately flaunting the law. In finding Kevorkian guilty of second-degree murder and sentencing him to 10-25 years in gaol, Judge Cooper reminded Kevorkian that his licence to practise medicine had been suspended eight years earlier and stated:

You had the audacity to go on national television ... and dared the legal system to stop you. Consider yourself stopped.

In 2001, on appeal, Kevorkian sought to rely upon the DDE as a defence to the murder charge. He was not permitted to do so because, as was the case with Martin, the evidence that he intended to kill Youk was incontrovertible. As noted in Chapter One, Kevorkian was released from gaol after serving seven years of the sentence.

294 Oakland Circuit Court, LC No. 98-163675-FC (1999).
295 Ibid.
296 Vitez, above n286.
D. Canada

A conviction and a custodial sentence is as unlikely in response to AS in Canada as it is in the other common law jurisdictions. In a leading Canadian case of AS, Dr Timothy Quill helped a person known as ‘Diane’ to commit suicide by providing her with a prescription for barbiturates and giving her directions on how to use them to end her life. Diane had been diagnosed with leukaemia. With treatment, she had a 25% chance of survival but she did not want to be hospitalised. She wanted to remain independent and in control. Dr Quill subsequently wrote about assisting Diane to commit suicide in *The New England Journal of Medicine*. As a result, he was prosecuted in the Supreme Court of Rochester (Canada) for AS but the jury refused to convict him. According to Quill, this was partly because Diane was alone when she died. It is also likely that juror sympathy played a role in the outcome.

At first blush, a subsequent case of AS appears not to fit the rule of a more lenient outcome than one might expect. In 1998, Dr Genereux pleaded guilty to AS after having prescribed lethal medication for two of his patients who were suffering from HIV but who had not progressed to AIDS. The first took the medication and successfully committed suicide. The second took the medication but was unsuccessful and was revived. However, it is important to note that Genereux was an unusual case. The prosecutors in Toronto already knew of Dr Genereux because he had been charged with sexual offences involving six of his patients. In addition, the partner of the patient who successfully committed suicide released details of Dr Genereux’s involvement to the media so there was no doubt as to his

---

298 The judgment in the case was ‘sealed’ and was not published: email from Dr T Quill to V Hiley (10 March 2006).
intent. Dr Genereux also had a history of drug and alcohol abuse and multiple suicide attempts. Furthermore, the two patients were not terminally ill, they were depressed about their diagnoses.

Dr Genereux was reportedly sentenced to two years less a day in a reformatory, which is a more relaxed environment than gaol. This was to be followed by three years probation. However, the fact that his sentence was less than two years meant that he was eligible for parole after having served only a third of it. Both sides appealed the sentence but it was reportedly upheld by the Ontario Court of Appeal. The Medical Board was not as sympathetic to Dr Genereux. He was subsequently struck off the Medical Register.

To sum up thus far, in the common law jurisdictions, a gap has developed between what the law says it will do in response to AS and what it tends to do in practice. Notably, in Larkin, Hoddy and Maxwell suspended sentences were imposed notwithstanding a guilty plea. In Chard there was a high degree of involvement and an intent that death would result on Chard’s part but the situation was categorised as merely providing ‘an option’. In Quill a grand jury refused to enter a conviction for AS even though Dr Quill had published details of how he provided ‘Diane’ with the means to commit suicide and instructed her how to kill herself. In the case of Kevorkian, it took 130 assisted suicides, three acquittals for AS, a videotape showing the murder of Thomas Youk and a non-jury trial before Kevorkian was convicted of second-degree murder and incarcerated in 1999. However, like Martin, he was released from prison early. Genereux was convicted of AS but there was clear evidence of his guilt and he was already known to the prosecution because of sexual misconduct with some of his patients.


303 T Tyler, ‘Doctor Jailed After Losing Court Appeal – Ruling Upholds Two-Year Sentence for Assisting Suicide’, The Toronto Star (29 April 1999) 1


305 Tyler, above n303.
Nevertheless, whilst the Crown pushed for a custodial sentence the court imposed a sentence of two years less a day in a reformatory rather than a gaol and, as a result, Dr Genereux was eligible for parole after serving only a third of his sentence.

7. Conclusion

Many of the cases discussed in this chapter suggest that, in the context of the law around AVE and AS, a gap has developed between how the law says it will respond to such cases and how it actually does respond. This gap is very common in what I shall refer to as the typical case of euthanasia: the accused was a medical practitioner; the deceased was terminally ill at the relevant time; the deceased expressed a wish for assistance to die; and there was no evidence of bad intent on the part of the medical practitioner.

In the context of AVE, I consider that a gap has developed because of the availability of the DDE and from what I infer from case outcomes to be a tendency for the judge or the jury to feel sympathy toward the accused. In the context of AS I am of the view that a gap has developed as a result of the need for a high degree of involvement on the part of the accused, the need for evidence of an intent that death would be the outcome of the assistance and/or from what I deduce from the cases to be a tendency for the judge or the jury to feel sympathy toward the accused in a typical euthanasia scenario.

These developments are understandable in that they permit the law to be more responsive to changing sensibilities toward death and dying, permitting factors that are crucial to determining moral blameworthiness to be taken into account, albeit indirectly. These factors include the deceased’s prognosis, diagnosis and wishes about death. However, these developments are also problematic. As Otlowski notes: there is the potential for unequal application of the law; there is the risk that

the law could be brought into disrepute if the public were to perceive outcomes to be more lenient than they ought to be; there is no legal precedent upon which doctors can rely; there is the potential for patients to have their rights undermined as a result of unequal access to euthanasia; and there is a risk that euthanasia may be carried out without consent because it is not regulated by legislation or case law.\(^{307}\) In addition, as we saw in Part 2, the DDE can be used to hide an intent to kill.

The present, unsatisfactory response on the part of the law could be cured by permitting matters that are not formally relevant in such cases such as the deceased’s prognosis, diagnosis and expressed wishes about death, to be openly taken into account by the judge or the jury in reaching a determination as to whether criminality should attach to the action in question and what punishment, if any, ought to be handed down following euthanasia. However, on the basis of discussion of the attitudes of key groups in the common law jurisdictions toward euthanasia in this and the previous chapter, I consider these problems to be incurable in the sense that they are unlikely to be addressed via changes to the criminal law. There is a community sensibility of support for euthanasia in each of the common law jurisdictions in response to a typical euthanasia scenario. Yet, attitudes among key groups, whilst far from united, are largely against the legalisation of euthanasia.

In the next chapter I continue to question whether the law in the common law countries is responding in an adequate manner to changing sensibilities toward death and dying. However, I focus upon right to die applications in the context of constitutional and international law. By examining changes in sensibilities around the interpretation and use of rights discourse and outcomes in right to die applications, I show that rights discourse is not well suited to the task of grounding legal recognition of a right to die. I suggest ways in which legal process could be made more responsive to changing sensibilities in relation to death and dying as

---

\(^{307}\) Otlowski, above n53 at 149-152.
expressed in such applications. However my conclusion, in keeping with the conclusion I have reached in this chapter, is that it is unlikely that the changes I propose will be made via case law.
CHAPTER THREE
IN PURSUIT OF A GOOD DEATH: THE MISTAKEN RESORT TO RIGHTS TALK

Rights are trumps … if someone has a right to something then it is wrong for the government to deny it to him even though it would be in the general interest to do so.¹

… the language and approach of rights are [not] well suited either to sound personal decision-making or to sensible public policy in this very difficult and troubling matter.²

1. Introduction

In the previous chapter, I considered whether the judicial systems in the common law countries are responding in an adequate manner to changing sensibilities in relation to death and dying in the context of the law around AS and unlawful killing in the form of AVE. I concluded that the response of the law is unsatisfactory because of a difference between what the law says it will do in response to those circumstances and what it in fact tends to do. This leads to a lack of certainty for doctors and patients alike and does not assist in protecting against abuse of the practice of assisting dying.

In this chapter, I ask the same question albeit in a different context. I question whether the courts in the common law countries and the European Court of Human Rights are responding in an adequate manner to changing sensibilities as expressed in the recent trend of petitioners utilising rights discourse to secure legal recognition of a right to die.

There is a tendency nowadays to advance moral claims, even highly-contested claims such as the right to control the manner and timing of one’s death, in terms

¹ G Dworkin, Taking Rights Seriously (reviewed ed, 1978) at 269.
of rights. Sumner argues that the use of rights talk is ‘out of control … there is virtually no area of public controversy in which rights are not to be found on at least one side of the question – and generally, on both.’ This is certainly the case in the euthanasia debate where the claim for a right to die is automatically countered by the opposing claim for a right to life.

The popular appeal of rights talk, reflected in the quote from Gerald Dworkin at the beginning of this chapter, can be better appreciated when we consider that the common law jurisdictions, by ratifying human rights instruments, have adopted numerous human rights such as: the right to life; the right to liberty and security of the person; the right to be free from torture, cruel, inhumane or degrading treatment or punishment; the right to the economic, social and cultural rights indispensable for one’s dignity and the free development of one’s personality; the right to be free from arbitrary interference with one’s privacy, family, home or correspondence and attacks on one’s honour and reputation; the right to rest and leisure; and the right to a standard of living adequate for the health and well being of oneself and one’s family, including food, housing, medical care and necessary social services.

---

5 For example, the Universal Declaration of Human Rights 1948 (hereafter UDHR), the International Covenant on Civil and Political Rights 1976 (hereafter ICCPR) and the International Covenant on Economic, Social and Cultural Rights 1973 (hereafter ICESCR).
6 UDHR Article 3; ICCPR Article 6.
7 UDHR Article; ICCPR Article 9.
8 UDHR Article 5; ICCPR Article 7.
9 UDHR Article 22; ICESCR Article 9,15.
10 UDHR Article 25; ICESCR Article 11.
11 UDHR Article 24; ICESCR Article 7(d).
12 UDHR Article 25; ICESCR Article 11. Recently, Professor Smith of the Catholic University School of Law, Washington DC has argued that each of us, under the principle of autonomy or self-determination, has a right to exercise a good or dignified death provided this is in accordance with the DDE: G Smith III, 'Pain Management, Palliative Care and Self-Determination,' paper presented at the Congress of the International Academy of Law and Mental Health, Padua (26 June 2007) at 1. See also, T Campbell, "Euthanasia as a Human Right" in S McLean (ed) First Do no Harm: Law, Ethics and Healthcare (Hampshire, Ashgate Publishing Limited: 2006) 447. Campbell's argument is based on autonomy and humanitarian reasons in the context of those who are in grave need of euthanasia.
The rights outlined above are positive rights\textsuperscript{13} that attach to the individual and are generally capable of being exercised with little involvement on the part of other people beyond forbearance.\textsuperscript{14} A right to die is different. What is often not well articulated in the euthanasia debate is that a right to die commonly cannot be exercised without the assistance of a third party. Yet, it is the act of assisting that makes this sought-after right so controversial because providing assistance to die is categorised as AS or unlawful killing throughout the common law jurisdictions. And, as we saw in the previous chapter, a conviction for either may result in the offender being incarcerated.\textsuperscript{15}

At the present time there is, in fact, no right to die in the common law jurisdictions other than in Oregon in the United States of America.\textsuperscript{16} Rather, there is a moral claim, pressed by some, that the law ought to recognise and enforce a new human right; a right to obtain assistance, from a third party, so that one can die at the time and in the manner of one’s own choosing.

This chapter is divided into four parts. In Part 2, I examine changes in sensibilities in rights discourse in the common law countries from the medieval period to the present in order to show, contrary to what many assume to be the case, that rights discourse is not a static, unchanging, immutable concept and nor has it always occupied the privileged position it occupies today. Therefore, as the quote from Leon Kass at the beginning of this chapter suggests, we need to question whether rights discourse is likely to be determinative particularly in the context of highly contested claims such as the claim for a right to die.

In Part 3, I discuss the problems and limitations, at a theoretical level, with the use of rights discourse in order to show that rights discourse does not provide a firm

\textsuperscript{13} A positive right is a right that is recognised by law. Hence, the right holder is entitled to call upon the State to take measures to enforce the right.


\textsuperscript{15} See Chapter Two for discussion of the law around unlawful killing/ AVE and AS in the common law jurisdictions.

\textsuperscript{16} The situation in Oregon is discussed in detail in Chapter Two.
doctrinal basis for a right to die. In addition, I show that rights discourse tends to be adversarial, dogmatic and elitist. As a result, a resort to rights discourse tends to thwart ongoing debate and to prevent opponents from finding common ground. Rights discourse demands that, for a new right to be recognised, there must be widespread and compelling support for it.\textsuperscript{17} This is not the situation at present with regard to the call for a right to die. As we saw in the previous chapter, whilst there is a community sensibility of support for the legalisation of euthanasia in the common law countries in a typical case of euthanasia, attitudes within key groups are often opposed to the legalisation of euthanasia.

In Part 4, I examine outcomes in American, Canadian and English case law\textsuperscript{18} in which rights discourse has been utilised, via human rights instruments, to ground a claim for a right to die. I show how, in the absence of any guidance from rights discourse as to how to choose between competing rights, appellate courts have invariably denied such applications on the basis of established legal doctrines such as the DDE\textsuperscript{19} and moral claims such as the SLD.\textsuperscript{20} Rights talk fails to provide a compelling reason why the status quo, the criminalisation of euthanasia, ought to be changed. In Part 4 I also examine two additional cases which suggest that the SLD is not the fixed, immutable concept that opponents of a right to die typically assume it to be. In each of the additional cases I discuss, the defence of necessity played an important role and it is a matter to which I return in the conclusion to this thesis. Hence, I also outline the elements of the defence and how it operates.

In Part 5, I consider proposals that have been put forward for an alternative approach to determining contested claims about the end of life. I argue that lawmakers ought to be permitted to take a broader range of issues into account in determining these claims, in addition to matters reflected in legislation such as the

\begin{footnotesize}
\textsuperscript{17} T Campbell, Rights: A Critical Introduction (2006) at 3.
\textsuperscript{18} There is no case law on point in the other common law jurisdictions examined in this thesis, namely, Australia and New Zealand. See the text accompanying footnote 53, below.
\textsuperscript{19} The doctrine of double effect is discussed in Chapter Two.
\textsuperscript{20} The sanctity of life doctrine is discussed in Chapter One.
\end{footnotesize}
slippery slope argument\textsuperscript{21} and the SLD. Those matters could include: the petitioner’s diagnosis, prognosis and degree of suffering; the presence of any special circumstances that could impact on personal autonomy such as a disability;\textsuperscript{22} beliefs about the end-of-life (whether secular or religious); and the attitudes of those in a caring relationship with the petitioner.

In light of the shortcomings of rights discourse that are set out in this chapter, in the final part I conclude that those who approach the courts seeking legal recognition of a right to die via human rights instruments are mistaken. Further, due to the attitudes that have been expressed toward legalised euthanasia by leading parliamentarians, law reform bodies and medical associations in the common law countries in recent times, I conclude that it is unlikely that the changes I suggest in this chapter will be legislated for.

\section*{2. Rights Talk – Changing Sensibilities}

Many people assume that rights have always existed and that governments have always observed and protected citizens’ rights. This is not so. Rights have not always existed and, over time, the claimed ideological basis of rights has shifted. So, rather than just assuming, as many proponents of legalised euthanasia appear to, that rights talk is the best means of pursuing contested moral claims such as a right to die,\textsuperscript{23} we need to gain greater perspective on the issue. One way of doing so is to examine changing notions of rights over time, a task to which I now turn.

The notion of rights can be traced to the natural law philosophy of Ancient Greece. From about 500 BC, Greek philosophers believed in a form of higher law that was

\textsuperscript{21} The slippery slope argument is discussed in Chapter Five.

\textsuperscript{22} McLean & Williamson note that attitudes among disabled people as to whether euthanasia should be legalised are not united. The authors, acknowledging that there is evidence of discriminatory practices against the disabled in the context of health care, recommend a cautious approach to the issue until such time as there is evidence that shows whether or not there is a link between the legalisation of euthanasia and discrimination against the disabled: Sheila McLean & L Williamson, \textit{Impairment and Disability: Law and Ethics at the Beginning and End of Life} (2007) at 178-181.

\textsuperscript{23} See for example: Dworkin, above n1 at 269; H Tunnah, 'Freed Campaigner: I'll Fight on for Right to Die', \textit{New Zealand Herald} (14 December 2004) A04.
usually expressed as the unwritten law of the Gods or of heaven or as moral knowledge derived from human experience. The concept of a higher law passed into Christian thinking as a belief in a universal or natural law of God that was above all human laws.24

During the 1200s, the notion of natural rights was extended when the courts in England began to develop rights-based remedies such as trespass to the person, assault, battery and false imprisonment. However, natural rights were not as wide-ranging as human rights are today. Natural rights were subordinate to the monarch’s right to exercise power over his or her subjects with little restraint (the divine right). It was dissatisfaction with the divine right which led, in 1215, to the Barons pressuring the English King into signing the Magna Carta, a document which made the monarch subject to the rule of law. However, it was not until 1688, with the passage of the Bill of Rights,25 that the notion of the divine right was completely ousted in England.26

During the 1600s, the notion of natural rights became more accessible as a concept following key publications by two English philosophers. In 1651, Thomas Hobbes (1588-1679) theorised, in Leviathan,27 that natural rights originated from the state of nature and attached to all men because all men have the ability to reason and to understand nature.28 Hobbes argued that men should give up their rights in equal measure to others, except the right of self-defence, in order to ensure their own self-preservation and in order to avoid a return to the state of nature.29 However, contrary to modern notions of rights, Hobbes believed that man could neither rescind this agreement nor appeal to an external body to review it.30 And, whilst Hobbes broke with existing ways of thinking by locating the source

25 The Bill of Rights 1688 (UK) (hereafter Bill of Rights).
26 O’Neill et al, above n24 at 4, 6, 7.
28 ‘Nature’ refers to the proper ordering of the universe: Campbell, above n17 at 5.
30 Minogue, above n14 at 7, 8.
of power in the people rather than in God, he did not go so far as to assert, as we do today, that governments are obliged to protect the rights of their citizens.\(^{31}\)

This expanded notion of rights, that governments should protect the rights of their citizens, was put forward by John Locke (1632-1704) in 1690 in *Two Treatises of Government*.\(^{32}\) Locke argued that governments which failed to protect the rights of citizens could justifiably be overthrown.\(^{33}\) At first blush, Locke’s views seem to accord with our own views today but Locke’s position was not based on a secular world view. He viewed rights as God-given. Consequently, men did not own themselves and they did not have the right to dispose of themselves or each other as they wished.\(^{34}\)

During the 1800s, the idea of natural rights became unfashionable and was attacked by other philosophers on the grounds that it lacked a firm doctrinal basis. Jeremy Bentham decried natural rights as ‘nonsense on stilts.’\(^{35}\) Bentham argued that the laws of nature were derived from an imaginary source and that the only real source of law was positive (man-made) law.\(^{36}\) Edmund Burke objected to natural rights because he believed that natural law only imposed duties on people and not entitlements. Burke argued that a belief in natural rights was harmful because it led people to have ‘false ideas and vain expectations’ that they should ‘not have to travel the obscure walk of laborious life’.\(^{37}\)

During the 20th century, in the wake of the extensive loss of life caused by the First and the Second World Wars, the notion of natural rights was replaced by the notion of human rights; rights that are believed to attach to people solely by virtue

\(^{31}\) O’Neill et al, above n24 at 9, 10.


\(^{33}\) O’Neill et al, above n24 at 4, 6, 7.

\(^{34}\) Minogue, above n14 at 8-10, 18; Campbell, above n17 at 7.


\(^{36}\) Ibid.

of their existing as a human being. 38 According to O'Neill et al, the phrase ‘human rights’ was probably first used in 1941 when President Roosevelt called for the four freedoms to be upheld: freedom of speech and expression; freedom of religion; freedom from want; and, freedom from fear. 39

Widespread acceptance of the notion of human rights was facilitated after the Second World War by the creation of the United Nations, 40 the enactment of the UDHR, the ICESCR and the ICCPR, the creation of the International Court of Justice which hears disputes between nations 41 and the creation of the European Court of Human Rights 42 which ensures that member states adhere to the European Convention on Human Rights. 43

The primary source of human rights today is each nation’s constitution. However, most of the common law countries have taken steps to recognise rights in addition to those contained in the constitution. America incorporated a Bill of Rights 44 into its constitution in 1791. In 1983, Canada enacted a separate Charter of Rights and Freedoms. 45 In 1990, New Zealand enacted a Bill of Rights 46 as part of ordinary legislation. And, in 1998, England enacted The Human Rights Act 47 which incorporates the ECHR into English law.

Australia is the only common law country examined in this thesis that does not have a national Bill of Rights or a Charter of Freedoms. 48 In July 2004, The

---

38 Minogue, above n14 at 5.
39 O'Neill et al, above n24 at 12-14.
40 Hereafter UN.
41 The International Court of Justice only hears disputes between nations when the parties agree to be bound by its decision, see: <http://www.globalpolicy.org/wldcourt/index.htm>.
42 (Hereafter European Court). O'Neill et al, above n24 at 12-14.
44 The Bill of Rights 1791 (USA).
46 The Bill of Rights 1990 (NZ).
48 The Australian Constitution contains the following express rights: acquisition of property on just terms; trial by jury; freedom of movement between States; freedom of religion; protection against discrimination on the basis of State residence; and to vote. The High Court of Australia has implied limited rights into
Human Rights Act,\(^{49}\) which recognises the rights contained in the ICCPR, came into effect in the Australian Capital Territory. However, the Act is of limited effect because it contains no mechanism whereby individuals can enforce the rights it contains.\(^{50}\) In Victoria, the Charter of Human Rights and Responsibilities Act\(^{51}\) also recognises rights such as those contained in the ICCPR. It focuses upon preventing a breach by new legislation and policies promulgated by public authorities. It permits domestic judicial review of an alleged breach.\(^{52}\) In October 2007, the Tasmanian Law Reform Institute issued a report that recommended the introduction of a Tasmanian Charter of Human Rights the suggested provisions of which are based upon the Victorian Charter.\(^{53}\)

Contrary to what some rights enthusiasts would have us believe, access to human rights is not uniform in the common law jurisdictions. Nationals\(^{54}\) of countries that have ratified the ECHR are entitled to appeal to the European Court, provided they have exhausted all available domestic remedies first, if they believe that their rights contained in the ECHR have been breached.\(^{55}\) There is no discussion of Australian, New Zealand, American or Canadian right to die case law involving applications to the European Court in this chapter because those countries have not ratified the ECHR. Consequently, nationals of those countries are unable to access the rights contained in the ECHR.\(^{56}\)

Notwithstanding the shifting ideological ground upon which rights talk is based and the lack of a firm doctrinal basis for it, rights talk in one form or another, has proven extremely durable. Smart suggests why this is so:

---

\(\text{The Human Rights Act 2003 (ACT).}\)

\(\text{O'Neill et al., above n24 at 12-14.}\)

\(\text{Charter of Human Rights and Responsibilities Act 2006 (Vic).}\)

\(\text{See Part 3, Division 1 & 4.}\)

\(\text{Tasmanian Law Reform Institute, A Charter of Rights for Tasmania: Report No. 10 (2007): see 1, 2.}\)

\(\text{Applications by individuals are brought pursuant to Article 34 of the ECHR: 'The Court may receive applications from any person … claiming to be the victim of a violation by one of the High Contracting Parties to the rights set forth in the Convention or the protocols thereto … .'}\)
The language of rights ... enters into a linguistic currency to which everyone has access. Moreover, whilst the expression of rights is associated with foundations of democracy and freedom, the claim to rights is already loaded. It is almost as hard to be against rights as it is to be against virtue. Rights have another appeal. They are depicted as a protection of the weak against the strong, or the individual against the State.  

To summarise thus far, rights talk is extremely popular today but this does not mean we should unquestioningly accept the appropriateness of its use in all the contexts in which it is deployed. History reveals that rights talk is not the stable, unchanging concept that many opponents and proponents of legalised euthanasia assume it to be. Rather, rights discourse is in a state of flux and continues to lack a firm doctrinal basis. Additional problems with rights discourse, at a theoretical level, have been highlighted by a number of commentators. This is a topic to which I now turn.

3. What's Wrong with Rights?

At a theoretical level, rights discourse has been criticised on the grounds that it is elitist, divisive and dogmatic. Rights talk is elitist because it is generally only wealthy litigants who are able to pursue rights claims in domestic and international arenas. Rights talk encourages dogmatism because by labelling an interest a right those who seek to assert the right are spared the task of having to provide cogent reasons in support of it. As Arkes point out, when asked to theorise the right to die, proponents of legalised euthanasia tend to simply state that people have a right to dispose of their bodies as they wish and so the right is asserted as though asserting it is enough to establish its truth. Perhaps it is frustration with this easy use of rights talk that has led Glendon to conclude 'the new rhetoric of

---

55 See ECHR Article 35.
56 See: <www.echr.coe.int/echr>.
57 C Smart, Feminism and the Power of Law (1989) at 143.
58 M Davies, Asking the Law Question (2nd ed, 2002) at 188.
rights is less about human dignity and freedom than about insistent, unending desires.\textsuperscript{61}

In the context of the euthanasia debate, there is already a tendency for dogmatic thinking in relation to key contested concepts such as dignity and respect.\textsuperscript{62} Proponents of legalised euthanasia commonly assert that recognition of a right to die is the hallmark of a civilised society that respects people’s dignity because people do not have to suffer at the end of life.\textsuperscript{63} Opponents of legalised euthanasia typically argue the exact opposite; a society that allows euthanasia would be one in which human life is regarded with little respect and death available on demand.\textsuperscript{64}

Another criticism that has been made of rights talk is that it leads to a contest between the rights of the individual (personal autonomy) and communitarian interests the latter of which are commonly reflected in the SLD. This stultifies debate and prevents opponents from finding common ground.\textsuperscript{65} On the other hand, Patricia Williams argues that rights talk is a boon for those in society who are truly disempowered; those who have no choice but to use every means at their disposal to advance their cause:

\begin{quote}
Although rights may not be ends in themselves, rights rhetoric has been and continues to be an effective form of discourse for blacks. The vocabulary of rights speaks to an establishment that values the guise of stability, and from whom social change for the better must come (whether it is given, taken or
\end{quote}

\textsuperscript{61} M Glendon, \textit{Rights Talk: The Impoverishment of Political Discourse} (1993) at 146. Glendon does not, however, believe that rights discourse should be jettisoned altogether but rather, that there should be a re-evaluation of how we think and speak about rights: Id at 15.


\textsuperscript{65} Campbell, above n17 at 14.
smuggled). Change argued for in the sheep’s clothing of stability (‘rights’) can be effective, even as it destabilizes certain other establishment values (segregation). The subtlety of rights’ real instability thus does not render unusable their persona of stability.66

Schneider claims that rights talk is not always divisive. She points out that rights can enable people to organise in order to effect change. She cites as an example women who, as a group, have won the right to be free of sexual harassment, the right to own property, to vote and to work.67 However, Schneider concedes that rights discourse does have its limitations:

Feminists understand that genuine equality for women will not be achieved by winning rights in court. Rather, equality requires social reconstruction of gender roles within the workplace and family. Rights claims … do not effectively challenge existing social structures.68

In sum, there are a number of problems, at a theoretical level, with the use of rights talk. Rights talk tends to be a domain that is reserved for the elite as it is usually only the wealthy who can afford to pursue such claims. Rights discourse can be divisive because it encourages an adversarial and dogmatic approach to issues that are in dispute. This, in turn, leads to the dampening of debate in relation to important issues such as whether there should be legal recognition of a right to die. There are additional problems when rights discourse is deployed to support applications, via human rights instruments, for legal recognition of a right to die. This is a matter to which I now turn.

4. The Mistaken Resort to Rights Talk

In researching actual cases of euthanasia involving health care workers in Australia and California, Magnusson discovered ‘the complexity of end-of-life issues, the subtle conflicts of interest that arise at the bedside, the cry for death as

68 Id at 629.

Rights talk ignores these subtle but important nuances. Instead, these complex issues are portrayed as black or white.

Proponents of a right to die typically cast the debate in the simplistic terms of a rational, autonomous human being who is terminally ill and suffering and who has ‘no gender, race or insurance status.’ Opponents of legalised euthanasia commonly cast the debate in the equally simplistic terms of an unavoidable slippery slope – legalising euthanasia will lead to a society in which the individual’s rights are ignored and vulnerable human beings are killed.

Case law outcomes in which petitioners have sought legal recognition of a right to die via a human rights instrument reveal that the claim has invariably been denied. It is in this context that additional failings of rights discourse become apparent. Case law outcomes suggest that rights discourse does not provide any guidance as to how to decide between competing rights and thus no convincing reason for changing the criminalisation of euthanasia, even in hard cases. In the case law that I examine in this Part, appellate courts have consistently resorted to long-standing legal principles such as the DDE and moral claims such as the SLD to justify maintaining the existing state of affairs. Regardless of which right is preferred, the courts do not focus upon the many issues at stake in such applications.

A further problem with utilising rights discourse in these applications is that the SLD is often reflected in the legislation that the courts are required to interpret in such cases whereas opposing views are not. This exacerbates a problem that

---

71 See, for example, H Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* (1997); Keown, above n64. See Chapter Five for discussion of the slippery slope argument in the context of the Netherlands.
72 In the case of the Canadian Charter of Human Rights, Preston Manning, the founder and leader of the now defunct Reform Party of Canada, has observed that: ‘it [the Charter] froze the values and priorities that came out of the 60s and 70s into a constitutional form … as you get further and further down the road, when issues change and emphasis changes, that becomes more and more of a problem’: Editorial,
Davies has identified; the existential concerns that drive right to die applications typically end up being subordinated to the legal process.  However, as we shall see in subsection D below, in some cases lower courts have adopted what could be described as a more pragmatic response to changing community sensibilities in relation to death and dying.

A. Canada

The first Canadian right to die case, *Rodriguez v Attorney General of British Columbia* was brought before the Supreme Court of Canada in 1993. It remains the leading case on right to die applications in Canada. The petitioner, Ms Rodriguez, was suffering from amyotrophic lateral sclerosis, a disease that causes progressive muscle wasting so that the sufferer is eventually unable to exercise the muscles necessary to breathe let alone to eat, care for herself or move around. When Ms Rodriguez had a life expectancy of between two and 14 months, she applied to the Supreme Court of British Columbia for a declaration that section 241(b) of the Canadian Criminal Code (Federal) which criminalises AS, was invalid on the grounds that it violated her rights under Articles 7, 12 and 15(1) of the Charter of Human Rights and Freedoms. She also argued that section 241(b) was discriminatory because it is legal for the able-bodied to die by their

---

73 Davies above n58 at 188, 189.
76 ‘Everyone who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.’ See Chapter Two for discussion of the law around AS in Australia, England, America, Canada and New Zealand.
77 ‘Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.’
78 ‘Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.’
79 ‘Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.’
80 *Rodriguez* at 520.
own hand whereas those who are disabled cannot commit suicide because section 241(b) criminalises AS.81

After the application was denied by the Supreme Court of British Columbia, Ms Rodriguez appealed to the Supreme Court of Canada. The Supreme Court of Canada, by a narrow majority, rejected Ms Rodriguez’s claim.82 The five judges in the majority (La Forest, Sopinka, Gonthier, Iacobucci and Major) held that the interests of liberty and security of the person protected by Article 7 of the Charter cannot be divorced from the SLD. Abuse of the vulnerable justified a blanket prohibition on AS which was not considered to be arbitrary or unfair and was not in breach of Article 7. So far as Article 12 was concerned, the majority held that the prohibition of an action by the state did not constitute ‘treatment’ under that section. The majority conceded that section 241(b) breached Article 15(2) but said that this was justified by Article 183 of the Charter because the criminalisation of AS is a reasonable limit in a democratic society.84

Due to the slim margin between the majority and the minority in Rodriguez, it is fair to say that the Supreme Court of Canada came close to recognising a right to die. The four judges in the minority (McLachlin, L’Heureux-Dubé, Cory and Chief Justice Lamer) rejected the SLD and the slippery slope argument and afforded greater weight to the principle of personal autonomy. The minority judges found that section 241(b) did breach Ms Rodriguez’s rights under the Charter. Chief Justice Lamer focused on Article 15. He held that section 241(b) infringed Article 15 because it deprived disabled persons from selecting the option of suicide. Chief Justice Lamer also held that the reach of section 241(b) was over-inclusive and this could not be justified by fear of abuse. He directed that section 241(b) be

81 Rodriguez at 520.
82 According to Downie, Svend Robinson, a member of the Parliament from British Columbia was present at Ms Rodriguez’s subsequent death. He stated that a doctor assisted her to commit suicide. The case was never prosecuted because the identity of those who were present and the person who had provided AS could not be established: Downie, above n75 at 34.
83 ‘The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms as set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society’.
84 Rodriguez at 544-580.
declared to be of no force or effect for a period of 12 months whilst the situation was reviewed. In the meantime, he was prepared to grant Ms Rodriguez a constitutional exemption from the statute, a remedy with which the other minority judges agreed.

Justices L’Heureux-Dubé and McLachlin considered that Article 7 was the key issue in the case rather than Article 15. They held that the denial of a person’s ability to end his or her own life was arbitrary and amounted to an unlawful fetter on the right to security of the person in Article 7. Justice Cory focused on both Article 7 and Article 15. He held that, since the right to choose death is open to those who are not disabled, there was no reason to deny the same choice to those who are disabled.

B. The United States of America

The first American right to die case was brought before the Federal Court of Appeals in 1996. In Compassion in Dying v. State of Washington, three terminally ill patients, four doctors and Compassion in Dying sought a declaration that a Washington statute prohibiting AS was contrary to the United States Federal Constitution. The petitioners argued that the Washington statute prevented them exercising a liberty interest under the Constitution and violated the Due Process Clause of the 14th Amendment. In the alternative, the petitioners

---

85 Rodriguez at 616-629.
86 Id at 629.
87 Id at 616-629.
88 Id at 629-631.
89 Compassion in Dying v State of Washington 79 F 3d 790 (1996) (hereafter Compassion). The case was on appeal from the United States District Court for the Western District of Washington, DC No. CV-94-119-BJR, in which summary judgment was entered for Compassion in Dying. That decision was subsequently reversed by a three-judge panel (49 F 3d 586 (9th Circuit, 1995). The Court of Appeals then elected to review the matter en banc.
90 Compassion in Dying is an organization ‘dedicated to expanding options at the end of life’ <http://www.compassionindying.org>.
91 The Due Process Clause provides as follows: ‘No one shall be deprived of life or property arbitrarily’.
92 In the United States of America, civil cases are governed by explicit guarantees of rights under the Bill of Rights which are incorporated under the Fourteenth Amendment. Article 1 of the Fourteenth Amendment provides that: ‘All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life,
argued that the statute discriminated between people in violation of the Equal Protection Clause\textsuperscript{93} of the 14\textsuperscript{th} Amendment because others have a right to refuse treatment even if doing so leads to death.\textsuperscript{94}

Circuit Judge Reinhardt, delivering the majority judgment upholding the appeal, favoured the principle of personal autonomy. He held that there is a constitutionally-protected liberty interest in determining the manner and timing of one’s own death. The case law in relation to the right to privacy revealed a common thread in that all of the cases deal with the need to make a decision about something that is of a highly personal and intimate nature and of great importance to the individual. The court categorised the right to control the manner and timing of one’s own death as a liberty interest protected by the 14\textsuperscript{th} Amendment. The majority said this interest was not outweighed by the competing state interests: the prevention of suicide; the SLD; preventing adverse effects on a person who assists another in such circumstances; the principle that joint action is more serious; the effect of such practices on children, other family members and loved ones; the need to protect the integrity of the medical profession; and the need to protect against adverse consequences for society as a whole.\textsuperscript{95}

In holding that the statute was of no force or effect, the majority judges eschewed traditional attitudes expressed via legal theory such as the claimed distinction between acts and omissions. The theory generally takes the following form: to omit to save a life is acceptable whereas to act to end a life is not; the withholding and withdrawal of potentially life-sustaining treatment is an omission whereas AVE and AS are acts; and therefore, the withholding and withdrawal of potentially life-

\begin{flushright}
\textsuperscript{93} The Equal Protection Clause of the Fourteenth Amendment provides that: ‘All persons similarly circumstanced shall be treated alike.’
\textsuperscript{94} Compassion at 794-797.
\textsuperscript{95} Id at 812, 813, 820-825, 827, 830, 832.
\end{flushright}
sustaining treatment is acceptable but AS and AVE are not and should remain unlawful.\textsuperscript{96}

Instead, the court adopted what could be seen as a more pragmatic approach to death and dying:

In disconnecting a respirator … a doctor is unquestionably committing an act; he is taking an active role in bringing about the patient’s death. In fact, there can be no doubt that in such circumstances the doctor intends that, as a result of his action, the patient will die an earlier death than he otherwise would. Similarly, drawing a distinction on the basis of whether the patient’s death results from an underlying disease no longer has any legitimacy. While the distinction may once have seemed tenable, at least from a metaphysical standpoint, it was not based on a valid or practical legal foundation and was therefore quickly abandoned. When Nancy Cruzan’s\textsuperscript{97} feeding and hydration tube was removed, she did not die of an underlying disease. Rather, she was allowed to starve to death. In fact Ms Cruzan was not even terminally ill at the time, but had a life expectancy of 30 years.\textsuperscript{98}

In 1996, the Federal Court of Appeals, albeit differently constituted, again preferred the principle of personal autonomy to the SLD in the second American right to die appeal, \textit{Quill v. Vacco}.\textsuperscript{99} In \textit{Quill}, three doctors wanted to prescribe a lethal dose of medication for a group of patients who were terminally ill but could not do so because section 125.15\textsuperscript{100} of the \textit{New York Penal Law} criminalises AS. The petitioners argued that the 14\textsuperscript{th} Amendment guarantees the right of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives and should also guarantee a doctor’s liberty to practise medicine in accordance with his or her best professional judgment and that this

\begin{itemize}
\item \textsuperscript{96} \textit{Downie, above n75 at 89.}
\item \textsuperscript{97} \textit{Cruzan v Director, Missouri Department of Health} 111 L Ed 2d 224 (1990) (hereafter \textit{Cruzan}). \textit{Cruzan} was the first case to come before the United States Supreme Court in which the right to refuse medical treatment, even if this would lead to death, was upheld.
\item \textsuperscript{98} \textit{Compassion} at 822.
\item \textsuperscript{99} 80 F 3d 790 (9th Circuit, 1996) (hereafter \textit{Quill}). The case was on appeal from the summary judgment for the defendants entered by Chief Justice Griesa in the District Court of the Southern District of New York: \textit{Quill v Koppell} 870 F Supp 78 (SDNY,1994).
\item \textsuperscript{100} ‘A person is guilty of manslaughter in the second-degree when:
1. He recklessly causes the death of another person; or
2. …
3. He intentionally causes or aids another person to commit suicide.’
\end{itemize}
should include helping persons to hasten inevitable death by prescribing medication. The petitioners argued that section 125.15 of the *New York Penal Law* denied the patients and doctors equal protection by denying them the right to hasten death while others have the right to refuse life support measures, whether terminally ill or not, even when this will result in death.\textsuperscript{101}

Circuit Judge Miner declined the plaintiffs’ invitation to identify a fundamental new right (a right to die) on the basis that there was a lack of precedent for it and because of the court’s reluctance, clearly stated in previous cases, to expand the concept of Equal Protection beyond the existing categories.\textsuperscript{102} However, Judge Miner opened the door for legal recognition of a right to die by holding that the New York statute breached the Equal Protection Clause of the 14\textsuperscript{th} Amendment because it discriminated against disabled people in the absence of any competing state right that could justify such interference.\textsuperscript{103}

At oral argument and in its brief, the State’s contention has been that its principal interest is in preserving the life of all its citizens at all times and in all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state’s interest lessens as the potential for life diminishes … And what business is it of the state to require the prolongation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient’s right to define their own concept of existence, of meaning, of the universe and of the mystery of human life when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: ‘none’.\textsuperscript{104}

These case outcomes in America could be interpreted as the expression of more liberal attitudes which are arguably more responsive to changing sensibilities in

\textsuperscript{101} *Quill* at 718-719.

\textsuperscript{102} The United States Supreme Court has actually or impliedly identified the following as fundamental rights protected by law: freedom of association; voting; traveling interstate; due process in criminal proceedings; procedural fairness in claims against the government; privacy; life, liberty and property; and the rights contained in the Bill of Rights. The right to privacy has been held to encompass decisions relating to: marriage; procreation; family relationships; child rearing and education; conception; and abortion: *Quill* at 723, 724.

\textsuperscript{103} Id at 727.

\textsuperscript{104} Id at 729-730.
relation to death and dying. However, in each case, the courts failed to address all of the difficult moral and ethical issues that commonly arise in such cases.

The potential for legal recognition of a right to die was overturned in 1997, when Quill and Compassion were taken on appeal to the United States Supreme Court. In the Compassion appeal, Justice Renquist turned to long-held views expressed in moral claims such as the SLD and the slippery slope argument, to reject the claim for a right to die. He stated that Anglo-American law has punished AS for at least the last 700 years. The claimed liberty interest was not an interest protected by the Due Process Clause because it was not rooted in the nation’s history. His Honour said that the lower court had wrongly interpreted previous case law which only related to the right to terminate a pregnancy and the right to refuse unwanted medical treatment. He held that the statute criminalising AS was lawful because it protected the following state interests: the preservation of human life; the prevention of suicide; the ethics of the medical profession; protecting the vulnerable from pressure to end their life; and preventing a slide toward involuntary euthanasia. Justice Renquist held that it was not necessary to weigh up these competing interests against each other in order to reach a decision.

Notably, in a concurring judgment Justice Souter suggested that the petitioners were mistaken in expecting the courts to decide whether there should be legal recognition of a right to die:

Legislatures have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for fact finding than the judiciary but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions ... while I do not decide for all time that the respondents’ claim should not be recognized, I acknowledge that the legislative institutional competence is the better one to deal with that claim at this time.

---

106  The Compassion Appeal at 2258-2261.
107  Id at 2293.
In the second right to die appeal, in *Quill*, the United States Supreme Court again relied upon traditional attitudes expressed via long-held legal principles such as the act/omission distinction as well as accepted medical practice to justify refusing to recognise a right to die:

Neither the Statutes nor the ban on assisted suicide treat anyone differently than anyone else. Everyone, no matter what their physical condition is entitled to refuse medical treatment. No-one is permitted to assist a suicide … The laws are even handed and therefore comply with the Equal Protection Clause … Unlike the Court of Appeals, we think the distinction between assisted suicide and the withdrawal of life sustaining treatment a distinction widely endorsed by the medical profession. The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining treatment he dies from an underlying fatal disease or pathology but if a patient ingests a lethal medicine prescribed by a physician he is killed by that medication …

At present, the status of the law in America is such that further challenges to statutes which criminalise AS on the basis that they are discriminatory and/or on the basis that they deny a liberty interest are unlikely to succeed.

C. England

Legal recognition of a right to die was first pursued in England, in 2001, by Dianne Pretty. Unlike the courts in America, the English courts were not prepared, at any stage, to entertain any of the arguments derived from the principle of personal autonomy that Mrs Pretty advanced in support of her claim.

Mrs Pretty suffered from motor neurone disease, a condition which causes the central nervous system to gradually deteriorate to the point where death usually

---

109 The Quill Appeal at 841, 842.
110 Lewis points out that the possibility of the courts recognising a right to AS in the United States of America is even less likely since the passing of The Assisted Suicide Funding Restriction Act 1997 which prohibits the use of federal funds for AS: P Lewis, Assisted Dying and Legal Change (2007) at 19. However, she considers that petitioners will continue to seek legal recognition of a right to die utilising rights discourse in the future: Id at 75.
111 R (on the application of Pretty) v DPP [2001] EHWC Admin 788 (hereafter Pretty No. 1).
occurs from respiratory failure.\textsuperscript{112} She wanted her husband to be able to assist her to commit suicide but, according to section 2(1) of the \textit{Suicide Act},\textsuperscript{113} \textit{AS} is a criminal offence. Under section 2(4) of the Act the consent of the Director of Public Prosecutions\textsuperscript{114} is required before proceedings can be commenced for breach of section 2(1). Mrs Pretty asked the DPP for an undertaking that no action would be taken against her husband if he assisted her to die. The DPP refused.\textsuperscript{115}

In October 2001, Mrs Pretty sought judicial review of the DPP’s refusal to give the undertaking sought. In the alternative, she sought a declaration that section 2(1) of the Act was incompatible with Articles 2,\textsuperscript{116} 3,\textsuperscript{117} 8,\textsuperscript{118} 9\textsuperscript{119} and 14\textsuperscript{120} of the ECHR. The Divisional Court dismissed the application on its merits and held that the DPP’s decision was not amenable to judicial review.\textsuperscript{121}

In November 2001, Mrs Pretty appealed to the House of Lords. She asked the House of Lords to decide whether the DPP had power not to consent, in advance, to the request she had made of him, if so; whether he had to undertake not to prosecute her husband having regard to the ECHR; if not, whether section 2(1) of the Act was incompatible with Articles 2,3,8,9 and 14 of the ECHR.\textsuperscript{122}

\begin{flushleft}
\begin{enumerate}
\item[113] \textit{The Suicide Act} 1961 (UK) (hereafter \textit{Act}). Section 2(1) provides that: ‘A person who aids, abets, counsels of procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction to imprisonment for a term not exceeding fourteen years.’
\item[114] Hereafter \textit{DPP}.
\item[115] Wynne, above n112.
\item[116] ‘Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction for a crime for which this penalty is provided by law.’
\item[117] ‘No one shall be subjected to torture or to inhuman or degrading treatment or punishment.’
\item[118] ‘Everyone has the right to respect for his private life and family life, his home and his correspondence.’
\item[119] ‘Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.’
\item[120] ‘The enjoyment of rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.’
\item[121] \textit{R (on the application of Pretty) v DPP} [2002] 1 All ER 1 (hereafter \textit{Pretty No. 2}).
\item[122] Pretty No. 2 at [4], [11], [17], [29], [31], [32].
\end{enumerate}
\end{flushleft}
Before the House of Lords, Mrs Pretty argued that Article 2 guarantees autonomy in relation to a person’s right to make decisions about her own life and death. With regard to Article 3, Mrs Pretty argued that she would be subjected to inhuman treatment were her request to have assistance to end her life not met. She argued that Article 8 safeguarded autonomy and included the right of the individual to decide when and how to die and that Article 9 should allow her to follow her belief in AS. With regard to Article 14, Mrs Pretty argued that she was discriminated against because the able-bodied can commit suicide without assistance whereas disabled persons need assistance which is denied them by the Act.\footnote{Pretty No. 2 at [1].}

In rejecting Mrs Pretty’s claim, the House of Lords relied upon traditional views expressed in the SLD and established definitions of key terms in the Articles. The House of Lords held that Article 2 guarantees a right to life and embodies the SLD with the result that no one can be deprived of life by methods involving deliberate human interference. The DPP had not by his decision denied Mrs Pretty a right to life.\footnote{Id at [5], [87], [88]} Article 3 was held not to impose a positive obligation on the United Kingdom to ensure AS to a person who was terminally ill or to guarantee that the person providing AS would not be prosecuted. In addition, the case did not involve inhuman or degrading treatment. Palliative care was available to Mrs Pretty and the DPP had not brought about her condition.\footnote{Id at [15], [60], [91], [92]} Article 8, it was held, related to how a person lives his or her life and not to how he or she departs from it.\footnote{Id at [18], [61], [100],} Article 9 entitled Mrs Pretty to believe in AS but it could not authorise AS which is an illegal act.\footnote{Id at [31], [63], [101].} Article 14 did not come into play because the other Articles did not apply.\footnote{Id at [34], [64], [105].}
In December 2001, Mrs Pretty appealed from the decision of the House of Lords to the European Court.\textsuperscript{129} Before the European Court, Mrs Pretty reiterated the arguments she had raised in the House of Lords but added some new arguments directed at the government of the United Kingdom. With regard to Article 2, Mrs Pretty argued that some countries other than the United Kingdom who are member states of the UN allow AS so to allow AS could not represent a breach of Article 2 of the ECHR. With regard to Article 3, Mrs Pretty argued that the government of the United Kingdom had a duty to take steps to prevent her from suffering by allowing her husband to facilitate her death.\textsuperscript{130}

The European Court also resorted to established views expressed this time in the slippery slope argument and the SLD, as well as established definitions of key terms in rejecting the appeal. The European Court held that Article 2 is not concerned with issues such as quality of life or choice in the manner and timing of one’s death and does not support a right to die. The court held that it was irrelevant what other member states were doing with regard to AS. Article 3 was said to be absolute in its terms and had only ever been interpreted to impose an obligation on states to refrain from inflicting harm on persons whereas in this case the state was not inflicting harm on Mrs Pretty. With regard to Article 8, the European Court noted there had been no previous case in which self-determination had been recognised as falling within the definition of private life. Rather, the focus of the Article was said to be on personal autonomy. The court conceded that Article 8 encompasses notions of quality of life and hence the desire of people to avoid lingering in old age, but said that prevention of AS by the state was justified under Article 8(2) because it is in accordance with law and has an aim that is necessary in a democratic society. Article 9 was said to protect religion and religious beliefs but not a belief in a right to die. Article 14 was said to be engaged because Article 8 had been engaged but there were good reasons to maintain the existing approach; making an exception would undermine the

\textsuperscript{129} Pretty v The United Kingdom, Application No. 2346/02, European Court of Human Rights (Fourth Section) [2002] 2 FLR 45 (hereafter Pretty No. 3).
\textsuperscript{130} Pretty No. 3 at [4], [11].
protection of life that the Act provides and would greatly increase the risk of abuse.131

Pretty remains the leading English authority on right to die applications. However, the outcome in a more recent case illustrates that in some circumstances litigants can secure what could be described as a de facto right to die.132

D. A De Facto Right to Die?

Mrs Pretty died in 2002, ‘in the distressing and undignified way which she had most feared.’133 However, as Dame Hale, who was a judicial member in the Divisional Court in Pretty No. 2 points out, in some circumstances litigants can secure a de facto right to die. Dame Hale compares Dianne Pretty’s case with the circumstances of Ms B134 who also died in 2002, aged 43.

Ms B had an undiagnosed cavernoma135 in her cervical spine (neck) which meant that she was at risk of having a spontaneous haemorrhage. Ms B suffered one haemorrhage which resolved and she was able to return to work but shortly afterwards she suffered a second haemorrhage which resulted in her becoming a tetraplegic. Although she was unable to move from the neck down she was mentally alert. Due to her condition, Ms B began to experience difficulty breathing and was placed on a ventilator. She had executed a living will stating that she wanted medical treatment to be withdrawn if she were suffering from a life threatening condition, permanent mental impairment or permanent

131 Pretty No. 3 at [27], [31], [32], [35], [36], [39], [41].
132 See also, Nancy B v Hôtel de Québec (1992) 86 DLR (4th) 385 (hereafter Nancy B), a Canadian case in which Nancy B, who was suffering from Guillain-Barre syndrome, sought and obtained an order that the ventilator that was keeping her alive be removed. The granting of the order was justified on the basis that Nancy B’s death would result from the disease taking its course (the act/omission distinction). Nancy B was followed in Ms B v An NHS Hospital Trust [2002] 2 All ER 449, discussed below.
134 Ms B v An NHS Hospital Trust [2002] 2 All ER 449 (hereafter Ms B). Ms B is non-contentious as an example of case in which a person was allowed to refuse treatment but is a useful case for comparative purposes.
135 An irregularity in the blood vessels which can result in spontaneous bleeding (haemorrhage).
unconsciousness. After she had recovered from a surgical procedure that did not improve her condition, Ms B asked the medical staff to switch off the ventilator.\textsuperscript{136}

After much lobbying on the part of Ms B, the hospital acceded to her request but would only agree to ween her off the ventilator gradually and without the provision of sedation. Ms B responded that she wanted a quick and painless death and therefore did not wish to be weened off the ventilator. To Ms B, a quick death was a far more attractive option than to die slowly by being weened off a ventilator without sedation. The hospital refused to re-consider its position. Accordingly, Ms B applied to the High Court of England & Wales for a declaration that she had capacity to choose and that the hospital had been treating her unlawfully since August 2001 when an independent psychiatrist had provided an opinion that she was competent to refuse treatment.\textsuperscript{137} The court allowed the declaration. Ms B was transferred to another hospital where the ventilator was switched off and, on one view of the situation, she was assisted to die, if not killed.\textsuperscript{138}

In many cases involving contested medical issues, the courts rely heavily on accepted medical practice in reaching a decision but Ms B reveals, contrary to what many assume to be the case, that attitudes can differ between hospitals and between medical practitioners. Clearly the medical staff at the hospital to which Ms B was transferred had no issue with removing the ventilator that was keeping her alive. Thus, the situation is more complex than it at first appears; attitudes to death and dying among medical practitioners are not uniform.\textsuperscript{139}

Shortly, I turn to discuss two additional, contrary cases. The first case calls into question the assumption made by many opponents of legalised euthanasia that the SLD is a fixed immutable concept.\textsuperscript{140} The second case calls into question the

\textsuperscript{136} Hale, above n\textsuperscript{133} at 2.
\textsuperscript{137} Ibid.
\textsuperscript{138} Ibid.
\textsuperscript{139} This is a theme to which I return in Chapter Four.
\textsuperscript{140} See also, G Zdenkowski, Human Rights and Euthanasia: Occasional Paper No. 3 (1996) at 31. His work shows that the extent of the right to life in contexts such as Article 6 of the ICCPR cannot be taken for
assumption made by many proponents of legalised euthanasia that the principle of personal autonomy is unchanging and self-evident. In each of the two cases, the defence of necessity played an important role. Hence, before discussing the cases, I explain how the defence of necessity works.

E. The Defence of Necessity

The defence of necessity has been accepted in each of the common law jurisdictions. Whilst there are slight differences in the way in which it is articulated in each jurisdiction, each formulation includes a need for proportionality; the accused’s unlawful act must have been proportionate to the evil or the risk that s/he sought to avoid.

In Australia the defence of necessity is governed by the common law in the Australian Capital Territory, New South Wales, South Australia, Victoria and Tasmania. In the Northern Territory, Queensland and Western Australia the defence is codified.

The elements of the defence of necessity were distilled in *R v Loughnan*:

First, the criminal act or acts must have been done only to avoid certain consequences which would have inflicted irreparable evil upon the accused or

---


142 ‘Subject to the express provisions of this Code relating to self-defence and duress, a person is excused from criminal responsibility for an act or omission done or made under such circumstances of sudden and extraordinary emergency that an ordinary person similarly circumstanced would have acted in the same or a similar way; and he is excused from criminal responsibility for an event resulting from such act or omission’: *Criminal Code* (NT) s33.

143 ‘Subject to the express provisions of this Code relating to acts done upon compulsion or provocation or in self-defence, a person is not criminally responsible for an act or omission done or made under such circumstances of sudden or extraordinary emergency that an ordinary person possessing ordinary power of self-control could not reasonably be expected to act otherwise’: *Criminal Code* (Qld) s25.

144 ‘Subject to the express provisions of this Code relating to acts done upon compulsion or provocation or in self-defence, a person is not criminally responsible for an act or omission done or made under such circumstances of sudden or extraordinary emergency that an ordinary person possessing ordinary power of self-control could not reasonably be expected to act otherwise’: *Criminal Code* (WA) s25.

145 McSherry, above n141 at 11.


116
upon others whom he [or she] was bound to protect. The second element is that the accused must honestly believe on reasonable grounds that he [or she] was placed in a situation of imminent peril. Thus, if there is an interval of time between the threat and its expected execution it will be very rarely if ever that a defence of necessity can succeed. The [third] element of proportion simply means that the acts done to avoid the imminent peril must not be out of proportion to the peril to be avoided. Put another way, the test is: would a reasonable [person] in the position of the accused have considered that he [or she] had any alternative to doing what he [or she] did to avoid the peril.\textsuperscript{147}

In England the courts have held that three elements must be met for the defence of necessity to apply: the accused carried out an act in order to avoid inevitable and irreparable evil; s/he did no more than was reasonably necessary in order to avoid the evil; and the evil inflicted was not disproportionate to the evil that was avoided.\textsuperscript{148}

In the United States of America, the defence of necessity or choice of evils defence is available when: the accused’s unlawful conduct was necessitated by a specific and imminent threat of injury or harm which was not the result of the accused’s own conduct; the circumstances were such that s/he had no reasonable, legal and viable alternative; s/he reasonably anticipated or believed in the existence of a direct causal relationship between his or her conduct and the harm to be avoided; and the action taken was proportionate to the evil that was avoided.\textsuperscript{149}

In Canada, the Supreme Court has held that the defence of necessity will be made out when four elements are met: there was a situation of imminent risk; an action was taken to avoid a direct and immediate peril; there was no reasonable

\begin{footnotesize}
\textsuperscript{147} Loughnan at 448 (Young CJ & King J).
\textsuperscript{148} This was the interpretation of the defence in Re A Children (Conjoined Twins: Surgical Separation) [2001] Fam 147, discussed below. The English interpretation is based on the leading Canadian case in relation to necessity, Perka v The Queen (1984) 42 CR (3d) 113 (SCC). Hereafter Perka.
\end{footnotesize}
opportunity for an alternative course of action that did not involve breaking the law; and the harm inflicted was less than the harm that the offender sought to avoid.\textsuperscript{150}

In New Zealand, the defence of necessity, which is referred to as ‘duress of circumstances,’ will be made out in the following circumstances: the accused believed, on reasonable grounds, that there was imminent peril or death or serious injury and that there was no realistic choice other than to commit a criminal act; the act was carried out in response to the perceived peril; and the conduct was proportionate to the perceived peril.\textsuperscript{151}

It is not clear whether the defence of necessity could be raised following a typical euthanasia scenario in the common law countries. In Australia and New Zealand, the defence is still in the process of development in the context of criminal proceedings.\textsuperscript{152}

In Canada, the defence of necessity was raised but was removed from the jury, by the judge, in \textit{R v Latimer},\textsuperscript{153} the second of the contrary cases that I discuss below. Notably, as we shall see, \textit{R v Latimer} was not a typical euthanasia scenario.

In England and in the United States of America, there is old authority that suggests that the defence of necessity cannot be raised to justify or excuse having killed another, innocent person. In \textit{R v Dudley and Stephens}\textsuperscript{154} the Queens Bench held that two sailors who killed and ate the cabin boy in order to avoid starving to death whilst adrift on the high seas, were guilty of murder. In \textit{United States v Holmes}\textsuperscript{155} the Federal Court of America held that a sailor who had directed that unmarried men be thrown out of an overcrowded life boat was guilty of murder. However, the logic of each of these cases has been challenged.

\begin{flushleft}
\textsuperscript{150} \textit{Perka} at 233 (Ritchie, Dickson, Chouinard & Lamer JJ).
\textsuperscript{151} \textsuperscript{151} \textsuperscript{151} \textit{McSherry}, above n141 at 11.
\textsuperscript{152} Id at 10.
\textsuperscript{153} [2001] 1 SCR 3.
\textsuperscript{154} [1881-1885] All ER Rep 61. Hereafter \textit{Dudley & Stephens}.
\textsuperscript{155} 26 Fed Cas 360 (1842). Hereafter \textit{Holmes}.
\end{flushleft}
Holmes was challenged during the Cyclone Katrina disaster in 2007 when a grand jury refused to indict a doctor for murder after she ordered doses of analgesia that were large enough to kill the patients to whom it was given. 156 Dudley & Stephens was challenged in 1987 after the Zeebrugge ferry disaster. The coroner who investigated the disaster held that it was acceptable for a group of people who were in the sea after the ferry capsized, to push a man to his death in order to stop him from blocking their way to safety. The man in question was stuck half way up a rope ladder and would not move, possibly due to fear. He was not seen again after he was pushed off the ladder and into the ocean. 157 Dudley & Stephens was challenged again, in 2001, in Re A Children (Conjoined Twins: Surgical Separation), 158 the first of the contrary cases which I now turn to discuss.

F. Contrary Cases

In Re A the English Court of Appeal had to decide whether twins 'Mary and Jodie,' 159 who were joined at the lower abdomen, should be separated by surgery. There was no doubt that an operation to separate the twins would result in the death of Mary. Mary’s lungs and heart were too weak to function on their own. She was only alive because she was able to obtain oxygenated blood from Jodie’s common artery. If the twins were not separated it was alleged that both would die within a period of three to six months because Jodie’s heart would eventually fail under the strain of keeping both of them alive. 160

Mary and Jodie's parents were devout Catholics. They believed that the fate of their twin daughters should be left in God's hands. The medical staff at the hospital disagreed and approached the Family Court for a declaration that it was lawful to

---

159 At the time of the appeal, the true identity of the twins was suppressed. They were subsequently identified as Rose and Gracie Attard born to Maltese couple, Rina and Michaelangelo Attard. Gracie survived the operation but Rose did not: Editorial, 'Siamese Twin and Parents Fly Home to Malta', Yorkshire Post (18 June 2001) 3.
160 Re A at 155-162, 170.
carry out the operation to separate the twins as they believed it would then be possible to save Jodie's life. After the application was allowed, Mary and Jodie's parents appealed to the Court of Appeal.\textsuperscript{161}

The Court of Appeal noted that the following competing rights were at stake: the right of each twin to life; the right of each twin to bodily integrity; and the right of the parents to refuse medical treatment on behalf of their twin daughters. There were three possible options: permanent union in which case both twins would probably die because Jodie's heart was not strong enough to keep them both alive; elective separation which could lead to Mary's death but would give Jodie a chance to survive; and semi-urgent or urgent separation which no-one was in favour of because it would probably lead to the death of both of the twins.\textsuperscript{162}

Due to section 1(1) of the \textit{Children Act}\textsuperscript{163} the court was obliged to make the children's welfare (the children's best interests) the paramount consideration in deciding the case.\textsuperscript{164} In contrast to the reluctance shown by the House of Lords to delve into contested issues around death and dying in \textit{Pretty}, in \textit{Re A} Lord Justice Ward robustly stated:

\begin{quote}
There has been some public concern as to why the court is involved at all. We do not ask for work but we have a duty to decide what parties with a proper interest ask us to decide … Deciding disputed matters of life and death is surely and pre-eminently a matter for a court of law to judge. That is what courts are here for.\textsuperscript{165}
\end{quote}

Contrary to the position adopted by the English courts in \textit{Pretty}, in \textit{Re A} the court adopted a different interpretation of the SLD – one which justified denying Mary a right to life. Lord Justice Ward stated that the doctors looking after the twins faced a conflict of duties. On the one hand, they had a duty to operate to save Jodie but, on the other hand, they had a duty not to operate because it would result in the

\textsuperscript{161} \textit{Re A} at 155-157.
\textsuperscript{162} \textit{Id} at 162-166 (Lord Justice Ward).
\textsuperscript{163} \textit{The Children Act} 1989 (UK).
\textsuperscript{164} \textit{Re A} at 180.
death of Mary. Relying on the judgment of Justice Wilson in the leading Canadian case in relation to necessity, *Perka*, he held that the defence of necessity ought to apply but in the broader sense of a justification rather than as an excuse. In this way he avoided the problem that the doctors did not face an emergency situation in which case they would have been forced to act regardless of accepted moral standards. Lord Justice Ward rejected Justice Wilson’s assertion in *Perka* that the principle of proportionality requires the court to assess all of the competing rights and duties involved in a case on the grounds that *Re A* was a life or death situation. He conceded that the court was bound by the test of intent to kill in *R v Woollin* and he said that, on that basis, the operation would amount to murdering Mary. However, he considered the operation to be lawful as the lesser of two evils. In addition, he reasoned that Jodie had a plea of ‘quasi-self-defence.’

… she [Mary] has little right to be alive. She is alive because, and only because, to put it bluntly but nonetheless accurately, she sucks the lifeblood out of Jodie … Mary’s parasitic living will be the cause of Jodie’s ceasing to live. If Jodie could speak, she would surely protest, ‘Stop it, Mary, you’re killing me’ … Mary is beyond help.

Lord Justice Brooke agreed that, in the absence of an excuse or justification to carry out an operation that would result in Mary’s death and in light of existing

---

165 *Re A* at 174.

166 *Perka* was not a case that involved a life and death situation. In *Perka* the appellants were charged with trafficking marijuana into Canada. The appellants alleged that they had not planned to traffic in Canada; their destination was Alaska but their Captain ordered them to offload the cargo of marijuana when their boat foundered on rocks on the Canadian shoreline. They argued that they faced a situation whereby they had breached Canadian law only through the necessity of getting the cargo off the boat. Her Honour Justice Wilson held that: ‘the defence of necessity must be grounded either on excuse or on justification. The only way in which the defence can be applied as an excuse is where the accused’s act is done in the interest of self-preservation … the act may be exempted from culpability if it arose in a life-threatening situation of necessity … Where necessity is invoked as justification, the accused must show that he operated under a conflicting legal duty which made his seemingly wrongful act right. Such justification must be premised on a right or duty recognized by law. This excludes conduct … on the ground of an ethical duty internal to the conscience of the accused as well as conduct … on the basis of a perceived maximization of social utility … the conduct must stem from … legal obligations and to respect the universality of rights …’: *Perka* at 234,235.

167 [1999] 2 AC 82. Hereafter *Woollin*. *Woollin* is authority for the principle that an accused can be convicted of murder where intent is not clear-cut but the jury finds that death was ‘a virtual certainty’ and the accused must have appreciated this. *Woollin* is discussed in detail in Chapter Two.

168 *Re A* at 187, 190, 204.

169 Id at 197.
case law on intent (Woollin), the operation would amount to murdering Mary. He conceded that Dudley and Stephens\(^{170}\) remains authority for the proposition that necessity cannot be pleaded as a defence to murder but he distinguished Re A on its unique facts and because there was no need to choose someone to die – Mary was already ‘self-designated for a very early death’.\(^{171}\) As to the twins’ best interests, he reasoned that because of Mary’s condition, Jodie’s best interests were to be preferred to Mary’s.\(^{172}\)

Lord Justice Brooke also rejected the need to weigh up all of the competing rights and interests in the case. He advanced policy reasons for allowing the defence of necessity: the unique circumstances of the case; and the fact that in such cases the medical profession always seeks prior judicial authorisation. He concluded his judgment by turning the SLD on its head. He noted that the SLD respects the dignity of the human body and asserted that his decision was in keeping with it because performing the operation would give each child the bodily integrity that nature had denied her. This was despite the fact that restoring Mary’s bodily integrity effectively meant killing her:

> Finally, the doctrine of the sanctity of life respects the integrity of the human body. The proposed operation would give these children’s bodies the integrity that nature denied them.\(^{173}\)

Lord Justice Walker acknowledged the problem posed by Woollin but did not consider whether the mens rea for murder would be satisfied if the operation were performed. He stated, contrary to the position adopted by Lord Justice Ward, that ‘it would be absurd to suggest that Mary, a pitiful and innocent baby, is an unjust aggressor.’\(^{174}\) He noted that there was no useful analogy upon which he could draw in deciding the case and concluded that the defence of necessity ought to


\(^{171}\) Re A at 239. By comparison, the sailors in Dudley & Stephens selected the person who was to die (the cabin boy).

\(^{172}\) Re A at 240.

\(^{173}\) Ibid.

\(^{174}\) Id at 250, 255.
apply because of the conflicting duties in the case. He too held that the operation would be in the best interests of both of the twins and that it would be in keeping with the SLD:

An operation to separate would be in the best interests of both. Every being has a right to bodily integrity and autonomy. Mary’s death would not be the purpose of the operation. She would be given bodily integrity and would die because her body cannot sustain her life. Life would not be in her best interests because she would have pain and discomfort.175

In contrast to Re A is the high profile Canadian case of R v Latimer176 the outcome of which suggests that personal autonomy is not necessarily the fixed, unaltering concept that many proponents of legalised euthanasia would have us believe.177 In Latimer, Robert Latimer was charged with first-degree murder after he asphyxiated his 12-year-old daughter, Tracy. Tracy was quadriplegic, totally dependant on others for care and suffered between five and six seizures per day. She had the mental capacity of a four-month-old baby178 and was in constant pain from a dislocated hip caused by an operation to correct a curve in her spine. Tracy’s doctors informed Mr Latimer that they planned to do another operation to correct Tracy’s dislocated hip. The operation involved removing the upper thighbone, leaving the skin and tissue in place and would take a year to heal. Mr Latimer considered the operation to be a form of mutilation. He decided that his daughter would be better off dead. Accordingly, he placed her in the cab of his truck, inserted a hose into the cab that was connected to the exhaust pipe of the truck and turned the engine on. Initially, he claimed that Tracy had died in her

175 Re A at 259.
176 There is no transcript or judgment available for the Latimer case at first instance. As a result, I have taken the facts of the case from the appeal by Mr Latimer, in 2001, against the decision of the court at first instance: R v Latimer [2001] 1 SCR 3.
177 See, for example, Dworkin, above n63.
178 Compare the slightly different but equally harrowing account of Tracy’s circumstances provided by Sneideman & Verhoef, above n157 at 380: ‘Tracy had the mind of a three-month old baby, weighed thirty-eight pounds, wore diapers, and could not walk, talk or feed herself. Her life was spent either in bed or in a wheelchair.’
sleep. He admitted to asphyxiating her after a post mortem revealed that there was carbon monoxide in her blood. 

At first instance, Mr Latimer was convicted, albeit of second-degree murder. A sentence of life imprisonment, without the possibility of parole for ten years, was instituted in accordance with sections 235 and 745 of the Criminal Code. However, it was subsequently discovered that the Crown had interviewed jurors prior to the trial seeking their views on matters that would be in issue at the trial. As a result of this, a new trial was ordered.

In the first and the second set of proceedings, various individuals and organisations intervened because of Tracy’s disability. Submissions were made which were designed to alert the court to the danger to disabled persons of accepting the assumptions upon which Mr Latimer’s defence was based. Those assumptions were: that Tracy had such a poor quality of life that there was a necessity to put an end to her life (the defence of necessity); that Mr Latimer had the right to make proxy end-of-life decisions for Tracy because he was her father; and that Tracy’s pain could be dealt with as an issue that was separate from her disability. The interveners identified numerous references that the judge at first instance had made to Tracy’s poor quality of life. They submitted that taking these factors into account in reaching a decision would breach Article 7 and Article 15(1) of The Charter of Rights and Freedoms and that it was not possible to objectively determine the quality of someone else’s life. The interveners argued

---

180 ‘Every one who commits first-degree murder or second-degree murder is guilty of an indictable offence and shall be sentenced to imprisonment for life.’
181 ‘... the sentence to be pronounced against a person who is to be sentenced to imprisonment for life shall be:
   (a) ...
   (b) ...
   (c) in respect of a person who has been convicted of second-degree murder, that the person be sentenced to imprisonment for life without eligibility for parole until the person has served at least ten years of the sentence ...’
183 See footnote 77 above.
184 See footnote 79 above.
that: Tracy should be treated the same as a child who was not disabled and suffering pain; to allow Mr Latimer to make end-of-life decisions for his daughter would offend the UN Convention on the Rights of the Child; and there was no precedent in support of allowing proxy decision-making in these circumstances.\textsuperscript{185}

At the conclusion of the re-trial, the judge removed the defence of necessity from the jury:

\begin{quote}
… I must tell you as a matter of law that the doctrine does not apply in this case. The defence of necessity exists only where the perpetrator’s decision to break the law is inescapable and unavoidable and necessary to avert some imminent risk or peril. It arises only in cases where there is no option, no other choice. That was not the situation here. There was an option, albeit it not a particularly happy one. The option was to persevere in the attempts to make Tracy comfortable in her life, however disagreeable and heart wrenching those attempts might have been.\textsuperscript{186}
\end{quote}

In response to a jury recommendation for a lighter penalty, the judge permitted a constitutional exemption from sections 235 and 745 of the Criminal Code and instituted a sentence of one year in gaol followed by one year less one day probation.\textsuperscript{187} The interveners objected strongly to this sentence, arguing that it had been based on sympathy for Mr Latimer on the part of the judge and because of widespread sympathetic sensibilities on the part of the public as evidenced by a public outcry in response to the sentence instituted at first instance.\textsuperscript{188}

On appeal, the competing sensibilities and difficult moral and ethical issues raised by the case were not addressed. The original sentence of ten years\textsuperscript{189} was re-

\begin{footnotesize}
\begin{enumerate}
  \item \footnotesize{H Heavin, 'Perspectives on the Latimer Trial' (2001) 64 Saskatchewan Law Review 613 at [1]-[7].}
  \item \footnotesize{R v Latimer (1995) 99 CCC (3d) 481 Saskatchewan Court of Appeal at 78-9.}
  \item \footnotesize{Heavin, above n186. Subsequent appeals on the basis that the defence of necessity should have been put to the jury and the original sentence should not have been re-instituted, were disallowed: see R v Latimer [1998] Saskatchewan D Crim 15 and Latimer No. 2.}
  \item \footnotesize{Heavin, above n185 at [1] – [7].}
  \item \footnotesize{Compare the outcome in a recent Australian mercy killing case in which Margaret and Raymond Sutton, the parents of 28-year-old Mathew, who was born without eyes and who had severe mental and physical disabilities, killed him with sedatives in April 2001, the day before he was to have surgery for an ear infection that would probably have removed what was left of his hearing, sense of taste and limited powers of speech. Mathew had the mental age of a child of three or four years of age. Justice Barr, in the Supreme Court of New South Wales, reportedly said that to gaol the parents would be ‘cruel.’ He imposed a five-year good behaviour bond after the parents pleaded guilty to manslaughter: D King,}
\end{enumerate}
\end{footnotesize}
instituted on technical grounds. The court held that the trial judge at the second trial was bound by the earlier court’s decision on sentence; the Criminal Code does not allow any reduction in sentence once the *mens rea* for second-degree murder\(^{190}\) has been made out on the facts of a case.\(^{191}\) The lower court’s rejection of the defence of necessity was upheld. In the process, by suggesting that Mr Latimer should have just moved Tracy to a group home, the court arguably failed to appreciate that the issue for Mr Latimer was not the burden of caring for Tracy but what he perceived to be Tracy’s extremely poor quality of life:

> [The case] deals with the deliberate decision to terminate another’s life rather than continue with the scheduled medical treatment and care. In such circumstances it is no defence for a parent to say because of a severe handicap, a child’s life has such diminished value that the child should not live any longer. It does not advance the interest of the state or society to treat such a child as a person of lesser status or dignity than others.

> … the evidence is clear that the appellant and his family did have an option. If they could no longer bear the burden of caring for Tracy, there was the real prospect of permanent placement in a group home.\(^{192}\)

To sum up thus far, the cases examined at the beginning of this Part illustrate the many ways in which rights discourse is ill-suited to the task of grounding legal recognition of a right to die. The cases are consistent in that in no instance did an appellate court embark on a full and considered analysis of the competing rights and views at stake. Indeed, in the case of *Re A*, in the *Compassion Appeal* and in *Latimer* the court rejected the need to do so. Instead, the courts reduced the complex issues involved in the euthanasia debate to a contest between the principle of personal autonomy and communitarian interests and then provided various justifications for choosing one or the other.

---

\(^{190}\) As Sneiderman & Verhoef point out, Mr Latimer’s actions clearly fell within the definition of first-degree murder. However, the trial judge chose to instruct the jury in relation to first and second-degree murder: Sneiderman & Verhoef, above n157 at 381.

\(^{191}\) *R v Latimer* [1998] Saskatchewan D Crim 15 at [64] – [71].

\(^{192}\) *R v Latimer* [2001] 1 SCR 3 at 84-86.
In the Federal Court of Appeal in *Compassion* and in *Quill* and in the minority judgment in *Rodriguez* the court preferred the principle of personal autonomy. In these cases, the court’s approach could be seen as the expression of a more practical approach, arguably more responsive to changing sensibilities in relation to death and dying. In each case, the court was prepared to accept the argument that it is discriminatory to allow the able-bodied to commit suicide and to permit the removal of life support even if this leads to death, whilst at the same time denying assistance to die to those who are not on life support measures and who are unable to end their own life without assistance.

By comparison, in the appellate decisions in *Compassion* and *Quill*, in *Pretty* at all levels and in *Rodriguez* the judges appeared anxious to maintain the existing order of things. This they achieved by, inter alia, a resort to established, long-held views in the guise of moral doctrines such as the SLD and the slippery slope argument. The courts referred to the SLD as if it is a fixed and immutable concept. However, *Re A* and *Ms B* reveal that this is not so. In *Re A*, the SLD was successfully utilised to justify denying one of the twins a right to life. In *Ms B*, the principle of personal autonomy was preferred with the result that Ms B was permitted by law to have her life ended by a third party disconnecting the ventilator that was keeping her alive. On the other hand, as *Latimer* suggests, personal autonomy is not a straight-forward concept by any means\(^\text{193}\) and its existence should never be assumed.

The many shortcomings of rights discourse highlighted in this part, prompt us to ask whether there is a better way forward in responding to the issues at stake in the euthanasia debate. This is a topic to which I now turn and to which I return, along with the defence of necessity, in the conclusion to this thesis.

5. Some Alternative Approaches

In Rethinking Life and Death: The Collapse of our Traditional Ethics philosopher Peter Singer\(^{194}\) suggests new ways of thinking about contested issues around death and dying. Singer’s central premise, that the SLD has collapsed, is not reflected in most of the cases examined in this chapter. This is arguably because the SLD is expressed in a secular as well as a religious version and hence it has very broad support. Nevertheless, I consider Singer’s suggestions in some detail as they provide greater insight into the issues at stake in the right to die debate.

Singer identifies three established ways of thinking about the euthanasia debate which he refers to as ‘the old commandments.’ He then suggests that we can move forward in our thinking around end-of-life issues by replacing these old commandments with three new ways of thinking which he calls ‘the new commandments’. The first old commandment Singer identifies is: ‘treat all human life as of equal worth’. Singer argues that, in reality, we already do not adhere to this commandment. If we did we would never allow people to refuse treatment and we would institute all medical measures necessary to save life regardless of a person’s diagnosis or prognosis – from those who are comatose to those with inoperable cancer.\(^{195}\) Singer is correct in saying this, as the cases of Re A and of Ms B demonstrate. He suggests that we replace the first old commandment with a new commandment: ‘recognize that the worth of human life varies.’\(^{196}\)

In keeping with Singer’s first new commandment, the process of making decisions about the worth of human life would be based on agreed indicia such as consciousness, the capacity for physical, social and mental interaction, a conscious preference to continue living, an ability to enjoy life and inter-relational matters such as the interests of relatives and the feelings of significant others.\(^{197}\) As the case law examined in this and the previous chapter suggests, many of

\(^{194}\) P Singer, Rethinking Life and Death: The Collapse of our Traditional Ethics (1996) at 1.
\(^{195}\) Id at 190.
\(^{196}\) Id at 190, 191.
these matters are already routinely taken into account in hospitals and in courts, albeit often in a covert manner. That being the case, as I argued in a different context in the previous chapter, it would be better if these value judgements were openly acknowledged and incorporated into end-of-life decision-making in addition to other important indicia such as a person’s expressed or known wishes.

The second old commandment Singer identifies is: ‘never intentionally take innocent human life.’ Singer suggests that we should reject this belief because it is too absolute and inadequate to deal with the circumstances of individual cases and may simply prolong suffering. He argues that in some cases it would be preferable to adopt more active means of ending life. Singer suggests that we replace the second old commandment with: ‘take responsibility for the consequences of your decisions.’ Singer argues that doctors should stop concerning themselves with categories such as refusal of treatment and instead ask themselves whether a treatment decision that will end a patient’s life is the right decision, all things considered. This is likely to be the case when active measures will bring about a more merciful death than a death that is drawn out as a result of letting a person die slowly.

Singer’s second new commandment is good on one level because it permits us to recognise the lived experience of people such as Ms B and Mrs Pretty, discussed in the previous part, but Singer ignores the fact that participants in the euthanasia debate generally hold deeply entrenched views about the taking of human life; whether it can ever be justified and, if so, in what circumstances. Opponents of euthanasia may agree with killing in self-defence, in time of war and/or in the case of capital punishment but they typically do not agree with killing near the end of life because a person wants to die sooner; they see this as inherently wrong. The views of opponents of legalised euthanasia, which find expression in the SLD, are

---

197 Singer, above n194 at 190-192.
198 Id at 190.
199 Id at 192.
200 Id at 192-196.
often underpinned by deeply held religious views which cannot simply be replaced. Singer’s second new commandment also ignores the burden that this change would place on doctors to determine the level of another person’s pain and unhappiness.

A better approach in the context of legal decision-making, would involve developing mechanisms to allow the judiciary and juries to take into account the level of suffering likely to be experienced by a petitioner as a result of each available option being acted upon, in conjunction with the other matters outlined by Singer, discussed above. The most appropriate person to provide this information should be, wherever possible, the dying person him or herself.

The third old commandment Singer identifies is: ‘never take your own life, and always try to prevent others taking theirs.’\textsuperscript{202} It is not clear that this commandment is still current because, as outlined in the previous chapter, it is no longer illegal to commit suicide and, in most cases, people are not under a duty to prevent other people from taking their own life.

Singer recommends that we replace the third old commandment with a new commandment which involves respecting a person’s desire to live or die. He goes on to argue that those without reason and reflection should not be defined as persons and that only a person has a right to life.\textsuperscript{203} Singer’s third new commandment is highly objectionable because it offends both the religious and the secular version of the SLD. Yet, it is instructive to note that this type of thinking was deployed by the House of Lords in the case of \textit{Re A} to justify killing Mary, albeit dressed up in the respectable language of necessity and legitimated by the unique circumstances of the case.

\textsuperscript{201} See, for example, B Santamaria, ‘A Prayer for the Dying’, \textit{The Weekend Australian} (3-4 June 1995) 24.
\textsuperscript{202} Singer, above n194 at 196.
\textsuperscript{203} Id at 196-198.
Leslie Bender suggests an alternative, feminist paradigm for resolving contested issues around death and dying. Bender calls for a care-based ethics instead of the existing rights-based model. In this schemata, individuals are understood as relational, interdependent and supportive as opposed to separate, autonomous, equally empowered actors. Individual autonomy is seen as a process nurtured in webs of relationships rather than as a static condition that pre-exists those relationships. Bender argues that:

What should matter is whether a physician thoroughly discussed the medical aspects of the dying process and care options with the dying person, and whether there have been ongoing conversations about dying between the dying person and loved ones, caregivers and medical providers.

Bender’s suggested broader approach cleverly gets around rights discourse’s overweening focus on the individual and has regard for what Elias has identified as the fundamentally interdependent nature of human social life. Bender’s suggestions could easily be incorporated into end-of-life lawmaking. However, a weakness with her argument is that she fails to appreciate that it is unlikely opponents of legalised euthanasia will ever come to view the provision of assistance to die as a caring act. In addition, she does not tell us how we are to resolve competing views and ambivalence among family members, friends and carers.

204 The circumstances surrounding the death of Bob Dent who chose to be assisted to die pursuant to the ROTIA illustrate the anguish that strong adherence to the principle of personal autonomy can cause for family members: S Sandham & J Brough, ‘Family at War as Dent Rushed to Hospital’, The Sydney Morning Herald (5 December 1996) 10. However, this is not always the case: M Martindale & D Price, ‘Dr Death’s Freedom Rekindles Debate: as Kevorkian is Paroled Today, Widow of Man he was Convicted of Killing Admires his Stand’, The Detroit News (1 June 2007) 1.


206 Id at 536.

207 See Chapter One.
6. Conclusion

Contrary to what many people assume to be the case, rights discourse has not always existed in its current form, nor has it always been accorded the important position it holds today. From natural rights to human rights, the notion of rights continues to rest on shifting views as to what rights the individual ought to be able to exercise as opposed to the degree of control the state ought to be able to exercise over him or her in order to protect communitarian interests.

A teleological examination of rights discourse reveals that rights discourse lacks a firm doctrinal basis. An examination of rights discourse at a purely theoretical level reveals that rights discourse can prevent the finding of common ground by encouraging an adversarial approach to issues that are in dispute. An examination of outcomes in right to die applications reveals that, in the absence of any guidance from rights discourse as to how to choose between competing rights and in the absence of any compelling reason to change the existing order of things, the courts invariably deny such applications. As a result, the courts’ response to changing sensibilities in relation to death and dying expressed via right to die claims is unsatisfactory. Responses are inflexible and do not address contextual matters or changing sensibilities.

I have argued that it would be better if matters in addition to those recognised in legislation and in long-held doctrines and moral claims such as the SLD and the slippery slope argument were taken into account in end-of-life lawmaking. Those additional matters could include: the petitioner’s diagnosis and prognosis; his or her present degree of suffering and anticipated degree of suffering in response to each available option; his or her beliefs about a good death (whether secular or religious); risk factors such as disability which can impact upon personal autonomy; and the views of those in a caring and close relationship to the petitioner. The courts should be required to weigh up all of these competing interests in a considered manner before reaching a decision.
However, in light of the strong adherence to the SLD evidenced in the *Compassion* Appeal, the *Quill* Appeal and in *Pretty* at all levels and in view of the stance that has been adopted toward euthanasia in the common law countries by leading parliamentarians, medical associations and law reform bodies\(^{208}\) I consider it unlikely that the changes I have explored in this chapter will be instituted via case law at this time.

In this chapter and in the previous chapter, I concluded that the courts in the common law countries are not responding in an adequate manner to changing sensibilities toward death and dying. I examined alternative approaches and put forward suggestions as to how the law could be made more responsive to changing sensibilities in relation to death and dying and contextual matters. Given that I have concluded that the changes I have suggested are unlikely to be made via case law, in the next chapter I alter my line of enquiry to the domain of medicine. I question whether the response of medicine to changing sensibilities in relation to notions of the good death is satisfactory. By examining changing attitudes to pain and suffering within mainstream medicine and within the subspecialty of palliative care and by analysing the results of original research, I find it likely that it is not.

\(^{208}\) See Chapter Two.
CHAPTER FOUR
THE PALLIATED (? GOOD) DEATH

It seems that many people imagine the circumstances that might drive them to ‘end it all’, and excruciating pain comes to mind. This picture of terminally ill patients writhing in uncontrolled or even uncontrollable pain requesting euthanasia or PAS [physician-assisted suicide] has dominated all discussions about whether euthanasia or PAS is ethical and should be legalized.¹

I have lost 25kg in weight … My current program involves taking 30 tablets a day! For months I have been on a roller-coaster of pain made worse by the unwanted side effects of the drugs. Morphine causes constipation – laxatives work erratically. I have to have a rubber sheet on my bed, like a child who is not yet toilet-trained. I can do little for myself and require 24-hour nursing care. There is now the constant fear of a fall which could cause terrible injury to my fragile bones. I cannot even get a hug in case my ribs crack. My own pain is made worse by watching my wife suffering as she cares for me … I have always been an active, outgoing person, and being unable to live a normal life causes much mental and psychological pain, which can never be relieved by medication … ²

1. Introduction

In the previous two chapters of this thesis, I questioned whether the courts in the common law countries are responding in an adequate manner to changing sensibilities in relation to death and dying. In Chapter Two, I focussed on the law around AS and unlawful killing (AVE). In Chapter Three, I concentrated on right to die applications in England, Canada and America. In both contexts, I concluded that the response of the judiciary is unsatisfactory. In the first case this is because of a gap between what how the law says it will respond to euthanasia and how it tends to respond. In the latter case, this is because the law is inflexible. Further, the judicial framework takes many matters into account but does not openly address changing sensibilities in relation to death and dying. In this chapter, I re-focus my enquiry on the domain of medicine in order to determine whether the

medical profession is responding in an adequate manner to changing sensibilities toward death and dying as expressed in contemporary notions of the good death.

As the quotes at the beginning of this chapter suggest, pain\(^3\) and suffering are key issues in the right to die debate. Proponents of legalised euthanasia generally claim that, when a person is terminally ill and is suffering from pain that cannot be relieved, the person ought to be able to obtain assistance to die. I refer to this situation as the typical euthanasia scenario. This attitude is often reflected in opinion polls regarding the legalisation of euthanasia.\(^4\) Proponents of legalised euthanasia generally do not object to palliative care.\(^5\) Rather, they argue that patients should be entitled to opt for death, in preference to palliative care, when the latter does not meet their needs.

On the other hand, opponents of legalised euthanasia typically argue that pain and suffering at the end of life can be controlled in almost all cases to a level that is satisfactory to the patient and that the few patients whose pain cannot be adequately controlled do not justify the legalisation of euthanasia. They generally argue that public funds should be spent on making sure that all patients who are dying have access to palliative care rather than on setting up the legislative and procedural framework necessary for the safe provision of euthanasia.

‘Pain and suffering’ were prerequisites for AVE and AS in the ROTIA.\(^6\) ‘Suffering’ was a qualifying condition for AVE and AS pursuant to the Assisted Dying for the Terminally Ill Bill\(^7\) which was defeated in the House of Lords in 2005. ‘Severe

\(^3\) For reasons of relevance, in this chapter I do not explore the problem of acute pain in the sense of short-lived pain that is not related to a malignant cause or chronic pain that is not related to a malignant cause.

\(^4\) See Chapter Two.

\(^5\) According to Doyle & Barnard, the term ‘palliative care’ was coined in 1974 to replace the word ‘hospice’ because the latter had a meaning in Spanish and French that was different to its English meaning: D Doyle & D Barnard, ‘Palliative Care and Hospice’ in W Reich (ed), Encyclopedia of Bioethics (3rd ed, 1978) 1969 at 1970.

\(^6\) Section 7 of the ROTIA set out the conditions under which a medical practitioner could legally assist a person to end his or her life. In relation to pain and suffering, section 7 (d) merely stated: ‘the illness is causing the patient severe pain or suffering’. Neither term was defined in the interpretation section of the ROTIA (section 3). See Chapter Two for discussion of the ROTIA.

\(^7\) See Chapter Two for discussion of the Assisted Dying for the Terminally Ill Bill 2005 (UK).
physical or mental pain’ was a prerequisite for legal assistance to die in Bill C-407\(^8\) which was unsuccessful in the Canadian Parliament in 2005. By contrast, pain and suffering are not necessary for AS in the ODDA\(^9\) and nor were they requirements for AS pursuant to draft euthanasia legislation that was defeated in the Parliament of Vermont\(^10\) and the Californian Parliament\(^11\) in 2007.\(^12\)

Given the importance of pain and suffering in the euthanasia debate we need to question assumptions that are made by both sides of the debate in relation to the role that these factors play at the end of life. This chapter is divided into three parts. In Part 2, I examine changes in attitudes within and outside medical discourse in relation to pain and suffering in order to problematise assumptions that are made by those on both sides of the euthanasia debate. I show that commentary within and outside the discourses associated with medicine suggests that medicine’s understanding of pain and suffering is flawed because it privileges physical pain in circumstances where the available evidence suggests that it is existential\(^13\) pain that motivates requests to be assisted to die.

In Part 3, I review and discuss the results of original research that I carried out in Sydney during the year 2000, among palliative care specialists. On the basis of the literature that is reviewed in Part 2, I decided to examine whether palliative care experts would de-emphasise the importance of existential pain in treating patients at the end of life. In addition to answering this question I decided to go further and theorise whether it is likely that, if they do de-emphasise the existential aspect of pain, this impacts upon their ability to facilitate a good death and thus

---

\(^8\) See Chapter Two for discussion of Bill C-407 (Can).


\(^10\) See Chapter Two for discussion of HB 169 (Ver).

\(^11\) See Chapter Two for discussion of AB 651 (Cal).


\(^13\) In this chapter, I use the term ‘existential’ to mean factors that are of a non-physical nature but are, instead, of an emotional or spiritual nature. Kelly has highlighted the lack of an agreed definition for this term in the medical context: M Kelly, ‘Dying with Dignity: Dissecting ‘Palliative Care’ for ‘Existential Pain’”, paper presented at the Congress of the International Academy of Law and Mental Health, Padua, (26 June 2007) at 5.
prevents them from responding in an adequate manner to changing sensibilities toward death and dying.

In Part 4, I conclude that it is likely that medicine is not responding in a fitting manner to changing sensibilities in relation to death and dying and I consider whether there is a better way forward. At present, the euthanasia debate appears to have become entrenched and meaningful dialogue has all but ceased. However, in light of the anticipated demographic changes in relation to aging outlined in Chapter One of this thesis, it is important for the debate to continue. Before this can occur, we must first overcome the misconceptions in relation to pain and suffering that are perpetuated by both sides of the right to die debate.

In the final part of the chapter, I conclude that we can move forward by developing a more nuanced understanding of pain and suffering; an understanding that incorporates and gives importance to the factors that lead to requests to be assisted to die. If this does not occur, then it is likely that the ability of palliative care specialists to facilitate a good death will be compromised and, draft euthanasia legislation which incorporates this flawed interpretation of pain and suffering will not contain proper safeguards against abuse.

Having outlined the contents of each part of this chapter, I now turn to examine changing sensibilities and attitudes toward pain and suffering from the end of the Middle Ages to the present time. My aim in doing so is to highlight the limited nature of our understanding of these concepts, in general, and in the context of the euthanasia debate.

2. Pain and Suffering – Changing Sensibilities

There is a tendency in the literature, in the framing of draft euthanasia legislation, and in the public debate in relation to a right to die, to use the terms ‘pain’ and ‘suffering’ as though they are synonymous with each other. However, whilst the relationship between the two is undoubtedly of a symbiotic nature, they are in fact distinctly different forms of distress. The following definition of pain taken from the
Encyclopedia of Bioethics shows how pain is primarily seen as a physical experience:

Pain is a function of the nociceptive apparatus. Skin, muscles, and internal organs are supplied with nerve endings that come from several types of nerve fibres. Some are specifically responsive to mechanical, thermal and chemical stimuli that give rise to the noxious physical sensation called nociception. These nociceptive fibres enter the spinal cord and make complex connections with the spinal nerves that ascend to the thalamus and from there to areas of the cortex of the brain. Neural pathways from the higher centres, in what is called the endogenous pain control system, descend to make connections in the dorsal horn of the spinal cord in the area where the pain fibres make their initial central connections. These descending tracts are able to modulate the nociceptive signal by exerting an inhibitory effect specifically on pain transmission neurons.

In addition ... chemical messengers and their receptors within the nervous system also have an influence on the message. Naturally occurring brain peptides ... collectively known as endorphins, exert analgesic effects in different areas of the nervous system by binding to specialized receptors. These same receptors also bind drugs such as morphine ... allowing them to provide pain relief. Other neurotransmitters, such as serotonin and dopamine, also have effects that temper the transmission of nociceptive messages.14

By comparison, the term suffering is frequently used to capture the existential aspects of the experience of pain:

... a specific state of severe distress induced by the loss of integrity, intactness, or cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity. Suffering continues until integrity is restored or the threat is gone. The whole person does not mean solely the whole biological organism of the solid-bounded object, although it may be the object of the threat. Persons, while they may be identified with their bodies, cannot be whole in body alone. Nor should the threat to the whole person be understood as solely a quantitative matter ... since one individual may suffer from pain considered unimportant by another. Suffering may occur in relationship to any part of a person.15

The distinction between pain and suffering is well-illustrated by the example of child birth. As Cassell, a professor in public health with a special interest in suffering, points out, there are many different forms of pain relief available today to

15 Id at 1963.
women in labour. In spite of this, the process of childbirth may be associated with a significant degree of suffering. In childbirth, the important issue appears to be the degree to which the woman feels in control of her own labour and delivery rather than her level of physical pain. By Based on my own experience, I agree with what Cassell says about this matter.

As noted, the definition of pain provided above focuses on the physical aspect of the experience of pain. Looking back in time reveals that pain has not always been perceived in this way so we should not assume that Western medicine’s interpretation of pain is right or beyond question. In Europe, prior to the time of Descartes (1596-1650), sensibilities were such that people had a metaphysical understanding of pain and did not believe, as we do today, that pain could and should be vanquished. There were two main reasons for this: pain was not considered to be a mechanical dysfunction; and people believed that pain was an experience of the soul and was present all over the body. So, to do away with pain meant doing away with the patient.

It was not until 1644 that pain began to be perceived as a matter that involved the person in a physical sense. At this time, Descartes put forward the specificity theory of pain in which he theorised that there is a specific pain pathway in the body from a single channel in the skin to a pain centre in the brain. In Descartes’ purely mechanistic schemata the body and the mind are completely separate except for a connection of the two via the pineal gland. The body is sentient but

\[\text{\[16\] Cassell, above n14 at 1962.}\]
\[\text{\[17\] I Illich, Limits to Medicine: Medical Nemesis, the Expropriation of Health (1990) at 149.}\]
\[\text{\[18\] Descartes’ theory of pain is illustrated by the example of a person who burns his or her foot. In Descartes’ schemata, fast-moving particles of the fire disturb filaments in the nerves of the foot. These filaments transport the pain message along nerve fibres until it reaches the brain and activates the ‘animal spirits’ which travel down the nerves to the muscles controlling the foot and cause the movement that allows the person to remove his/her foot from the flame: S Williams & G Bendelow, ‘Pain and the ‘dys-appearing’ Body’ in The Lived Body: Sociological Themes, Embodied Issues (1998) at 156.}\]
the mind is not. Thus Descartes did not contemplate that there could be an existential aspect to pain. In Descartes’ view pain was a purely physical event.

By the mid-1800s, changes in attitudes toward pain and suffering were well under way in some quarters of the medical profession and in society in general. During the 1840s, the idea that pain was an inevitable part of life was challenged with the successful use of ether and chloroform for surgery, gynaecological procedures and dentistry. Another notable challenge to prevailing wisdom occurred in 1853 with the release of the first analgesic in Wisconsin in the United States of America.

Halttunen confirms that a sensibility developed at this time which saw pain as unacceptable and this contributed to the intensification of medical efforts to find ways of minimising pain. However, changes in sensibilities were not uniform. Thus, in 1847 a doctor in Edinburgh was ostracised by his colleagues and the church for providing a woman in labour with pain relief. The doctor’s detractors claimed that he had acted in a sacrilegious manner because pain in labour was thought to be ‘the divine lot of women.’

Notwithstanding these changing sensibilities toward pain, Descartes’ conception of pain remained the dominant way of thinking about pain until von Frey put forward a more sophisticated version of the specificity theory of pain in 1894. Von Frey posited that there are four major sensory receptors in the skin: touch; warmth; cold; and pain each with its own special system of transmitting a particular

---

20 Williams & Bendelow, above n18 at 141.
22 The ancients knew of the narcotic analgesics derived from the poppy and the Greeks knew of other analgesic substances such as willow bark but narcotic analgesics were not widely used by physicians due to concerns about drug addiction: H ten Have & D Clark, The Ethics of Palliative Care: European Perspectives (2002) at 23.
24 M Mannes, Last Rights (1975) at 68.
sensation to the part of the brain responsible for registering that particular sensation.26 This more highly developed version of the specificity theory was a major breakthrough in medicine’s understanding of pain but it too is a mechanistic, physical understanding of pain.

Throughout the 1800s, changes in attitudes within medicine in relation to pain and suffering continued so that, by 1900:

Disease, sickness and pain were no longer accepted as a matter of fate. They were now understood to be problems to be broken down, analysed and solved … In unprecedented numbers infirmaries and hospitals, armed with the new tools of anaesthesia, antiseptics and surgery sprang up … to meet the afflictions of growing urban populations. Qualified public health and administrative officials and professional medical associations of doctors … established themselves as society’s experts on illness, disease and pain … doctors and health officials launched a major offensive to take control of the kingdom of pain and suffering. Medicine differentiated itself into specialties to conform to new knowledge and to confront newly diagnosed pains and illnesses.27

These developments, in conjunction with rapid advances in medical technology resulted, by the 1950s, in medical practitioners becoming the custodians of a whole new range of products and procedures designed to control pain. But there was still a widespread attitude within the medical profession that prevented many of those who were experiencing pain from getting adequate pain relief. It was still widely thought that pain relief should be rationed, even at the end of life, in order to prevent patients from becoming drug addicts.28

During the 1960s, Dr Cecily Saunders, who has been recognised as the founder of the hospice movement,29 challenged the notion that pain relief is addictive in all circumstances. Saunders advanced the concept of ‘total pain;’ a model in which pain is understood as a complex of physical, emotional, social and spiritual

26 Bendelow & Williams, above n18; Thomas, above n25 at 141.
elements which can only be effectively treated by total care (multidisciplinary care) which, she argued, should be provided in a hospice where the focus would be care rather than cure, the latter being the business of mainstream medicine.\(^{30}\)

Saunders’ call for a more nuanced understanding of pain; one that would encompass an existential aspect, was reiterated in 1965 with the publication of Melzack and Wall’s gate control theory of pain.\(^{31}\) The gate control theory of pain posits that physiological gates exist within the body that can selectively shut to block out the experience of pain. The authors challenged the specificity theory of pain, pointing out that it does not explain why the location of pain is sometimes different to the site of the injury, why pain sometimes persists even after tissue damage has healed and why certain forms of pain such as lower back pain or migraine often do not respond to treatment.\(^{32}\) Notably, they argued that there are numerous factors at play in the experience of pain, not just physical ones:

> The psychological evidence strongly supports the view of pain as a perceptual experience whose quality and intensity are influenced by the unique past history of the individual, by the meaning he [sic] gives to the pain-producing situation and his [sic] ‘state of mind’ at the moment.\(^{33}\)

Notwithstanding this call within medicine for a more nuanced understanding of pain, at about the same time, mainstream medical thinking began to divide pain into two categories; organic pain or psychogenic pain. Organic pain is said to result from irritation to nerve endings or from a lesion in the central nervous system (a physical cause) whereas psychogenic pain is said to be pain that is...

---

\(^{29}\) Clark, above n28.


\(^{31}\) Note that, in 1962, Weddell put forward the pattern theory of pain in which he argued that there was no separate system for feeling pain but that pain was due to intense peripheral stimulation of non-specific receptors which produced a pattern of nerve impulses which was interpreted centrally as pain: Thomas, above n25 at 6 citing G Weddel, ‘Activity Pattern’ Hypothesis for Sensation of Pain’ in G Grenell (ed) Neural Physiopathology: Some Relationships of Normal to Altered Nervous System Activity (New York, Hoeber: 1962) at 134-177. The pattern theory of pain is not widely addressed in the literature, possibly because it was overshadowed by the gate control theory in 1965.

\(^{32}\) Bendelow & Williams, above n18 at 142.

\(^{33}\) R Melzack & P Wall, The Challenge of Pain (reviewed ed, 1988) at 32.
independent of peripheral stimulation or damage to the nervous system and is instead due to emotional factors (a mental cause).\textsuperscript{34}

Today, pain theories are still derived from the gate control theory,\textsuperscript{35} but focus upon the role of neurochemicals in the pain experience. Current theories hold that, when tissue is damaged, peripheral chemicals sensitise the sensory endings of nerves leading to changes within the nerve itself which result in a sensation of pain. Thus the modern day view of pain is still a mechanistic one that focuses upon physical events and arguably undermines ongoing attempts to establish a more holistic understanding of the experience of pain.\textsuperscript{36}

Knowledge in relation to pain, within and outside the realm of medicine, continues to suggest that pain is a complex process which is intrinsically existential in nature, the experience of which is mediated by many factors. Whilst Baszanger,\textsuperscript{37} a medical sociologist who examined the role of culture in the experience of pain, concluded that it is not mediated by culture, others, such as Helman,\textsuperscript{38} Zola\textsuperscript{39} and Beecher\textsuperscript{40} do not agree. Accordingly, it appears that culture does in fact play a role in the experience of pain even though, as Scarry points out, by its sheer intensity pain may sometimes transcend culture and negate all meaning by 'deconstructing' the world to which we are accustomed.\textsuperscript{41}

Sociological research in relation to a possible link between culture and pain dates back to 1959 with the pioneering work of Mark Zborowski who interviewed 103 patients and their doctors at a Veterans Hospital in New York. The research

\textsuperscript{34} H Merskey & F Spear, \textit{Pain: Psychological and Psychiatric Aspects} (1967) at 19.
\textsuperscript{38} C Helman, \textit{Culture, Health & Illness} (2nd ed, 1990) at 158.
\textsuperscript{39} I Zola, ‘Culture and Symptoms: An Analysis of Patient’s Presenting Complaints’ (1966) 31 American Sociological Review 615.
\textsuperscript{40} H Beecher, \textit{Measurement of Subjective Responses: Quantitative Effects of Drugs} (1959).
subjects were divided into four ethnic groups: first or second generation Americans of Jewish, Italian, or Irish descent; and ‘Old Americans.’ Most of the patients were suffering from pain due to neurological disease. All were male. Zborowski found that the Jewish and Italian patients were much more vocal about their pain whereas the Irish and Old American patients adopted a more stoic approach. In each case, this reflected cultural expectations of behaviour which had been transmitted to them by their family. The patients’ reactions to pain also had important ramifications for how they were dealt with by health care workers. The American staff at the hospital expected the patients to adopt a stoic response to pain which is more in keeping with American mores. As a result, staff tended to devalue the Jewish and the Italian patients’ experience of pain and to categorise it as ‘deviant, hypochondriacal or neurotic.’

Differences in the experience of pain have also been found to occur between ethnic groups by Lipton and Marbach. The authors divided 476 research subjects, who were suffering from facial pain, into seven ethnic groups and then selected 50 from each of the five predominant groups: Black; Irish; Italian; Jewish; and Puerto Rican. Using one-way analysis of variance on 35 pain response items and multiple range tests for significant differences, the authors discovered that for Black people degree of medical acculturation determined their experience of pain. Degree of social assimilation determined the experience of pain for Irish people. The duration of pain determined the experience of pain for Italians whilst, for Jewish and Puerto Rican people, pain response was linked to their level of psychological distress.

Further evidence of a link between culture and the experience of pain is provided by Melzack and Wall who cite the hook-swinging ritual in India in which steel

42 The patients in this group were: White, native-born individuals, usually Protestant, whose grandparents, at least, were born in the United States of America and who did not identify themselves with any foreign group nationally, socially or culturally: M Zborowski, ‘Cultural Components in Response to Pain’ (1952) 8 Journal of Social Issues 16 at 19.
43 Id at 19-21, 23.
44 Id at 25.
hooks are inserted into the muscles of a man’s back and then connected to ropes which are attached to the top of a cart. As the cart travels around to various towns the man swings from the steel hooks without any sign of the pain that one would expect him to feel. Melzack and Wall also cite a procedure in East Africa called ‘trepanation’ which involves cutting the scalp and underlying muscles on top of the head in order to expose a large area of the skull. The skull is then scraped as the person sits, catching their own blood in a pan held under the chin. The person exhibits no signs of the pain that one would expect to accompany such a procedure.\textsuperscript{46}

Bendalow, a medical sociologist who studied patients attending a health centre in inner city London found that, at first blush, men were reluctant to acknowledge an emotional or psychological aspect to pain and there was a generally held view among the research subjects that women cope better with pain. Thus gender may also affect perceptions of pain.\textsuperscript{47} Bendalow’s research suggests that patients may also devalue existential pain:

\begin{quote}
... the meanings and definitions of pain for both men and women were not confined to physical sensations but included feelings and emotions … spiritual and existential notions … all acknowledged ‘emotional pain’ but [felt that] physical pain was more legitimate.\textsuperscript{48}
\end{quote}

The context in which pain occurs appears to influence how it is experienced. Anaesthesiologist Dr Henry Beecher, who studied the pain responses of 150 men wounded in battle and 150 civilians who had recently had major surgery, found that only 32 per cent of the soldiers reported pain severe enough to require narcotic analgesia as opposed to 83 per cent of the civilian group. Beecher theorised that the soldiers complained of less pain than the civilians because they

\textsuperscript{46} Melzack & Wall, above n33 at 15-17. See also: Bendelow & Williams, above n18 at 275 citing Zola, above n39; Zborowski, above n42. More recently, see F Rahim-Williams, J Riley III, D Herrera, C Campbell, B Haste & R Fillingim, ‘Ethnic Identity Predicts Experimental Pain Sensitivity in African Americans and Hispanics’ 129 (2007) \textit{Pain} 177.

\textsuperscript{47} More recently see, for example, E Keogh, ‘Sex and Gender Differences in Pain: A Selective Review of Biological and Psychosocial Factors’ (2006) 3 \textit{Pain} 236-243.

\textsuperscript{48} Bendelow & Williams, above n18 at 282, 288, 289.
believed they were going to be sent home and would no longer have to face armed combat. By comparison, for the civilian group an operation represented a major upheaval and pain might have meant that something had gone wrong with the surgery so in their case, less extensive wounds were associated with a higher level of reported pain.49

There is evidence to suggest that pain can be experienced as a result of mere suggestion. Morris cites a study in which 100 volunteers who agreed to take part in an experiment were told they might have a headache afterwards. Half of the subjects reported a headache even though there was no real risk whatsoever of a headache from taking part in the study.50 He also cites a condition known as Couvade syndrome in which the male partners of pregnant women take to their beds and groan with abdominal pain whilst their wives give birth in the fields.51

Clearly, pain is a much more complex experience than the dominant voices within the discipline of medicine would have us believe. However, when it comes to requests to be assisted to die, it appears that physical pain is rarely the sole or prime motivating factor and, there are differences in motivating factors across different disease types. In the case of cancer patients, there is a considerable body of evidence to suggest that depression, with or without hopelessness, is the factor most likely to lead to a request to die earlier.52

49 H Beecher, ‘Relationship of Significance of Wound to Pain Experienced’ (1956) 161 Journal of the American Medical Association 1609 at 1609, 1612.
Other factors of an existential nature that have been found to have some bearing on the experience of pain include: transitory and personality-based anxiety; a feeling of helplessness and neuroticism; severe existential distress; family member and health care worker fatigue; dependency; and spiritual pain as a result of a loss of a sense of belonging and connection.

Research in relation to patients living with HIV/AIDS suggests that among this group, a desire to die sooner may result from a perceived ‘loss of self’ due to a loss of function and a loss of opportunities to initiate and maintain close relationships. Requests to be assisted to die may also result from pain and discomfort (causing a poor quality of life), fears for the future and feelings of exhaustion, hopelessness and being ‘over it.’

A similar picture emerges in requests for euthanasia that are or were made under enacted legislation. In the eight annual reports that have been published to date in


53 Thomas, above n25 at 21-26.


57 This group has been a driving force in the call for legalised euthanasia in recent times. See R Magnusson, Angels of Death: Exploring the Euthanasia Underground (2002). However, due to new forms of anti-viral drug therapy those who are diagnosed with HIV nowadays can anticipate a normal life expectancy provided that they adhere to the drug regime prescribed for them: personal communication between Dr L Dayan, Staff Specialist in Sexual Health, and V Hiley (10 January 2007).


59 Magnusson, above n57 at 2, 77, 86. This sentiment is not limited to those living with HIV/AIDS. Being ‘over it’ was the motivating factor for assisted dying for Nancy Crick whose circumstances are discussed in Chapter Two and for Edward Brongersma whose circumstances are discussed in Chapter Five.
relation to the ODDA, the predominant concerns of those who sought to die sooner were: loss of autonomy; loss of the ability to engage in enjoyable activities; and loss of dignity.\textsuperscript{60} Similarly, of the seven\textsuperscript{61} patients who sought assistance to die whilst euthanasia was legal in the Northern Territory of Australia, existential concerns were paramount. One denied being depressed but had attempted suicide a year earlier and spoke of feelings of bitterness before successfully committing suicide. Six complained that the side effects of their illness could not be adequately controlled which arguably had a major negative impact on quality of life. Four had symptoms of depression. Only one had uncontrolled pain but pain was only one of a number of factors leading to such a poor quality of life that the person wanted assistance to die. Physical pain was not an issue at all for six of the seven patients. The dominant theme for each of the seven was existential in nature; a poor quality of life arising from physical symptoms that could not be


Note, however, that in the 2006 report more participants were concerned about inadequate pain control at the end of life than in previous years. This concern was mentioned by 48 per cent of 46 subjects in that year whereas only 22 per cent of the 246 patients who died pursuant to the ODDA from 1998 to 2005 mentioned inadequate pain relief as an issue. Additional data are needed to confirm whether this is an anomaly or an emerging trend. Further, it is not clear from existing data whether subjects were in pain or were fearful that they might be in pain near the end of life.

\textsuperscript{61} See D Kissane, A Street & P Nitschke, 'Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act' (1998) 352 \textit{The Lancet} 1097 at 1098. See Chapter Two for discussion of the situation in the Northern Territory of Australia during 1996.
effectively palliated such as itching, nausea, vomiting, incontinence, shortness of breath, extreme weight loss, and being unable to care for oneself.62

Notwithstanding growing evidence of the importance of existential factors in generating requests to die, mainstream medicine has only just begun to grapple with the concept of suffering (existential pain). According to Woodruff, instruments that have been developed to date are primarily used in clinical trials of the efficacy of cancer treatment. They are too long to be completed by terminally ill patients and focus upon the intensity of symptoms rather than the emotional effect of those symptoms thus they may not measure what is important from the patient’s perspective regarding quality of life.63

Cassell suggests that mainstream medicine’s adherence to a Cartesian understanding of pain, which sees the mind and the body as separate and pain as an experience of the body, is preventing the development of a more nuanced understanding of existential pain at this time:

> The relief of suffering, it would appear, is considered one of the primary ends of medicine by patients and the general public, but not by the medical profession, judging by medical education and the responses of students and colleagues. As in the care of the dying, patients and their friends and families do not divide suffering into its physical and nonphysical sources, the way doctors do who are primarily concerned with the physical … as long as the mind-body dichotomy is accepted, suffering is either subjective and thus not truly ‘real’ – not within medicine’s domain – or identified exclusively with bodily pain … suffering occurs because our intactness as persons, our coherence and integrity, come not only from the intactness of the body but from the wholeness of the web of relationships with self and others … 64

To summarise thus far, whilst sophisticated forms of the gate control theory of pain, which acknowledges that there is always an existential aspect to the experience of pain, continue to dominate medical thinking today, medical

---

62 Kissane et al, above n61 at 1098-1101.
63 R Woodruff, Palliative Medicine (4th ed, 2004) at 14, 15. An instrument that is more patient and quality of life focused has been developed by NSW Health: email from Associate Professor A Duggan, staff specialist in gastroenterology at John Hunter Hospital, to V Hiley (10 December 2007).
64 E Cassell, The Nature of Suffering and the Goals of Medicine (1991) at 32, 34, 40
practitioners continue to privilege the physical aspect of pain. It has been theorised by Kotarba that this situation persists because medicine is a conservative discipline which tries to bring anomalies into its existing framework rather than to allow new frameworks to be created. In addition, the dividing of pain into physical or organic is convenient: it fits the one disease/one cause paradigm that is the hallmark of traditional Western medicine; it is conducive to medical intervention; and it focuses on causes of pain that are easier to deal with.65

Having outlined changing sensibilities and attitudes in relation to pain and suffering and having showed that medicine’s understanding of existential pain is limited, I now turn to consider whether the attitude of mainstream medicine is replicated in the subspecialty of palliative care by discussing original research that I carried out in 2000 among palliative care specialists.

3. The Palliated (? Good) Death

During the 1960s, with the rise of the hospice movement, a new version of the good death began to emerge: the palliated good death. Hospice doctors began to hold themselves out as being able to facilitate a good death comprising open awareness, truth telling, acceptance of impending death, the free expression of feelings and the search for a sense of meaning and trust so that patients could live life to the fullest extent possible before they died.66 Early notions of the good death were heavily influenced by Dr Elisabeth Kübler-Ross’ theory of the five stages of dying: denial; anger; bargaining; depression; and acceptance.67 Whilst Dr Kübler-Ross’ work is much less influential in end-of-life care today, there is still a focus on the dying person achieving acceptance of death in palliative care’s version of the good death.68

68 J Hare, ‘The Hospice Movement and the Acceptance of Death’ in A Kutscher & L Kutscher (eds), Hospice USA (1983) at 9, 10, 15.
On one view, palliative care can be interpreted as a counter culture within mainstream medicine. However, the provision of palliative care still medicalises the experience of dying and removes it from the experience of the community. In *The Loneliness of the Dying*, Elias decried this trend:

> Never before in the history of humanity have the dying been removed so hygienically behind the scenes of social life; never before have human corpses been expedited so odourlessly and with such technical perfection from the deathbed to the grave.\(^{69}\)

Negative attitudes toward the way in which many people die at this time, may explain why the right to die movement has gathered momentum in recent years. In contrast to the palliated good death, the alternative version of the good death advanced by the right to die movement is increasingly shaped neither by religious ideology nor by the rules of medicine but more by notions of living only for so long as quality of life is acceptable and only for so long as a person is in control of his or her own destiny.\(^{70}\)

The tension between the palliative care version of the good death and that proffered by the right to die movement prompts us to ask whether the palliative care version of the good death is in fact good, or not. I turn to consider this issue in the context of independent research that I carried out in Sydney in 2000. I begin by discussing previous research that has been carried out in relation to notions of the good death.

---


A. Previous Research

Two key studies have been carried out in relation to the ability of palliative care workers to deliver a good death experience. Neither focused on the attitudes of palliative care experts. Both call into question the ability of these groups to facilitate a good death. The first study was carried out by McNamara in the early 1990s in a palliative care community in Western Australia. The initial research was followed up by 14 months of participant observation in a 26-bed free-standing inpatient hospice which included a day hospice and a community care service covering an entire metropolitan area. The results of the study were not published until 2004. McNamara gathered her data by: open-ended interviewing of 32 health care professionals; attending family conferences, counselling sessions and clinical team meetings; attending nursing handovers; and by informal observations in staff rooms. Comments made by the research subjects led McNamara to conclude that the staff were aware that palliative care workers are not always able to provide a good death. The staff put this down to an increasing climate of patient autonomy and consumer choice and they tended to be satisfied with facilitating a death that was good enough. To do this they focused on alleviating physical pain and discomfort.

Research has also been carried out in relation to the views of patients and of nurses as to what constitutes a good death. Kellehear, examining the experiences of cancer patients at the end of life, found that the key features of a good death were: the social life of the dying person; open awareness; social adjustment and personal preparation; public preparations such as in relation to work; and, final farewells: A Kellehear, *Dying of Cancer: The Final Year of Life* (1990). Wilkes found that 16 nurses believed that a good death involved the patient being comfortable, alert, pain free, accepting and surrounded by their family: L Wilkes, ‘Nurses’ Descriptions of Death Scenes’ (1993) 2 *Journal of Cancer Care* 11-16 cited in S Payne & A Langley-Evans, ‘Perceptions of a ‘Good’ Death: A Comparative Study of the Views of Hospice Staff and Patients’ (1996) 10 *Palliative Medicine* 307 at 309. Taylor, who studied Australian nurses’ perceptions of a good death, discovered that it encompassed giving support, gaining trust, effective symptom control, and making a difference: B Taylor, ‘Hospice Nurses Tell their Stories about a Good Death: The Value of Storytelling as a Qualitative Health Research Method’ 3 (1997) *Australian Review of Health and Social Science* 97. See also Payne & Langley-Evans, above, ‘Perceptions of a ‘Good’ Death’: on reviewing semi-structured interviews carried out with 18 patients who were dying and 20 staff of various disciplines at a palliative care facility in the south of England, the authors found that there were major differences between staff and patients as to what constitutes a good death. Patients focused on dying quietly, painlessly, suddenly or in one’s sleep whilst staff focused on symptom control, family involvement, peacefulness and lack of distress.

The second study was carried out by Lawton in 1994. Lawton worked as a volunteer in a palliative day-care centre and a hospice, in England, for a period of ten months. She discussed experiences of dying with all of the patients who consented to take part in the study, attended all professional group meetings and had access to all areas of both palliative care facilities. Lawton was primarily concerned to challenge Western views which focus on the person as a physical entity. She did this by carrying out empirical research into the experiences of dying patients who were receiving palliative care.73 However, her findings are also relevant to the ability of palliative care experts to facilitate a good death.

Focusing on the experiences of dying patients, Lawton noted that bodily deterioration frequently had an extremely debasing impact on a person’s sense of self and his or her ability to sustain relationships with family and friends. In her research results, published in 2000, Lawton questioned whether it is realistic to expect or to hope for a good death in the hospice setting because the palliated good death is based on a disembodied conception of the dying patient. Palliative care does not fully apprehend the lived experience of dying patients. Thus, Lawton questions the relevance of palliative care to contemporary debates about death and dying,74 let alone its ability to facilitate a good death.75

Having outlined previous research in relation to the ability of palliative care workers to bring about a good death, I now turn to outline my research question before moving on to explain the methodology that I adopted.

---

73 J Lawton, The Dying Process: Patients’ Experiences of Palliative Care (2000) at 1, 2
74 The palliative care movement faces a number of significant challenges. In 1994, McNamara et al spent eight weeks interviewing 22 nurses in an inpatient hospice unit and a community-based hospice service. She found that the hospice ideal faces five challenges: encroachment by mainstream medicine and the medical technical imperative; differences in attitudes between patients, relatives and staff about open communication; imposition of the organisation’s view of the good death on patients; focus on patient compliance rather than autonomy; and the routinisation of the hospice’s version of the good death: B McNamara, C Waddell & M Colvin, ‘The Institutionalization of the Good Death’ (1994) 39 Social Science & Medicine 1501-1508.
75 Lawton, above n73 at 179.
B. Research Question

On the basis of the literature reviewed in Part 2 above concerning changing attitudes and changing sensibilities in relation to pain and suffering, I decided to investigate whether palliative care experts de-emphasise the importance of existential pain in their clinical practice and privilege physical pain. In addition, I decided to theorise how their attitude to pain impacts upon their ability to make possible a good death.

C. Research Methodology

My research was approved by the University of Sydney in November 1999. In December 1999, I asked the Palliative Care Association of New South Wales for a list of palliative care experts in Sydney and surrounding suburbs. Each of the population of 26 palliative care experts identified, all of whom were qualified medical practitioners, was sent a letter inviting him or her to participate in a study regarding ‘the attitudes of palliative care experts to the legalisation of active voluntary euthanasia and/or doctor-assisted suicide.’ Specialists who did not respond to the letter were followed up by telephone on two occasions.

The population comprised 14 males and 12 females. Of the 13 subjects who took part in the study, seven were female and six were male therefore there was no gender bias inherent in the population or in the sample. Two of the population of 26, both female, indicated either directly or through their secretary that they wished to have no involvement in the research despite being assured that the information gleaned would be kept confidential and that anonymity was guaranteed. A further three subjects, one male and two female, indicated that they wanted to take part in the study but did not respond to telephone messages following them up. Eight subjects did not respond either to the initial letter or to telephone follow-up and one could not be located.

76 See Appendix 6 for the text of the letter inviting subjects to take part in the study.
Subjects were not randomly selected because the small size of the research population allowed all members of the population to be included. The resultant sample of 13 was 50 per cent of the entire research population and so the results are likely to be meaningful. However, the results are limited in that outcomes were highly dependent on subjects giving honest answers in circumstances where they were asked questions such as whether they had ever killed a patient or assisted a patient to commit suicide. In addition, it is possible that the results were skewed by subjects with stronger views agreeing to take part in the study rather than subjects with less passionate views. Further, the conclusions that can be drawn are limited in that demographic variables such as age, religion and ethnic background were not elicited. Notwithstanding these limitations, the results are indicative of the attitudes held by at least half of the palliative care specialists in Sydney and surrounding suburbs in 2000.

Each palliative care expert who agreed\textsuperscript{77} to take part in the study was interviewed for between 30 and 40 minutes. The interview questions\textsuperscript{78} were designed in consultation with Roger Magnusson.\textsuperscript{79} The questions were not pilot tested because of the small size of the sample. The interviews were semi-structured and usually took place in the subject’s work place, in private. All subjects who were interviewed were interviewed in person, except one subject who was unable to attend an interview due to work pressures but agreed to be interviewed by telephone whilst driving between appointments. Subjects were asked a series of ten questions as outlined below.

1. How long have you been practicing as a palliative care specialist?

2. In your experience, can palliative care control pain to a level that is satisfactory to the patient on every occasion?

\textsuperscript{77} See Appendix 7 for the consent to take part in the research.

\textsuperscript{78} See Appendix 8 for the text of the interview questions.

\textsuperscript{79} Associate Professor, Faculty of Law, University of Sydney.
3. Have you had any cases in which palliative care did not control the patient’s pain? Why did this occur? What measures were taken to make the patient as comfortable as possible?

4. Do you consider active voluntary euthanasia or doctor-assisted suicide to be valid alternatives to palliative care? In what circumstances?

5. Have you ever had a patient request active voluntary euthanasia or doctor-assisted suicide? What was your response? How many patients (if any) have you assisted in this way?

6. Do you consider euthanasia to be compatible with the goals of medicine? In your view, what are the goals of medicine?

7. Do you believe that the introduction of legally-available euthanasia would result in a decrease in funding for palliative care? How do you think this would occur?

8. What sort of palliative care measures do you offer?

9. Do you believe the introduction of legally-available euthanasia would lead to a decreased level of effort by palliative care specialists or that it would lead to a loss of interest in finding cures for diseases? If so, how do you think this would come about?

10. What do you see as the problems for palliative care and for medicine in general if euthanasia were re-legalised in this country?

I now turn to outline the subjects’ responses to the research questions. I then go on to discuss the implications of the responses.

D. Subjects’ Responses

The average length of time that the subjects had been in practice since gaining a medical degree was just under eight years. The longest period of time any subject had worked as a palliative care specialist was 14 years. Two of the subjects had previously worked in medical oncology and one had worked as a general practitioner. The balance of the subjects (10) had only ever worked in the area of palliative care.

80 See Appendix 9 for a table summarising the major themes in the subjects’ responses to the interview questions.
In response to the second question, whether palliative care measures can reduce pain to a level that is acceptable to the patient on every occasion, every subject said ‘no’. However, when asked to estimate the efficacy of palliative care, the range of efficacy claimed was quite high. The lowest efficacy rate claimed was 85 per cent and the highest 98-99 per cent. The most common response was 98-99 per cent.

In dealing with the third question, why palliative care is not always effective, I did not refer to categories of pain. Subjects were asked: ‘Have you had any cases in which palliative care did not control the patient’s pain? Why did this occur?’ Nine of the subjects referred to nerve pain as the culprit. Nerve pain was said to be treated with nerve blocks, sedation and pain control. Two of the subjects referred to bone pain. Bone pain was said to be treated with large doses of pain relief such as morphine. One subject referred to increased intracranial pressure. All of the subjects referred to emotional pain as a cause of palliative care being ineffective. Some of the subjects used the term ‘emotional pain’, some used the term ‘existential pain’ and others used the term ‘psychogenic pain’ or ‘psychiatric pain’ to mean pain that is not physical. One subject referred to rapid onset of disease being a cause of pain and said it was treated by counselling and ‘resetting goals’. One subject said that pain was not an issue in the case of patients living with HIV/AIDS, rather, the issue was loss of function.

All subjects appeared to think of pain in accordance with the Cartesian mind/body divide; pain was either physical or mental in origin. Estimates of pain control failure due to existential pain were extremely broad. One subject estimated it as ‘rare’ whilst another stated that such pain occurs in 100 per cent of cases in which palliative care is ineffective. Patients suffering from existential pain were sedated and/or referred to a counsellor or a psychiatrist to identify and deal with ‘unresolved issues’. One subject mentioned the use of palliative (terminal)
sedation\textsuperscript{81} in this context but said its use was rare. Palliative sedation is a matter to which I return in the final chapter of this thesis.

The following are the responses that were given to this question.

For 15-20 per cent there is nerve involvement, a psychiatric component or drug dependency which means that the drugs don’t work. In this case I use nerve blocks or sedation.

This includes nerve pain and pain due to raised intracranial pressure. Nothing works for about 1 per cent of patients due to emotional pain. I offer the patient the full gamut of palliative care.

In about 20 per cent of cases there is a problem controlling pain due to nerve or bone pain. One per cent can’t be helped at all but they can be sedated. Existential pain is a problem in about 10 per cent of cases and is untreatable in one per cent of these cases. I offer counselling and sedation.

Some pain such as nerve pain is difficult to control. Also distress which is spiritual or existential. Five per cent of cases are due to nerve pain, another 5 per cent are due to psychiatric distress … For about 5 per cent of cases, pain cannot be controlled no matter what you do. I offer nerve blocks and sedation.

One or two per cent of cases cannot be controlled because of nerve or bone pain … There is psychological overlay in about 100 per cent of these patients. It is often in combination with physical pain. I give sedation and organise counselling.

Eight five to ninety five per cent of pain can be controlled. In the 10-15 per cent that can’t be controlled it is due to nerve pain involving cancer in difficult areas such as head and neck, tongue and tonsil or bone pain. About 1 per cent is due to psychiatric issues. I offer nerve blocks and counselling.

Two per cent cannot be controlled due to rapid onset of disease causing new symptoms, anxiety and other emotional problems … Most often it is the result of psychiatric issues. I arrange counselling and re-setting of goals.

In about 1-2 per cent you cannot control pain and this may be due to nerve pain or due to psychogenic problems. I use nerve blocks and sedation.

Pain is not so much the problem in patients with HIV. They only require small amounts of analgesia because they become physically wasted. The real problems are blindness and deafness. About 5 per cent have existential pain. I offer sedation and arrange counselling.

Five per cent are difficult … usually due to nerve pain or threshold issues … such as depression, isolation or lack of support … a patient may not be mature enough emotionally to accept death. I give sedation and organise counselling.

About 5 per cent … usually due to nerve pain … pain on movement … psychiatric issues for example depression, anxiety, social problems, unresolved issues, existential suffering … 5 per cent are due to unresolved emotional issues. I use nerve blocks, anti-epilepsy drugs, epidurals and morphine.

Two per cent [can’t be controlled] … it is often incident pain (pain on moving) or anguish. The pain also might be due to personal reasons for example an inability to come to terms with illness. I give narcotic analgesia and offer counselling.

Pain can be relieved in about 90 per cent of cases … 10 per cent of pain can be partially but not completely controlled. A small per cent is due to mental suffering but this is rare. In most cases it is due to an organic (physical) reason. I give analgesia and arrange counselling so the patient feels more in control.

In general, existential pain was seen as a matter for the mental health team rather than as a matter to be dealt with by palliative care experts. The subjects exhibited little interest in discussing existential pain. Each indicated this in one way or another: by changing the topic of conversation; by rolling his or her eyes; by looking slightly pained; or by looking away. As a result, I formed the impression that such pain was viewed with disinterest by all of the subjects to a greater or lesser extent.

When asked about giving gradually increasing doses of narcotic analgesics in the knowledge that this may contribute to a patient’s death (also referred to as pyramid pain relief), two subjects stated that they are able to so carefully titrate the amount of pain relief administered to the patient that the patient’s life is never
shortened. As noted in Chapter Two, this practice is sanctioned in the common law jurisdictions by the DDE\textsuperscript{82} and is considered to be in keeping with the SLD.\textsuperscript{83} All of the subjects appeared to approve of the practice of passive euthanasia in that none said it should not be engaged in. None of the subjects interviewed admitted to having administered pain relief to a patient with the intent of shortening the patient’s life.

Despite evidence that some Australian doctors engage in euthanasia and/or support its legalisation,\textsuperscript{84} all subjects answered ‘no’ or ‘never’ when asked whether AVE or AS are ever valid alternatives to palliative care.\textsuperscript{85} The following are typical of the responses given and suggest that attitudes were more contradictory and complex than one might expect.

There are always alternatives to euthanasia.

No, they [AVE and AS] are never valid alternatives.

No, not for patients but for myself, I would like the option of assisted suicide at the end of my life. People should organize their own death or get some assistance but it is not necessary for palliative care specialists to do it.

No, all lives are worth living.

It is often the case that the patient’s goals have not been clarified [when they ask for assistance to die].

Such people should go to the Hemlock Society.

No, but they might be valid outside the context of palliative care.

In response to the fifth question, whether the subject had ever been asked by a patient for assistance to die, all but one of the subjects answered ‘yes’. When asked how many times requests for euthanasia had been received, the range of

\begin{flushleft}
\textsuperscript{82} The doctrine of double effect.
\textsuperscript{83} The sanctity of life doctrine is discussed in Chapter One.
\textsuperscript{84} See Appendix 1.
\end{flushleft}

160
answers was very broad with the maximum number of requests cited at 40-50 and the minimum at none.

None of the subjects had provided a patient with assistance to die. Six of the subjects had responded to a request by trying to find the underlying cause for the request and/or by reassuring the patient or providing the patient with more information in order to make the patient feel more ‘in control’. One subject mentioned that the patient should be encouraged to ‘re-set [his or her] goals’ suggesting that a goal of dying sooner simply was not a valid desire in that subject’s view. A request for assistance to die was, by and large, viewed as a technical problem that could be solved by a technical approach. If this failed, then it was considered no longer to be a palliative care problem but was re-categorised as a problem for the mental health team to deal with and a referral was arranged.

Most of the subjects appeared comfortable with the concept of suicide whilst at the same time being demonstrably uncomfortable with the concepts of AVE and AS. The following comments, which are representative of views that were elicited in relation to these practices, suggest that attitudes among the subjects were not united:

Suicide is OK but euthanasia is not – it is killing

I would not provide either but I would be prepared to refer the patient to the Euthanasia Society.

I have no problem with suicide and self-deliverance already exists in the HIV community but I don’t agree with euthanasia.

I reassured a patient a few years ago that I would assist him to die but I would not have acted on what I said.

I might intervene if I thought someone wanted to commit suicide but I would need a high degree of suspicion. I wouldn’t help someone to die.

I would not stop someone from committing suicide but I wouldn’t help them to die myself.

I have known of planned suicides and not intervened.

I wrote ‘HIV’ as the cause of death on a Death Certificate but I knew that in fact the patient had committed suicide.
In response to the sixth question, ‘Do you consider euthanasia to be incompatible with the goals of medicine?’ all but three of the subjects answered ‘yes’. One subject stated that euthanasia was contrary to his own personal ethics rather than the goals of medicine whilst two stated that euthanasia was not necessarily incompatible with the goals of medicine in that the subject could see that euthanasia might end suffering but it should not be allowed. In setting out the goals of medicine, most of the subjects focused on the provision of comfort and care, doing no harm and relieving pain. One respondent stated that although the goals of medicine are to improve quality of life and to treat illness, medicine is futile in that everyone will die. This was not a typical response. The following are representative of the answers that were given in response to this question.

The goal of medicine is to achieve health – euthanasia does not do that.

Euthanasia may end suffering but doing it by ending life is not the goal of medicine.

Doctors should not engage in euthanasia.

Euthanasia is active killing. The goal of medicine is to do no harm so they are incompatible.

Killing people is not the goal of medicine.

In response to the seventh question, whether the legalisation of euthanasia would result in a decrease in funding for palliative care, seven of the thirteen subjects answered ‘yes’. Most thought that this would occur because there would be a decrease in demand for palliative care services. Six voiced concerns about the progress of palliative care as a specialty should euthanasia be legalised either as a result of a decrease in funding or demands that palliative care justify its existence by showing an ability to generate revenue (which it does not do) in the same way that other more glamorous areas of medicine are able to do such as surgery. Of the five subjects who answered ‘no’ to this question, most reasoned that patients would not be interested in euthanasia as an option. Only one subject out of the entire sample mentioned that palliative care services improved in the Northern Territory.
following the enactment of the ROTIA. Only one subject mentioned that neither major political party in Australia at the Federal level, from whence the funding for health care services comes, supported the legalisation of euthanasia.

All subjects gave the same response when asked about the eighth question as to the treatments that are offered by palliative care. This question was a distracter, posed with the intent of preventing subjects from becoming defensive in the manner in which they answered the balance of the questions which dealt with AVE and AS and their feelings about palliative care and its place in medicine. Each subject confirmed that a multidisciplinary approach is adopted in treating patients who are terminally ill. Further questioning revealed that a multidisciplinary approach involves a broad range of disciplines such as social work, psychiatry, occupational therapy, nursing, physiotherapy, palliative care medicine, pharmacy and pastoral care. A multidisciplinary approach encompasses a broad range of therapies such as: hot packs; cold packs; massage; anti-depressants; counselling; spiritual support; diversion therapy; physiotherapy; acupuncture; drugs to counter anxiety; pyramid pain relief (gradually increasing doses of analgesia such as morphine) and palliative sedation.

In response to the ninth question whether legalised euthanasia would lead to a decreased level of effort by palliative care specialists or a loss of interest in finding cures, nine of the thirteen subjects answered ‘no’ and one said ‘possibly’. Most reasoned either that people will never stop wanting to live as long as possible or that palliative care experts are against legalising euthanasia and would remain committed to the principles of palliative care. Three subjects said that legalising euthanasia could lead to a loss of interest in finding cures but not to a loss of interest by palliative care experts in providing palliative care.

The responses to the tenth question as to what problems would be faced by medicine and society in general if euthanasia were legalised revealed a high

---

86 See Chapter Two for discussion of the ROTIA and the ODDA. Compare the situation in Oregon. Oregon reportedly became ‘a laboratory for improvements for care of the dying’ after the ODDA was passed: J
degree of concern that the value of palliative care as a specialty would be called into question. Nine subjects referred to the problem of the ‘slippery slope’ namely that legalisation of euthanasia would lead to uncontrolled abuse. Five of the thirteen subjects considered that the legalisation of euthanasia would have negative implications for palliative care as a specialty by undermining its authority and status or by instilling fear into people of what palliative care experts might do to them. Four voiced concerns about being forced to provide euthanasia. The following responses are representative:

People would think that palliative care means euthanasing people.

People are already reluctant to have palliative care. They think that it is going to kill them. This situation would worsen.

It would put immense pressure on palliative care experts to come up with all the answers and to get involved in euthanasia.

There would be an expectation to provide euthanasia.

People are already mistrustful of palliative care. That would become worse.

Palliative care would be forced to show results as other areas of medicine such as surgery have to in order to get funding.

It would slow down the progress of palliative care as a specialty.

There would be no chance to carry out palliative care.

E. Discussion of the Subjects’ Responses

The research subjects were mostly experienced palliative care practitioners who had had little to do with other areas of medicine other than the obligatory training as an intern, a resident and as a registrar prior to specialising in a particular area of medicine. Thus, the majority were likely well schooled in the ideology of palliative care which is to facilitate a good death experience by providing comfort care and by assisting patients to come to accept their impending death.  

\[87\]


\[87\]

Given that there are still some commentators in the euthanasia debate who insist that pain can be controlled on virtually all occasions to a satisfactory level and who use this to reason that euthanasia should therefore remain illegal, the subjects’ responses to the second question as to whether palliative care works for all patients, were refreshingly honest. Moreover the answers reflect retrospective research carried out in South Australia which revealed that 25 per cent of 56 patients did not appear, from a relative’s point of view, to have had adequate pain control near the end of life. Responses were also in keeping with the position that has been adopted by Palliative Care Australia:

> While pain and symptoms can be addressed, complete relief is not always possible in all cases, even with optimal palliative care.

In terms of textbook answers to this question, satisfactory pain control is said to be possible for about 90 per cent of patients with advanced cancer (who form the bulk of the hospice population) using drugs and other treatments that are presently available, in conjunction with treatment of psychosocial issues. It is interesting to note that, in light of this, the majority of the subjects actually overstated the efficacy of palliative care.

The broadness in the range of efficacy claimed by the subjects suggests that more research needs to be carried out in this area to find out whether pain and/or suffering are ever missed due to factors such as communication difficulties or factors that emerged in the literature review, such as ethnicity and gender. It is also possible that existential factors which can interfere with adequate pain relief such as depression are sometimes misdiagnosed. According to Emanuel, medical

---


91 Woodruff, above n63 at 53.
practitioners who do not specialise in psychiatry are generally poor at suspecting, identifying and diagnosing depression.\textsuperscript{92}

Answers to the third question in relation to the efficacy of pain control revealed that all subjects thought in terms of a Cartesian understanding of the body. Given that existential pain is implicated in requests to be assisted to die the lack of interest that was shown in it by the subjects was troubling. Only one subject stated that existential pain is present in 100 per cent of cases in which palliative care is ineffective. It is arguable that the lack of interest in existential pain exhibited by the subjects and the readiness with which referrals were made to other specialists could leave some hospice patients feeling abandoned and could lead some to feel that the delivery of care was fragmented rather than holistic which is the mode of care that palliative care promises to deliver. Given that modern palliative care textbooks acknowledge a symbiotic relationship between pain and suffering,\textsuperscript{93} it may be that attitudes have changed since the time of my research and/or that specialists do know of the importance of existential pain, in theory, but do not put this knowledge into practice.\textsuperscript{94}

The subjects’ defensive responses to discussion around passive euthanasia is not surprising given that so much of the literature that deals with passive euthanasia asserts that it is intellectually dishonest to allow passive euthanasia as a matter of public policy whilst criminalising AVE and AS.\textsuperscript{95} The basis for the argument is that there is no practical difference between the two.\textsuperscript{96}

\textsuperscript{92} Emanuel, above n1 at 6457.
\textsuperscript{93} See, for example, Woodruff, above n63 at 7-10, acknowledging criticism within and outside medicine of the limitations of the biomedical model of pain. See also, M Bennet, K Forbes & C Faull, ‘The Principles of Pain Management’ in C Faull, Y Carter & L Daniels (eds), \textit{Handbook of Palliative Care} (2\textsuperscript{nd} ed, 2005) at 116-188, without acknowledging criticism of the biomedical model of pain.
\textsuperscript{95} See for example, H Kuhse, ‘Euthanasia’ in P Singer (ed), \textit{A Companion to Ethics} (1993); J Rachels, ‘Active and Passive Euthanasia’ in J Rachels (ed), \textit{Moral Problems} (3\textsuperscript{rd} ed, 1979).
\textsuperscript{96} See the discussion of this topic in Chapter Three.
The fact that none of the subjects admitted to having shortened a patient's life by using pain relief is unsurprising given that this is completely anathema to the goals of palliative care and that such an admission would draw fierce criticism from proponents of legalised euthanasia. However, the responses are not consistent with my 13 years experience as a registered nurse in a large teaching hospital in Sydney (albeit not in the area of palliative care) where it was openly acknowledged amongst many of the nursing staff and some of the medical staff (but not to patients or their relatives) that it was acceptable to help a dying person to die sooner with the liberal use of pain relief. Pain relief was often given on a regular basis, whether or not there was any sign that the patient was in pain, particularly when a patient was moribund.  

It is also contrary to studies into the behaviour patterns of doctors in other areas of medicine in Australia. It may be that a commitment to palliative care medicine and a desire to see this relatively new specialty survive entails a refusal to ever engage in, admit to having engaged in, or sanction this type of conduct.

The fact that subjects were united in their rejection of AVE and/or AS as valid alternatives to palliative care in response to question four and that none had assisted a patient to die was anticipated. What I did not anticipate were the ____________

97 See A Strauss, 'Dying and Painless Comfort' in Politics of Pain Management: Staff-Patient Interaction (1977) at 157: 'If both doctor and nurse are aware that the patient is in the 'nothing-more-to-do' phase, then the doctor's instructions are very likely to allow the nurse to use her own discretion in the dosage necessary to keep the patient free of pain ... 'None of the nurses believe in euthanasia, but it's just that as you give these heavy doses of narcotics you think that this may be the last one he can take.' One nurse reported that her instructions gave her leeway that would allow the patient to die in the line of her duty. The implicit instruction was: 'Give [this degree of medication] to the patient every ___ hours until dead.'

subjects’ responses to the topic of suicide; some had provided a referral for assisted death, others had not intervened in a suicide and one subject had falsified a death certificate for a patient with HIV/AIDS, knowing that the patient had committed suicide. These results are hard to reconcile but perhaps highlight themes discussed in Chapter Two and Chapter Three: the degree to which people’s thinking about euthanasia is contradictory and messy and informed by moral dogmas such as the DDE and the SLD rather than by critical analysis. In addition, the results suggest that some subjects were able to separate the private sphere from the professional sphere. It is also possible that subjects were anxious to avoid any personal liability although, as we saw in Chapter Two, involvement can be difficult to establish in cases of alleged AS.

In response to question five, the incidence of requests for euthanasia ranged widely and was not consistent with commentary which suggests that such requests are comparatively rare.99 The subject who reported no requests was a person who was slightly taciturn and aloof during the interview. The subject who reported the most requests was of a more outgoing, open nature. Thus it is possible that practitioners, by their behaviour, either make patients feel that they can discuss contested issues with them or that such conversations would not be welcome. This may well be the situation with the practitioner who said such patients should re-set their goals. It is also likely that those who want assistance to die reject palliative care at the outset or soon afterwards as was the case with Bob Dent and Janet Mills who sought assistance to die pursuant to the ROTIA.100

The responses of the majority when asked questions seven, nine and 10 were not well-informed when we consider that palliative care services improved in the Northern Territory as a result of people seeking euthanasia under the ROTIA. That almost half of the subjects expressed concern about the future for palliative care as a specialty suggests that job protectionism may have been a major concern in addition to a desire to help dying patients. Concern about the status of palliative

99 C Saunders (ed), Hospice and Palliative Care: An Interdisciplinary Approach (1990) at 105.
care is consistent with the fact that palliative care did not become a recognised specialty until April 2006 and was not recognised for the purpose of the Medicare rebate until May 2006 even though the Royal Australasian College of Physicians has been training doctors in palliative care for more than 15 years. It is also consistent with the fact that palliative care is an area of medicine which is always potentially under threat because it is unable to justify its existence by generating funds for the government.

Responses to the eighth question seeking a description of palliative care were consistent among subjects and were in keeping with standard definitions which promise a mode of care which is comprehensive and holistic:

A concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person’s choice, and which provides physical, psychological, emotional and spiritual support for patients and their families and friends. The provision of hospice and palliative care services includes grief and bereavement support for the family and other carers during the life of the patient, continuing after death.

F. Palliative Care Experts and the Good Death

Extrapolating from my research results, I consider that it is likely that the ability of palliative care specialists to facilitate a good death is hampered for a number of reasons. Firstly, as we saw in Chapter One of this thesis, there is no one version of the good death. Yet, the hospice version of the good death is relatively inflexible with its focus on accepting one’s impending death. Secondly, it is likely that by de-
emphasising existential pain, palliative care experts cause some hospice patients to feel that an integral aspect of their experience is devalued. Finally, the tendency to refer these patients to the mental health team could leave some patients feeling that an arguably normal reaction to their predicament is inappropriately medicalised.

4. A better way forward?

Given that medicine’s view of pain and suffering as a predominantly physical event likely hampers the ability of palliative care specialists to deliver a good death and given that draft euthanasia legislation is typically based on the conventional medical interpretation of pain and suffering, the question arises whether there is a better way of responding to changing sensibilities in relation to death and dying in the context of the good death.

Morris has called for the development of a new, biocultural model of pain which would rest on four claims: pain is more than a medical issue and more than a matter of nerves and neurotransmitters; pain has historical, psychological and cultural dimensions; meaning is often fundamental to the experience of pain; and minds and cultures, as makers of meaning, have a powerful influence on the experience of pain. Morris criticises the existing biomedical model noting that it gives doctors the sole authority to speak about pain. He argues for the need to give serious attention to patient narrative in relation to the ‘lived reality’ of suffering as a social and knowable phenomenon, which he argues medicine tends to ignore in its quest to be recognised as a hard science.


105 Id at 215 acknowledging that the term ‘social suffering’ was coined by Kleinman & Kleinman in ‘The Appeal of Experience; the Dismay of Images; Cultural Appropriations of Suffering in our Times’ in A Kleinman, V Das & M Lock (eds) Social Suffering (Berkeley, University of California Press: 1997) 1-23.

106 Id at 12, 132, 194, 251.
Outside the realm of medicine, writers such as Scarry have pointed to the importance of listening to the patient and viewing the patient as a person, rather than as a collection of symptoms, in developing an effective approach to the experience of pain:

… the success of the physician’s work will depend on the acuity with which he or she can hear the fragmentary language of pain, coax it into clarity, and interpret it … many people’s experience of the medical community would bear out the … conclusion that physicians do not trust (hence, hear) the human voice, that they in effect perceive the voice of the patient as an ‘unreliable narrator’ of bodily events, a voice which must be bypassed as quickly as possible so that they can get around and behind it to the physical events themselves. But if the only external sign of the felt-experience of pain (for which there is no alteration in the blood count, no shadow on the X ray, no pattern on the CAT scan) is the patient’s verbal report (however itself inadequate), then to bypass the voice is to bypass the bodily event, to bypass the patient, to bypass the person in pain.107

Frank suggests that medical practitioners need to work more collaboratively in dealing with pain and suffering and agrees that medicine should develop a more open-minded approach to patient narrative rather than focusing on meeting the patient’s physical needs:

During my controlled experiment of pure suffering, all my needs were being met, yet I suffered. My suffering had little to do with needs. I was not in need but in mourning, grieving the life that I might not live as well as what I might be forced to live and what my family might be forced to live with me. The disconnection of my suffering would only have been made worse had some professional assured me that my needs were being met. The censoring of my suffering would only have added to my already gigantic fund of anxiety … Suffering is the subversive voice in biomedical discourse; it is central among all the things that do not fit. Social science and biomedical discourse perpetuate this censoring when they reduce suffering’s embodied locality to extralocal categories that organize responses. Clinicians informed by such discourse respond not to the person who suffers but to the person viewed as an instance of a type of suffering that the text has taught the professional to recognize.108

107 Scarry, above n41 at 6.
Morris also highlights the need for a truly consultative approach to pain and end-of-life care:

> Medicine ... because of its dominant position in our culture, tends automatically to suppress or overpower all the other voices that offer us a different understanding of pain, including voices of dissent within medicine ... what we need is a dialogue among disciplines that normally do not speak to one another ... The voices most often neglected belong of course to patients.109

Scott posits that a less dramatic, humbler approach to the process of dying is called for. Contrary to the stance adopted by proponents of a right to die, Scott argues that palliative care practitioners need to focus on what the patient wants in a broader sense rather than just in terms of the concepts of empowerment and autonomy. Otherwise, there is a real risk that patients will be caught up in professionalising drives on the part of various health care groups who may be in the process of gaining expertise in order to be recognised as experts in this field. According to Scott, conversations need to be framed in such a way that patients are encouraged to express their feelings, concerns and questions. As Scott points out, autonomy may be limited when a person is terminally ill. So, whilst autonomy does have a place in health care, undue reliance upon it may lead us to mind our own business instead of offering assistance where it may be needed. She notes that women, because they generally live longer than men, are even more likely to face barriers to autonomy near the end of life due to an increased likelihood of age-related physical and mental ailments.110

Scott’s concerns echo those of Elias who argued that we must reject the notion of the free, autonomous individual and focus instead upon:

---

109 Morris, above n50 at 2.
110 P Scott, ‘Autonomy, Power and Control in Palliative Care’ (1999) 8 Cambridge Quarterly of Health Care Ethics 139 at 140, 141, 143 – 146. See also, K George. Whilst George concedes there is no hard evidence that women as a group would be more at risk were euthanasia legalised, George points out that most of those assisted to die by Dr Kevorkian and by Dr Nitschke were female. She notes that many women are socialised to be passive and compliant and to help others rather than be dependant on others. Thus we need to scrutinise the autonomy of women’s decisions for death: K George, ‘A Woman's Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide’ (2007) 15 Medical Law Review 1 at 1, 2, 9, 18-22.
... the image of man as an ‘open personality’ who possesses a greater or lesser degree of relative (but never absolute and total) autonomy vis-à-vis other people and who is, in fact, fundamentally oriented toward and dependent on other people throughout his [sic] life. The network of interdependencies among human beings is what binds them together ... Since people are more or less dependent on each other first by nature and then through social learning, through education, socialization, and socially generated reciprocal needs, they exist, one might venture to say, only as pluralities ...  

Research suggests that Scott is correct in positing that those who are dying value a simple approach to care delivery. In 1993, Wakefield and Ashby conducted a structured interview with the caregivers of 100 patients who had died of cancer a year earlier, in South Australia. The research results suggest that patients value simple things such as compassion, a good relationship with palliative care staff and communication as well as, if not more than, the provision of equipment and the meeting of physical needs. Caregivers indicated that staff were judged as much on their degree of honesty and ability to empathise as they were on their technical ability or clinical knowledge. 

5. Conclusion

In light of the results of the research and the literature traversed in this chapter it is little wonder that Melzack and Wall considered medicine’s understanding of pain to be ignorant. In the realm of palliative care, one could join Lawton and claim that so long as palliative care experts continue to voice their opposition to euthanasia in terms of a discourse centring primarily on physical pain then the hospice movement will constitute little more than ‘a red herring in contemporary debates on euthanasia’. However, for their part, those in favour of a right to die have also perpetuated misconceptions about the role of physical pain in generating requests to be assisted to die and tend to justify the legalisation of euthanasia on the basis of personal autonomy when, for many dying people, autonomy is in short supply.

111 Elias, above n69 at 213, 214.
112 Wakefield & Ashby, above n89 at 536.
113 Melzack & Wall, above n33 at 289.
114 Lawton, above n73 at 203, footnote 12.
In order to move forward in the euthanasia debate, we need to develop a more holistic, more nuanced understanding of pain and suffering; an understanding that is multidimensional and able to respond to the lived experience of dying people. Morris’ biocultural model is a good starting point. Once we have achieved this, we will be in a better position to debate other, equally important but perhaps even more difficult issues that are yet to be ventilated in the euthanasia debate such as: what type of suffering ought to allow a person to obtain assistance to die; and whether, if euthanasia is legalised, it is possible to safeguard against abuse.

In the next chapter of this thesis I consider the latter question in the context of the situation in the Netherlands where euthanasia was decriminalised in 2002. By examining changing sensibilities and attitudes in the Netherlands in relation to death and dying I show, contrary to what many proponents of a right to die assume to be the case, the Netherlands is not a model for reform for other countries. By examining empirical research into the incidence of euthanasia in the Netherlands I show, contrary to what many opponents of legalised euthanasia believe to be the case, nor is the Netherlands the epitome of a slippery slope. Notwithstanding this, I conclude that there is still much that we in the common law countries can learn from the Dutch approach to death and dying - a matter to which I return in the final chapter of the thesis.
CHAPTER FIVE
GOING DUTCH: A MODEL FOR REFORM OR THE EPITOME OF A SLIPPERY SLOPE?

The constructability of euthanasia ... means that all comparisons of ‘euthanasia’ rates over time and between jurisdictions are founded on quicksand: the relatively high rate in the Netherlands in the last few years, compared with a presumably low rate in other countries with which the Netherlands are (often unfavourably) compared, probably reflects the willingness of the Dutch and the reluctance of other cultures to call a spade a spade than it does any real difference in rates of behaviour.¹

Medicine’s basic rule, ‘whether you can help or not, first of all avoid doing harm’ is no longer valid. Euthanasia is not just changing medicine, it is replacing medicine.²

1. Introduction

In the previous chapter of this thesis, I examined changes in approaches to pain and suffering, within and outside the discourse of medicine, in order to problematise the assumption made by many on both sides of the euthanasia debate that physical pain is the prime motivating factor in a desire to die sooner. I showed, rather, that it is matters of an existential³ nature that drive requests for assisted dying and I argued that it is likely that the current medical model of pain, which de-emphasises the existential aspect of pain, hampers the ability of palliative care experts to assist in bringing about a good death.

Having examined medicine’s response to changing sensibilities to death and dying and found it to be wanting, I now focus upon the Netherlands – the only country in the world⁴ that has created a codified exception to the criminalisation of AVE and AS.

³ This term is defined in Chapter Four.
⁴ In Switzerland AS is legal provided it is carried out with a compassionate motive but AVE is not: K Heslop, ‘Euthanasia Around the World’, *The Observer* (19 September 2004) 9. However, AS is a criminal act if the person who provides it does so for his or her own gain: P Lewis, *Assisted Dying and Legal Change* (2007) at 9 citing Article 114 of the Penal Code (Swiz). AVE and AS were legalised in Belgium.
DAS and where statistics have been gathered in relation to the incidence of both practices.

As the quotes at the beginning of this chapter reveal, the decriminalisation (and previously the tolerance) of euthanasia in the Netherlands is a key contested issue in the euthanasia debate. Opponents of legalised euthanasia commonly assert that the Netherlands is the epitome of a ‘slippery slope’; that the practice of euthanasia is out of control. By comparison, proponents of legalised euthanasia typically argue that euthanasia is not out of control in the Netherlands but is adequately regulated by the due care guidelines, discussed below, and that the Netherlands is a model for reform for other countries where euthanasia is illegal. Both sides of the debate utilise the Dutch statistics, discussed in Part 4 below, to back up their claims.

In the Netherlands, unlawful killing is dealt with in the Penal Code. Murder involves the intentional and premeditated killing of another human being. By comparison, AVE is defined as ‘taking another person’s life at that person’s
express and earnest request.\textsuperscript{9} AS is defined as ‘providing the means for another person to commit suicide.’\textsuperscript{10}

The maximum penalty for murder is life imprisonment.\textsuperscript{11} The maximum penalty for AVE is 12 years incarceration\textsuperscript{12} and, for AS, is three years incarceration.\textsuperscript{13} There are no set minimum sentences for AVE or AS in the Penal Code. As we shall see, prosecutions for AVE or AS only proceed when the principles of due care have not been complied with.

Euthanasia\textsuperscript{14} was exempted from criminal law, in certain circumstances, in the Netherlands on 1 April 2002 following the proclamation of the \textit{Termination of Life on Request and Assisted Suicide (Review Procedures) Act}.\textsuperscript{15} The TLRASA formalised the situation that had existed in the Netherlands since 1973 with the landmark case of Postma, discussed below, in which an act of euthanasia was first tolerated by the courts. The TLRASA also changed the status quo by making it

\begin{itemize}
\item \textsuperscript{8} Criminal Code, Article 289: ‘Anyone who intentionally and after premeditation takes the life of another is guilty of murder and shall be subject to a life sentence, a prison sentence not exceeding 20 years, or a fine of the fifth category.’
\item \textsuperscript{9} Criminal Code, Article 293.
\item \textsuperscript{10} Criminal Code, Article 294.
\item \textsuperscript{11} See footnote 8 above.
\item \textsuperscript{12} The Criminal Code, Article 293: ‘1. Any person who terminates another person’s life at that person’s express and earnest request shall be liable to a term of imprisonment not exceeding 12 years or a fifth-category fine.
2. The act referred to in the first paragraph shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist [coroner] of this act in accordance with the provisions of Article 7, subsection 2 of the Burial and Cremation Act.’
\item \textsuperscript{13} The Criminal Code, Article 294: ‘1. Any person who intentionally incites another person to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or to a fourth-category fine.
2. Any person who intentionally assists another person to commit suicide or provides him with the means to do so shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fourth category fine. Article 293, paragraph 2 shall apply \textit{mutatis mutandis}.’
\item \textsuperscript{15} \textit{The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002} (henceafter TLRASA). See Appendix 2 for the text of the TLRASA.
\end{itemize}
legal for minors over the age of 12 to request euthanasia. Prior to the TLRASA no formal changes had been made to Articles 293 or 294 of the Penal Code. This was a source of uncertainty and confusion.

The TLRASA places acts of euthanasia outside the scope of the Penal Code provided that seven principles of due care, which were at first developed by case law, are complied with. Since the TLRASA was enacted, euthanasia must be reported to the coroner who then reports to one of five regional review committees. One of the committees reviews the case to see if the principles of due care have been complied with. If so, the matter goes no further. If not, the matter is referred to the Public Prosecutor who decides whether or not to prosecute. Prior to the TLRASA, the coroner reported to the Public Prosecutor which meant that the process was more legalistic in nature and there was a greater chance of the police being involved.

Given the centrality of the Netherlands in the euthanasia debate, in this chapter I examine changes in attitudes among key groups since 1973 in order to determine

---

16 TLRASA Article 2(2) and 2(3) respectively. The Act divides minors into two groups: 12-15 year olds who need the consent of their parents or guardian for euthanasia; and 16 and 17 year olds who can request euthanasia but their parents must be consulted.

17 The seven principles of due care are as follows: the doctor was convinced that the patient made a voluntary and well considered request to die; the doctor was convinced that the patient was facing interminable and unendurable suffering; the doctor informed the patient about his/her condition and his/her prospects; together, with the patient, the doctor was convinced that there was no other reasonable solution; the doctor consulted at least one independent doctor who saw the patient and confirmed that the due care requirements had been complied with; the doctor helped the patient to die with due medical care; and reported the death to the coroner as a case of euthanasia: TLRASA Article 2(1) (a)-(f).

18 See Appendix 10 for a table setting out the due care guidelines from 1973 up to and including the enactment of the TLRASA.

19 Each committee comprises a legal expert/ chairman, a doctor and an expert in the field of ethics or philosophy. After a doctor has provided euthanasia, s/he is required to notify the coroner of the death and that it was due to euthanasia. The doctor must issue a report containing the patient’s declaration, his/her report as to what was done and a statement from the consulting doctor. The coroner reviews the documents and then forwards them to one of the five regional review committees for consideration. In reaching a decision the review committee may speak to the doctor, ask questions, and give him/her feedback on whether his/her actions complied with the principles of due care. If the principles of due care have been complied with the doctor will be notified of that and there will be no report to the Public Prosecution Service (hereafter PPS). The PPS is only informed if the doctor has breached the principles of due care. Prior to the TLRASA, a doctor could still be prosecuted after a finding that the principles of due care had been breached but, in practice, this rarely happened: Cohen-Almagor, above n4 at 167; ten Have & Welie, above n4 at 113.

20 TLRASA Article 20A(2).
whether the Netherlands is, or is not, responding in a satisfactory manner to changing sensibilities in relation to death and dying.

This chapter is divided into three parts. In Part 2, I examine changing attitudes expressed via practices among the Dutch judiciary, medical practitioners and the government in order to show that these groups have consistently favoured a flexible response to changing sensibilities in relation to death and dying. However, the lack of a co-coordinated approach between them has meant that the permissibility of euthanasia in the Netherlands came about in a disorganised manner.

In Part 3, I examine changes in Dutch sensibilities in order to theorise why the Netherlands is the only country in the world to have legalised both AVE and DAS. Themes that emerge in this regard are the highly secular nature of Dutch society and a strong and widespread preference for personal autonomy over communitarian interests. Due to the many cultural and historical differences between the Netherlands and the common law countries examined in this thesis, I do not attempt to explain the Dutch phenomenon by comparisons. Instead, I highlight differences where they exist in order to encourage a fresh perspective on the response of the common law jurisdictions to the possibility of legalising euthanasia.

In Part 4, I discuss the major empirical studies that have been carried out in the Netherlands to date in relation to the incidence of euthanasia in order to determine whether the Netherlands is sliding down a slippery slope. Most of these studies were carried out prior to the enactment of the TLRASA but each remains an important source of information about the situation in the Netherlands. By examining the methodology used in the studies as well as the results I show that the studies support neither the claim that euthanasia is out of control nor the claim that the Netherlands is a model for reform for the common law countries.

---

\[21\] See Appendix 11.
In the final part of the chapter, I conclude that the common law jurisdictions should not follow the Dutch way of responding to changing sensibilities in relation to death and dying. In spite of the anticipated demographic changes in relation to aging outlined in Chapter One, I consider that it is premature to legalise euthanasia in the common law countries because sensibilities have not changed sufficiently to form a mandate for this to occur and, important issues such as what type of pain or suffering ought to qualify one for euthanasia are yet to be adequately debated. Nevertheless, I consider that there is still much that we in the common law countries can learn from the Dutch approach to death and dying. This is a matter to which I return in the final chapter of the thesis.

2. Changing Attitudes among Key Professional Groups in the Netherlands: A Model for Reform?

An examination of changing practices among the judiciary, the medical profession and the Executive in the Netherlands from 1952 to date,\(^22\) reveals that the decriminalisation of euthanasia came about in a disjointed and disorganised manner. In contrast to the situation in the common law countries examined in Chapters Two and Three of this thesis, the Dutch judiciary, the Royal Dutch Medical Association\(^23\) and the majority of the Executive have, since the early 1970s, favoured flexibility in end-of-life practices and leniency when new fact scenarios emerge or existing rules are broken, particularly where AVE or AS is provided by a medical practitioner.\(^24\) Thus, at first blush, there appears to be a united approach but, as I show, there was little planning involved in the legalisation of euthanasia.

---

\(^22\) See Appendix 12 for a timeline of the developments in relation to euthanasia in the Netherlands since 1952.

\(^23\) Hereafter RDMA.

\(^24\) Note that the Dutch courts have nearly always imposed custodial sentences for nurses who have engaged in AVE or AS: ten Have & Welie, above n4 at 187-210.
A. The Dutch Judiciary

Practices within the Dutch judiciary have led to an increase in the circumstances in which euthanasia will be permitted. Commentators often cast these changes in a negative light but a close examination of the case law reveals that the Dutch courts in permitting euthanasia are concerned to control its practice. However, prior to the TLRASA, the courts were limited by the slow manner in which judicial precedent is developed and by the government’s failure, until the mid-1990s, to develop a clear policy on euthanasia.

In contrast to the common law countries, the Dutch equivalent to the defence of necessity, the conflict of duties defence, can be raised to justify the provision of euthanasia. The conflict of duties defence, which was the catalyst for the decriminalisation of euthanasia in the Netherlands, will be made out when: a doctor has a duty to act in accordance with the law (to preserve life); s/he also has a duty to foster some other important interest (to relieve suffering); the two duties become incompatible in a particular situation; and in balancing the interests at stake most other people would have chosen the same interest even if that meant breaking the law.

The first significant case of euthanasia came before the Dutch courts in 1973 when Dr Gertruida Postma, a general practitioner, was prosecuted for ending the life of her elderly mother, Mrs van Boven. Mrs van Boven had had a stroke, was partly paralysed, had trouble speaking and was deaf. She repeatedly expressed a

25 In this part I only consider the leading cases in relation to AVE and AS. See Appendix 13 for a digest of outcomes in non-leading, reported cases in relation to Dutch treating doctors who have engaged in AVE or AS and who have breached one or more of the due care guidelines after 1973. See ten Have & Welie, above n4 at 187-210 for a digest of all reported Dutch euthanasia cases from 1952-2003. For an additional account see Cohen-Almagor, above n4 at 39-49.

26 I acknowledge that I relied upon secondary accounts of the case law that I discuss in this part. The reason for this is that the case law is in Dutch and has not been translated into English.

27 Ten Have & Welie, above n4 at 97, 98.

28 The very first case of euthanasia came before the District Court at Utrecht in 1952 when a doctor was convicted after he euthanased his brother. However, Postma is usually cited as the first euthanasia case in the Netherlands because, in the 1952 case, the court did not consider issues relevant to the acceptability of euthanasia: Otlowski, above n4 at 394, footnote 12.

wish to die. Dr Postma eventually acceded to her request, visiting her mother in
the nursing home and injecting her with 200mg of morphine. Mrs van Boven was
dead within an hour.\textsuperscript{30}

At trial, Dr Postma raised Article 40\textsuperscript{31} of the Penal Code. Article 40 allows a
person to be excused from criminal liability when he or she is faced with a conflict
of duties. The District Court at Leeuwarden rejected the conflict of duties argument
because there were other, legal alternatives that could have been resorted to. The
court held that palliative measures should have been considered before
euthanasia.\textsuperscript{32} Dr Postma was found guilty of manslaughter but received a
relatively lenient punishment of one week in gaol and a year’s probation.\textsuperscript{33} The
gaol term was subsequently suspended.\textsuperscript{34}

The decision in \textit{Postma} was problematic because the court did not lay down any
guidelines for the provision of euthanasia which was the central issue in the case,
but focused instead on the different but related issue of when patients can be
given drugs to relieve pain in circumstances where this might also shorten a
patient’s life,\textsuperscript{35} a situation that is sanctioned by the DDE\textsuperscript{36} in the common law
countries. Dr Hielke Kijlstra, an expert retained by the prosecution, gave evidence
that this should be permitted if a patient:

---

\textsuperscript{30} Otlowski, above n4 at 394.
\textsuperscript{31} Article 40 states that he who commits a crime while compelled to do so by \textit{overmacht} is not liable to
punishment. The term \textit{overmacht} means ‘overpower’ and is more commonly translated as \textit{force majeure}:
ten Have & Welie, above n4 at 97. According to ten Have & Welie (at 97, 98) the Penal Code does not
define \textit{force majeure}. It is defined in Dutch jurisprudence to mean a conflict of duties or, psychological
\textit{force majeure}. In the case of psychological \textit{force majeure} the offender must show that the stressful
circumstances of the case psychologically compelled him or her to act in a certain way. It is hard for
medical practitioners to raise this version of the defence because they are trained to deal with death and
suffering. As a result, most Dutch medical practitioners have raised the conflict of duties defence, the
elements of which are outlined on page 180, above.

\textsuperscript{32} Ten Have & Welie, above n4 at 99.
\textsuperscript{33} Otlowski, above n4 at 394.
\textsuperscript{34} Cohen-Almagor, above n4 at 40 citing C McKhann, \textit{A Time to Die: The Place for Physician Assistance}
\textsuperscript{35} Bostrum, above n5 at 474. See also, ten Have & Welie, above n4 at 6, 99.
\textsuperscript{36} See Chapter Two for discussion of the doctrine of double effect.
1. is terminally ill as a result of disease or accident;
2. is of the view that his/her physical or mental suffering is severe or unbearable;
3. expresses a wish to have his/her life ended;
4. has entered or is about to enter the terminal phase; and
5. pain relief is provided by a doctor or in consultation with a doctor.

The court rejected the fourth criteria on the grounds that it was too restrictive in that suffering can be unbearable prior to the terminal phase of an illness. However, the court did accept all of the other guidelines thus permitting euthanasia in certain circumstances. The guidelines in *Postma* subsequently became the basis upon which the Public Prosecutor determined whether to prosecute cases of euthanasia.37

For the next eight years, the legality of euthanasia was governed only by the principles laid down in *Postma* which likely gave rise to much uncertainty on the part of doctors and patients. Then, in 1981, a case of AS came before the Criminal Court of Rotterdam when Mrs Wertheim38 was charged with having assisted a friend to commit suicide. In reaching a decision, the court did not distinguish between AVE and AS, as the courts in the common law countries do, but laid down the following seven criteria that it said should be followed to avoid a conviction after the provision of euthanasia (AVE and/or AS).

1. The patient must repeatedly and explicitly express the desire to die.
2. The patient’s decision must be well informed, free and enduring.
3. The patient must be suffering from severe mental or physical pain with no prospect of relief.
4. All other options for care must have been exhausted or refused by the patient.

37 Ten Have & Welie, above n4 at 10; Otlowski, above n4 at 397.
5. Euthanasia must be carried out by a qualified doctor.
6. The doctor must consult with at least one other doctor.
7. The treating doctor must inform the local coroner that euthanasia has occurred.\textsuperscript{39}

\textit{Wertheim} not only confirmed the permissibility of euthanasia but also introduced the need to report cases of euthanasia to the coroner and the need to consult with a second medical practitioner beforehand. The decision confined the legal provision of euthanasia to the medical profession. Prior to this, according to \textit{Postma}, it had been possible to escape conviction if a doctor had been consulted at some point in the process of providing euthanasia. Thus, the decision in \textit{Wertheim} provided more clarity as to the requirements of due care but numerous issues remained unanswered. Key terms such as ‘severe mental pain’ and ‘other options for care’ were not explored and no guidance was provided on procedural matters such as reporting and consultation.\textsuperscript{40} Nevertheless, from this point on, the Public Prosecutor began to rely upon the principles laid down in \textit{Postma} in conjunction with those laid down in \textit{Wertheim} as principles of due care.\textsuperscript{41}

Two years passed before the courts again considered the issue of euthanasia. In the process, the circumstances in which euthanasia would be tolerated were expanded in that the requirement of terminal illness was formally abandoned. Thus in 1983, in \textit{Schoonheim},\textsuperscript{42} Mrs Barendregt who was extremely unwell though not terminally ill and who was suffering from what I have categorised in this thesis as existential pain\textsuperscript{43} was permitted to be assisted to die.\textsuperscript{44}

\textsuperscript{39} Otlowski, above n4 at 396, 397 citing M de Wachter, ‘Active Euthanasia in the Netherlands’ 262 (1989) \textit{Journal of the American Medical Association} at 3316, 3317.
\textsuperscript{40} Gomez, above n5 at 33.
\textsuperscript{41} Otlowski, above n4 at 397.
\textsuperscript{42} \textit{Schoonheim Case, Nederlands Jurisprudentie} 1985, No. 106, Supreme Court, 27 November 1984 cited in Otlowski, above n4 at 397. Hereafter \textit{Schoonheim}.
\textsuperscript{43} This phrase is defined in Chapter Four.
At 89 years of age, Mrs Barendregt moved into a nursing home under Dr Schoonheim’s care.\textsuperscript{45} She signed an advance directive saying that she did not wish to be kept alive if she became incompetent. At 94 years of age she fractured her hip and became unconscious. When she regained consciousness she said that she did not want to risk becoming unconscious again and asked Dr Schoonheim to end her life. Dr Schoonheim spoke with Mrs Barendregt’s son and an assistant doctor in relation to whether he should assist her to die. Both agreed that he should. Three days later, after confirming Mrs Barendregt’s request for euthanasia, Dr Schoonheim gave her a number of injections which caused her to have a respiratory arrest. Dr Schoonheim recorded that the death was not due to natural causes and informed the police. He was subsequently prosecuted.\textsuperscript{46}

At first instance, the District Court at Alkmaar accepted the argument put on behalf of Dr Schoonheim that his actions were not illegal because, at the time the Penal Code was drafted in 1886 the legal prohibitions contained in it were not meant to apply to euthanasia. The court acknowledged that more and more people support euthanasia on the basis of the principle of personal autonomy and that in order to end life in an acceptable and non-violent manner people sometimes need assistance from a third party. The court accepted the argument put on behalf of Dr Schoonheim that there was an absence of ‘material illegality’.\textsuperscript{47}

The prosecutor appealed to the High Court of Amsterdam. The appeal court rejected the argument that there was no material illegality (no breach of the Penal Code). The doctor’s actions were prima facie illegal according to its provisions.\textsuperscript{48} Dr Schoonheim’s legal representative argued, in the alternative, that Dr Schoonheim should be acquitted because he had been faced with a situation of emergency in that he had been forced to decide between his duty to abide by the

\begin{itemize}
\item \textsuperscript{45} Otlowski, above n4 at 397.
\item \textsuperscript{46} Id at 389, 399; ten Have & Welie, above n4 at 100, 101.
\item \textsuperscript{47} Ten Have & Welie, above n4 at 95.
\item \textsuperscript{48} Id at 102.
\end{itemize}
law and his duty to prevent suffering (psychological *force majeure*). The court rejected this version of the conflict of duties defence and found Dr Schoonheim guilty because it was clear that there were other alternatives to killing Mrs Barendregt. However, the court imposed no penalty because it considered that Dr Schoonheim had acted with integrity and due caution. At the same time, the court stated that consultation with Mrs Barendregt’s son and the assistant doctor was not sufficiently independent.

Dr Schoonheim appealed to the Dutch Supreme Court which is the highest court in the Netherlands. The Supreme Court accepted the conflict of duties defence which it interpreted as a conflict between the duty to save life and the duty to prevent suffering in circumstances where choosing the lesser of two evils had resulted in Dr Schoonheim having no choice but to break the law. In contrast to the common law decisions in relation to the defence of necessity discussed in Chapter Three which show that the application of the defence is unsettled in the context of unlawful killing, the Dutch Supreme Court held that the Dutch conflict of duties defence could be raised where there is unbearable suffering in a patient who is dependant on the treating doctor and where suffering can only be relieved by death. However, the court said that there must be an emergency situation according to responsible medical judgement and the norms of medical ethics.

This was the first time that the defence of conflict of duties had been raised in a case involving a therapeutic relationship; in *Postma* there had been no doctor/patient relationship between Dr Postma and her mother whom she had

---

50 See footnote 31, above.
51 Sneiderman & Verhoef, above n49 at 390.
52 Otlowski, above n4 at 400.
53 Sneiderman & Verhoef, above n49 at 390.
55 Sneiderman & Verhoef, above n49 at 390.
euthanased. In accepting the defence, the Supreme Court sanctioned a planned and deliberate act that is categorised as murder in the common law jurisdictions.\footnote{See Chapter Two for discussion of unlawful killing (AVE) in the common law countries.}

\textit{Schoonheim} was referred to the Court of Appeal of The Hague to review the following questions, which had not been considered by the lower court:

1. whether, and if so to what extent, according to professional medical judgement, increasing disfigurement of the patient’s personality and/or increasing deterioration of already unbearable suffering could be expected;

2. whether, also taking into account the possibility of new serious relapses, it was to be expected that the patient would soon no longer be in a position to die with dignity; and


The Court of Appeal of The Hague upheld the reasoning adopted by the Supreme Court and acquitted Dr Schoonheim. The court had sought and relied upon the view of the RDMA in relation to euthanasia. The RDMA’s view was that, although there was no consensus among the medical profession, the doctor’s actions were ‘justified according to reasonable medical insights.’\footnote{Otolowski, above n4 at 404. (Hereafter \textit{Chabot}). There are minor discrepancies in accounts of the fact scenario in \textit{Chabot} between Otolowski and Schneiderman & Verhoef. For example, Otolowski says that there were 24 counseling sessions and that the sons’ names were Patrick and Rodney. Where there are discrepancies, I have relied upon the account provided by Sneiderman & Verhoef, above n49 because Dr Chabot adopted their account as correct: Cohen-Almagor, above n4 at 47, footnote 52 (citing personal communication between Cohen-Almagor and Dr Chabot, 5 June 1999).} From this point on, the practice of the Dutch judiciary began to accord with the policy of the RDMA.

Eleven years passed before the issue of euthanasia came before the courts again. Then, in 1994, Dr Boudewijn Chabot\footnote{Chabot Case, Nederlandse Jurisprudentie, 1994, No. 656 cited in Otolowski, above n4 at 404. (Hereafter \textit{Chabot}).} was charged with having assisted Hilly Boscher to commit suicide in breach of Article 294. Mrs Boscher’s circumstances
had led her to become grief stricken. Her son Peter had committed suicide in 1986. At that time, Mrs Boscher wanted to commit suicide as well but decided to live for her other son, Rodney. In 1991, Rodney died of cancer. Mrs Boscher tried to commit suicide after Rodney’s death but did not succeed. There were also other factors that made Mrs Boscher’s situation difficult. Prior to consulting Dr Chabot, Mrs Boscher had divorced her physically abusive husband and her father had died.

The Dutch Voluntary Euthanasia Society put Mrs Boscher in touch with Dr Chabot, a practising psychiatrist, whom she consulted. She completed 30 hours of counselling but refused to take anti-depressants or have therapy for bereavement and continually told Dr Chabot that she wanted to die. Dr Chabot’s diagnosis for Mrs Boscher was adjustment disorder with depressed mood without any psychotic features in the context of a complicated bereavement process. He did not categorise her condition as a psychiatric illness but rather as a disorder. He did not consider her to be suffering from a major depression but he did consider her condition to be hopeless in that he thought she would continue to attempt to commit suicide until she succeeded. From the start, Mrs Boscher made it clear that her life was so inexorably bound up with her sons that she could not bear to go on living without them.

Dr Chabot provided four psychiatrists and a clinical psychologist with the transcripts of his therapy sessions with Mrs Boscher and sought their opinion. He also consulted a family physician and a theologian-ethicist. In contrast to the stance that has been adopted in the common law countries, reflected in the SLD, The sanctity of life doctrine is discussed in Chapter One.
the majority agreed that Mrs Boscher’s condition was hopeless. Dr Chabot asked one of the doctors to see Mrs Boscher but that doctor felt that it was unnecessary. He considered that he could understand Mrs Boscher’s circumstances merely by reading her file and said that to actually see her would only put her through more distress. After two months of treatment Mrs Boscher still wanted to die. So, Dr Chabot went to her house and provided her with a lethal dose of medication which she took in his presence and with her own doctor and a friend present. Dr Chabot reported her death to the coroner as a case of euthanasia.

The District Court at Assen held that the defence of conflict of duties was established on the facts of the case. Dr Chabot was found to have been properly indicted but not to have deserved to be punished. In reaching its decision the court relied heavily upon a 1993 RDMA discussion paper which stated that in appropriate circumstances euthanasia should be available to a patient with mental suffering if the patient were competent and the principles of due care were complied with.

The prosecution appealed to the High Court at Leeuwarden which affirmed the decision of the District Court. The Solicitor General of the appeal court then appealed to the Supreme Court. The Supreme Court laid down new law which again extended the allowable categories of euthanasia by holding that the conflict of duties defence could be raised in circumstances where a doctor had terminated the life of a patient who was not terminally ill but who was experiencing incurable mental suffering. The Supreme Court reversed the lower court’s acquittal of Dr Chabot because there was inadequate consultation. Yet the nature and degree of consultation needed had not been addressed in previous case law. The court held

---

67 Otlowski, above n4 at 405.
68 Hendin, above n5 at 65.
69 Otlowski, above n4 at 405; M Spanjer, ‘Mental Suffering as Justification for Euthanasia in the Netherlands’ (1994) 343 The Lancet 1630.
70 Otlowski, above n4 at 407 referring to Assistance with Suicide in the Case of Psychiatric Patients (RDMA discussion paper, 1993).
that there should be independent consultation dealing with the degree of suffering, incurability, and other avenues of treatment but said that consultation did not necessarily require an examination in person and a failure to consult would not necessarily preclude a person from raising the defence of conflict of duties.\textsuperscript{71}

Dr Chabot was convicted but no punishment was imposed because of the circumstances of the case.\textsuperscript{72} The conviction was, however, a serious matter because it meant that Dr Chabot had a criminal record. The decision has been criticised because it was not clear that Mrs Boscher’s condition was incurable; she had refused most of the available treatment when the incurableness requirement likely entails a need to try the available treatment in order to establish incurability in the first place.\textsuperscript{73}

By comparison, the Amsterdam Medical Disciplinary College was not entirely sympathetic toward Dr Chabot. The college subsequently found him guilty of professional misconduct and reprimanded him because: he had not insisted on therapy as an alternative to AS; he had failed to arrange for Mrs Boscher to be examined in person by another consultant; and he had not preserved his professional distance in that treatment sessions took place at his house.\textsuperscript{74} However, attitudes within the college were not sufficiently negative to invoke a more serious sanction such as suspension or revocation of Dr Chabot’s licence to practice.\textsuperscript{75}

Otlowski states that the decision in \textit{Chabot} provided a clear indication that a doctor must consult with another doctor prior to assisting a patient with a psychiatric illness to die and that the second doctor must examine the patient and confirm that

\begin{itemize}
  \item \textsuperscript{71} Otlowski, above n4 at 407, 408.
  \item \textsuperscript{72} Pursuant to Article 9(a) of the Dutch Penal Code, the Supreme Court has a prerogative to ‘waive any punishment … in light of the circumstances of the case and/or the character of the accused.’
  \item \textsuperscript{73} Otlowski, above n4 at 406, 407 citing the evidence of Professor H Leenen in Senate of Canada, \textit{Of Life and Death} (1995) at A-133 with regard to the requirement that the psychiatric illness be incurable.
  \item \textsuperscript{75} M Spanjer, ‘Dutch Psychiatrist Reprimanded for Assisting Suicide’ (1995) 345 \textit{The Lancet} 914.
\end{itemize}
the patient’s condition is incurable, the patient is competent and nothing further can be done.\(^7^6\) These requirements, other than examination in person, were stipulated in \textit{Chabot} and all were contained in the revised due care guidelines released by the RDMA in 1994 (discussed below). However, the results of the empirical studies discussed in Part 4 below suggest that a sizeable number of doctors fail to report to the coroner afterwards. Studies also suggest that a significant number of doctors fail to consult prior to providing euthanasia.\(^7^7\)

In 1995 and 1996, the circumstances in which the conflict of duties defence could be raised were extended again, this time to newborn babies who are severely handicapped and likely to die within 12 months when first Dr Prins and then Dr Kadijk, in separate proceedings, came before the District Court charged with breach of Article 293.\(^7^8\)

In the case of \textit{Prins},\(^7^9\) in 1995, a baby was born with spina bifida, hydrocephalus, a spinal cord lesion and brain damage. From the infant’s behaviour it seemed that she was in pain and that the pain was difficult to control. The baby’s parents did not want her to suffer and asked Dr Prins to end her life. He did so three days later after consulting with a range of other specialists and a pastor. The child was euthanased and died in her mother’s arms.\(^8^0\)

In \textit{Kadijk},\(^8^1\) in 1996, a baby was born with trisomy 13 which causes deformities of the skull, face, hands, heart and kidney as well as brain damage. The baby was expected to die within six months to a year. The baby was taken home on tube feeding but was brought back to the hospital after brain tissue came out of an

\(^7^6\) Otlowski, above n4 at 407.

\(^7^7\) See B Ontwuteaka-Philipsen, ‘Consultation with Another Physician on Euthanasia and Assisted Suicide in the Netherlands’ (2000) 51 \textit{Social Science and Medicine} 429.


\(^7^9\) \textit{Prins Case}, District Court at Alkmaar, 26 April 1995 cited in ten Have & Welie, above n4 at 112. Hereafter \textit{Prins}.

\(^8^0\) Ten Have & Welie, above n4 at 112; A Klotzko, ‘What Kind of Life? What Kind of Death? An Interview with Dr Henk Prins’ (1997) 11 \textit{Bioethics} 24 at 28.
opening in its skull. Treatment for pain was only partially effective. According to Jochemsen, it was not clear whether the baby’s parents explicitly requested euthanasia although they had already consulted an independent paediatrician about ending the baby’s life. The baby was euthanased a few days later by Dr Kadijk.82

Both doctors were charged with murder. In each case, three defences were raised: the expression ‘take a person’s life’ in Article 289 of the Penal Code does not apply in the context of euthanasia when carried out in accordance with the due care guidelines (no material illegality); the offence was not punishable because it was done as part of responsible medical practice and in agreement with medical standards (the medical exception defence); and the action was carried out as a result of a conflict of duties (the conflict of duties defence).83

In Prins, the Alkmaar District Court allowed the conflict of duties defence and held that the following minimum requirements should apply in order to successfully invoke the conflict of duties defence in the case of neonates: intolerable, incurable suffering that cannot be alleviated in a medically meaningful way; no prospect of improvement; the doctor’s actions comply with responsible medical opinion and prevailing medical ethics; and an explicit, repeated and consistent request from the parents that the baby be euthanased.84

The prosecution appealed to the High Court of Leeuwarden. The decision of the appeal court suggests a different approach to palliative care in the Netherlands to that in the common law countries.85 The court confirmed that the defence of conflict of duties applied and stated that curative treatment was not reasonable and that palliative measures were medically meaningless because the doses

---

81 Kadijk Case, District Court of Gronigen, 13 November 1995; High Court of Leeuwarden, 4 April 1996 cited in ten Have & Welie, above n4 at 204. Hereafter Kadijk.
82 Jochemsen, above n78 at 451.
83 Id at 452.
84 Ibid.
85 See Chapter Four regarding palliative care in the common law countries.
required would have rendered the baby unconscious, would have hastened death anyway and probably would have led to further complications that would have burdened the parents and the healthcare team. Further, if the treatment were ceased later on, it would have reduced the chances of any improvement. The court concluded, on the facts, that the parents had consented to the baby being killed by Dr Prins. The court approved the criteria laid down by the lower court, outlined above, and Dr Prins was acquitted.86

In Kadijk, at first instance, the District Court of Groningen held that euthanasia by proxy can never be justified in normal circumstances but in this particular case it was permissible because the defence of conflict of duties applied. The court concluded from the evidence that the parents had consented to the baby’s life being terminated and that the elements of the defence were made out. Dr Kadijk was acquitted. The prosecution appealed to the High Court at Leeuwarden.87

The appeal court followed the approach of the appeal court in Prins but added additional requirements for the defence of conflict of duties to be successfully relied upon in the case of newborn babies: there must be no doubt as to diagnosis or prognosis; there must be consultation with colleagues; death must be brought about in a careful and correct way; and the case must be reported to the coroner.88

Five years after Prins and Kadijk, the categories of permissible euthanasia were extended again, at first instance, to include being tired of life when the conflict of duties defence was accepted after Dr Sutorius helped a man who was neither terminally ill nor experiencing unbearable incurable suffering to commit suicide. In Sutorius,89 86-year-old Edward Brongersma, a former member of the Upper House of Parliament, sought assistance to commit suicide because, like Nancy

86 Jochemsen, above n78 at 452, 453.
87 Id at 453, 454.
88 Id at 454.
89 Sutorius Case, District Court at Haarlem, 30 October 2000 cited in ten Have & Welie, above n4 at 207. Hereafter Sutorius.
Crick whose circumstances are discussed in Chapter Two, he was tired of life. Mr Brongersma had no serious medical conditions and was physically well for his age but felt increasingly isolated as his friends were dying of old age. He was not considered to be depressed. During 1998, he took a lethal dose of medication that had been supplied to him by Dr Sutorius and died.\footnote{Ten Have & Welie, above n4 at 117, 118.}

The District Court at Harlem consulted a number of medical experts in order to determine whether Mr Brongersma’s suffering was so severe that it was unbearable and incurable. The views expressed suggest a very broad interpretation of suffering among Dutch medical practitioners.\footnote{See Chapter Four for discussion of medical interpretations of physical and existential pain in the common law countries.} Three psychiatrists concluded that Mr Brongersma’s suffering was more than likely incurable. Dr De Beaufort testified that Mr Brongersma’s suffering was genuine and his desire to die autonomous and that it was possible that the suffering was unbearable. Dr Reus stated that Mr Brongersma was suffering because he no longer found meaning in life and his suffering was not treatable because it was neither somatic nor mental. Dr Van Ree considered that Mr Brongersma’s suffering was incurable because the conditions that made Mr Brongersma happy such as debating issues with his friends could not be restored.\footnote{Ten Have & Welie, above n4 at 118 citing F van der Ree, ‘Genoeg van het Leven’ (2001) 56 Medische Contact 426-428.} On the evidence, the District Court determined that AS was justified because Dr Sutorius was faced with a conflict of duties.\footnote{Id at 118.}

The prosecutor appealed to the High Court. The High Court rejected the reasoning of the District Court and held that, since Mr Brongersma’s suffering was neither mental nor physical, it was outside Dr Sutorius’ experience and he should have referred Mr Brongersma to a therapist for treatment.\footnote{Id at 167.}

Dr Sutorius appealed to the Supreme Court. The Supreme Court also found him guilty of AS (breach of Article 294) and insisted that there must be a medical
condition which leads to the patient experiencing unbearable suffering – being
tired of life was not considered to be an acceptable basis for euthanasia because it
is not a recognised medical condition. The Minster for Justice at the time, Benk
Korthals, agreed that this was not a sufficient reason for euthanasia. However, no
sentence was imposed because Dr Sutorius had acted with compassion.95

The lack of any punishment in the final case to be discussed in this part, van
Oijen,96 is particularly problematic because, pursuant to the provisions contained
in the Penal Code, it was a clear case of murder. In 2000, Dr van Oijen was found
guilty of murder after he euthanased a patient at the request of the patient’s family.
The patient was reportedly unconscious at the time she was euthanased but when
asked her views on an earlier occasion had stated she wanted to be with her
children.97 Dr van Oijen, a leading campaigner for euthanasia, should have been
aware of the due care guidelines. Yet, he was also found to have falsely reported
the death as being due to natural causes.98

Dr van Oijen appealed against the conviction all the way to the Supreme Court but
was unsuccessful on each occasion.99 Upon the matter being referred back to the
District Court at Amsterdam, the verdict was confirmed because the patient had
never requested euthanasia. The defence of conflict of duties was rejected, as it
should have been, because the patient was not aware of her surroundings so she
could not be said to have been exhibiting suffering that gave rise to a conflict of
duties within Dr van Oijen. However, no punishment was imposed – not even a
probationary sentence as had been the case in the past.100 Whilst Dr Van Oijen

95 T Sheldon, 'Dutch GP Cleared after Helping to End Man's 'Hopeless Existence'' (2000) 321 British
Medical Journal 1174.
96 Van Oijen Case, District Court of Amsterdam, 24 November 1998; High Court of Amsterdam, 17 May
1999; Supreme Court, 26 September 2000; District Court of Amsterdam, 21 February 2001; High Court
of Amsterdam, 3 June 2003 cited in ten Have & Welie, above n4 at 207. Hereafter van Oijen.
97 Ten Have & Welie, above n4 at 113.
98 Id at 114.
99 T Sheldon, 'Two Test Cases in Holland Clarify Law on Murder and Palliative Care' (2004) 329 British
Medical Journal 1206.
100 Ten Have & Welie, above n4 at 114. For the separate offence of falsifying the death certificate Dr van
Oijen was given a suspended fine of 5000 guilders: T Sheldon, 'Dutch GP Found Guilty of Murder Faces
no Penalty' (2001) 322 British Medical Journal 509
was found guilty of AVE (breach of Article 293) it is questionable whether the lack of any punishment sent a clear message to Dutch medical practitioners that the due care guidelines must be complied with.

Dr van Oijen’s notoriety as an advocate for euthanasia is apparent in the 1994 Dutch documentary in relation to euthanasia entitled ‘Death on Request’.101 In the film, director Maarten Nederhorst documents the journey toward euthanasia of Cees van Wendel who has been diagnosed with amyotrophic lateral sclerosis. Cees is euthanased by Dr van Oijen who was Cees’ general practitioner. Yet, one gets the distinct impression that Cees’ wife, Antoinette, was the driving force behind Cees’ request for assistance to die.

B. The RDMA

Much of the commentary in relation to the role of the RDMA in the relaxing of the legal prohibition against euthanasia in the Netherlands is conflicting. Commentators such as Hendin,102 Cohen-Almagor,103 Gomez104 and Keown105 take a negative view of its role in this process whilst others such as Otlowski106 and many of the Dutch commentators107 do not. However, an examination of changes in attitudes as measured by statements and guidelines within the RDMA, the leading medical association in the Netherlands, reveals that, over time: the RDMA has become increasingly supportive of euthanasia in an increasing number of situations; its views have frequently played a significant role in judicial outcomes; prior to the TLRASA RDMA publications and statements on euthanasia likely exacerbated the confusion surrounding euthanasia; and some of its members may view the doctor-patient relationship as being beyond the purview of

101 M Nederhorst, Death on Request (1994).
102 Hendin, above n5 at 97.
103 Cohen-Amagor, above n4 at 175.
104 Gomez, above n5 at 38.
105 Keown, above n5 at 261.
106 Otlowski, above n4 at 410-416.
107 See, for example: R Dillman, 'Euthanasia in the Netherlands: The Role of the Dutch Medical Association' (1996) 5 Quarterly of Healthcare Ethics 100; Leenen, above n54; Rigter, above n6; G van der Wal, 'Euthanasia in the Netherlands' (1994) 308 British Medical Journal 1346.
the law. The stance of the RDMA is problematic in view of the need to safely regulate euthanasia.

Up until the early 1970s, the RDMA was not in favour of a lenient response to unlawful killing. In fact, in 1959 in the third edition of its booklet in relation to medical ethics, *Medische Ethiek en Gedragsleer*, the RDMA strongly rejected AVE and AS and emphasised that a doctor’s duty is to preserve life in all circumstances, for as long as possible.  

Attitudes within the RDMA began to change at about the same time as *Postma*. In 1973, the same year that *Postma* was decided, the board of the RDMA issued a working paper on what we in the common law jurisdictions refer to as AVE. The board was not ready at that stage to consider the issue of DAS. The board’s position was that the law should provide a defence to a doctor who shortens the life of a consenting patient who is terminally ill and in the process of dying but that the courts should deal with euthanasia on a case-by-case basis.

By 1984, attitudes within the RDMA had become more permissive. In that year, the RDMA published a new position statement on euthanasia which summarised the due care guidelines laid down by the courts up to that point in *Postma* and *Wertheim*. Over this period, the RDMA’s focus had changed from incurable terminal illness to intolerable and hopeless suffering (a much more subjective issue), in recognition of medical conditions such as multiple sclerosis and amyotrophic lateral sclerosis which typically have a long trajectory and can cause a great deal of suffering prior to death.

---


Expansionist attitudes within the RDMA continued in the early 1990s when the RDMA opened up debate in relation to extending the provision of euthanasia to those in the following categories: when treatment is no longer of any benefit and the patient is not dying in a quick and humane manner; severely defective newborn babies; long-term comatose patients; seriously demented patients; and psychiatric patients. The debate turned into a decided position, on some of these issues, in 1993 when the RDMA endorsed the position of the Dutch Association of Psychiatry that the provision of euthanasia be extended to psychiatric patients who are competent and experiencing incurable suffering of a mental or physical kind but who are not terminally ill. The Inspector for Mental Health supported the position of the RDMA on this matter and the National Inspectors for Public Health and for Mental Health withdrew a statement they had released just two years earlier stating that euthanasia can never be justified in a patient with a psychiatric condition.\(^\text{111}\) As set out above, the RDMA’s views on this matter were adopted by the Supreme Court in *Schoonheim* in 1994.

Whilst being demonstrably in favour of euthanasia, it was not until 1995 that the RDMA formulated a comprehensive approach to the provision of euthanasia when it published ‘Vision on Euthanasia’ in the RDMA journal, *Medisch Contact. Vision*, although a project spearheaded by the RDMA, was the product of a multidisciplinary working party comprising lawyers, ethicists and theologians as well as physicians\(^\text{112}\) so the RDMA was not, as Gomez\(^\text{113}\) suggests, the sole driving force behind the eventual decriminalisation of euthanasia in the Netherlands.

In order to understand attitudes within the RDMA, it is worth considering *Vision* in some detail. In it, the RDMA stated that there is no moral difference between what we refer to as AVE and DAS. Unlike the stance that has been adopted by the medical associations in the common law jurisdictions, the board stated that, in

---


\(^{112}\) Sneiderman & Verhoef, above n49 at 406. The authors do not say whether any judges were involved in the working party.

\(^{113}\) Gomez, above n5 at 131.
cases of euthanasia (AVE and DAS), the code of medical ethics would not be breached\(^{114}\) if there were:

1. a voluntary request for euthanasia;
2. a well-considered request;
3. a request which amounted to a durable wish;
4. suffering due to pain, whether or not based on a perceivable physical condition, or suffering due to a physical condition, or physical disintegration without pain that is unacceptable to the patient; and
5. consultation with a colleague with experience in the relevant field.\(^ {115}\)

These criteria were not identical to those developed by the courts up until that time in Postma, Wertheim and Schoonheim and may well have confused medical practitioners. The board also made a number of additional recommendations that both liberalised and constrained the practice of euthanasia and acknowledged ongoing uncertainty about its status at law. The board stated that: euthanasia should only be performed by doctors because only doctors have the necessary expertise (although a nurse may be asked to assist); doctors who objected to euthanasia should refer the patient to a doctor who would be willing to assist; AVE should only be performed as a last resort; overriding importance should not be attached to whether the patient’s death was imminent; there should be informal consultation with colleagues as well as formal consultation; doctors should report all cases of euthanasia; a committee of medical examiners should be set up to judge the merits of requests for euthanasia; and agreement should be reached as to prosecutorial policy until a means could be found to clarify the legal standing of euthanasia.\(^ {116}\)


\(^{115}\) Otlowski, above n4 at 411.

\(^{116}\) Id at 411, 412 and citing E Sutorius, ‘How Euthanasia was Legalised in Holland’, paper delivered in Arnhem (1985) at 15.
In 1997, by which time euthanasia had been tolerated in the Netherlands for over 20 years, the RDMA belatedly initiated a project in Amsterdam called Support and Consultation for Euthanasia.\(^{117}\) SCEA, which ran for 12 months, provided specially-trained doctors as independent euthanasia consultants to Amsterdam general practitioners, 24 hours a day.\(^{118}\) The project was subsequently extended to the whole of the Netherlands and was re-named Support and Consultation on Euthanasia in the Netherlands.\(^{119}\) SCEN, which continues to be part of the Dutch health care system, also educates general practitioners about palliative care.\(^{120}\) But, unlike the approach of the medical profession in the common law jurisdictions, there had been a greater focus on euthanasia than on palliative care in the Netherlands. Government publications suggest that palliative care\(^{121}\) became a focal point in 1996.\(^{122}\)

\(^{117}\) Hereafter SCEA.

\(^{118}\) B Ontwuteaka-Philipsen & G Van Der Wal, ‘Support and Consultation for General Practitioners Concerning Euthanasia: the SCEA Project’ (2001) 56 Health Policy 33 at 34.

\(^{119}\) Hereafter SCEN. During 2006, at which time euthanasia had been permitted in the Netherlands for over thirty years, SCEN was incorporated into the Dutch health care system and was rolled out to hospitals and nursing homes: M Jansen-van der Weide, B Onwuteaka-Philipsen & G van der Wal, ‘Quality of Consultation and the Project “Support and Consultation for Euthanasia in the Netherlands” (SCEN)’ (2007) 80 Health Policy 97 at 98. But SCEN can be ignored. In 2004, when a SCEN doctor would not endorse euthanasia for a patient who had requested euthanasia by advance directive and had subsequently developed Alzheimer’s disease, the treating doctor found another doctor who would and the patient was euthanased: T Sheldon, ‘Dutch Approve Euthanasia for a Patient with Alzheimer's Disease’ (2005) 330 British Medical Journal 1041.


\(^{121}\) The Dutch approach to palliative care is quite different to that in the common law jurisdictions. In 2005, the RDMA stated its approval of the use of Midazolam (a sedative) for palliative care. The RDMA does not approve of the use of morphine alone because it can cause convulsions and hallucinations: T Sheldon, 'Dutch Doctors are given Guidance on Sedation' (2005) 331 British Medical Journal 1422.

\(^{122}\) Hendin says that in 1999 that there were only 70 palliative care beds in the Netherlands: H Hendin, 'Euthanasia Consultants or Facilitators?' (1999) 170 The Medical Journal of Australia 351 at 352. In 1989, Dorrepaal et al claimed that palliative care was inadequate: K Dorrepaal, N Aarsonson & F van Dam, 'Pain Experience and Pain Management Among Hospitalized Cancer Patients' (1989) 63 Cancer 593-598. In 1991, Zylicz claimed that euthanasia was seen as a form of palliative care: Z Zylicz, 'Euthanasia' (1991) 338 The Lancet 1150 referring to P Admiraal, 'A Physician’s Responsibility to Help a Patient Die' & E Borst-Eilers, 'Euthanasia in the Netherlands: A Brief Historical Review and Present Situation' in R Misbin (ed) Euthanasia: the Good of Patient, Good of Society (Frederick Md, University Publishing Group: 1992). Government publications reveal a focus on palliative care from about 1996: A Francke, Palliative Care for Terminally Ill Patients in the Netherlands: Dutch Government Policy, International Publication Series Health, Welfare and Sport (2003). Note that the Dutch courts have begun to debate the border between palliative care and murder in relatively recent times. During 2003, a trainee anaesthetist, Dr Vencenek, gave a person who was dying, morphine at the rate of 5mg per hour and 5mg of midazolam in the absence of a request from the patient that he do so. He was charged with murder and was remanded in custody but was subsequently acquitted when his actions were categorised as palliative care: T Sheldon, 'Dutch Murder Case Leads to Talks with Attorney General' (2005) 331 British Medical Journal 473.
In 2002, the RDMA commissioned an enquiry into whether a doctor should be able to help a patient to die if the patient is not terminally ill or suffering from a recognised psychiatric illness but is ‘suffering through living’ (tired of life). The report\textsuperscript{123} which was released in 2005, after the TLRASA was enacted, reportedly contradicts the position adopted by the Supreme Court in \textit{Sutorius} that such matters are beyond the experience of doctors, and states that there is no reason to exclude such situations from a doctor's area of competence. The RDMA plans to continue to agitate this issue.\textsuperscript{124}

In 2003, the RDMA called for doctors who, like Dr van Oijen, have engaged in life terminating acts without an explicit request from the patient\textsuperscript{125} to be able to have their actions judged by a multidisciplinary team of lawyers and doctors instead of being judged by a court.\textsuperscript{126} The RDMA considers that Dr van Oijen’s actions were carried out ‘with complete integrity’ and that there is ‘a huge emotional gulf’ between what Dr van Oijen did and murder.\textsuperscript{127}

In 2005, Dutch doctors voted to adopt a set of guidelines proposed in December 2004 by the Groningen Academic Hospital for providing euthanasia to infants who are terminally ill and suffering (the Groningen Protocol).\textsuperscript{128} The protocol was officially introduced in the Netherlands in July 2005.\textsuperscript{129} The RDMA hopes that a

\begin{itemize}
\item \textsuperscript{123} Op zoek naar normen voor het handelen van artsen bij vragen om hulp bij levensbeeinding in geval van lijden aan het leven (In Search of Standards for the Treatment by Doctors of Requests for Help in Ending Life because of Suffering through Living). The report is not available in English: email from H Hoes, Librarian, RDMA to V Hiley (2 November 2006).
\item \textsuperscript{124} T Sheldon, ‘Dutch Euthanasia Law Should Apply to Patients ‘Suffering through Living,’ Report Says’ (2005) 330 \textit{British Medical Journal} 61.
\item \textsuperscript{125} Hereafter LAWER.
\item \textsuperscript{126} T Sheldon, ‘Court Upholds Murder Verdict on Doctor who Ended Woman's Life’ (2003) 326 \textit{British Medical Journal} 1351; T Sheldon, 'Two Test Cases in Holland Clarify Law on Murder and Palliative Care' (2004) 329 \textit{British Medical Journal} 1206.
\item \textsuperscript{127} Sheldon, above n95.
\item \textsuperscript{128} The protocol sets out the following criteria: the newborn was suffering hopelessly and unbearably with no prospect of future treatment; there was no doubt about the diagnosis and prognosis; both parents understood the decision and gave their written consent; the decision was confirmed by an independent doctor; and the death and the treatment were reported to the coroner: T Sheldon, ‘Dutch Doctors Adopt Guidelines on Mercy Killing of Newborns’ (2005) 331 \textit{British Medical Journal} 126.
\end{itemize}
committee can be established comprising three doctors and an ethicist to judge, at first instance, whether the protocol criteria have been met.130

C. The Dutch Government

Attitudes within the various Dutch Governments since euthanasia was first tolerated in 1973 can best be described as reactive and ad hoc. This is likely due, in large part, to the fact that the Dutch Government is always a coalition government131 as well as the fact that legalising euthanasia is an extremely controversial issue.

It was not until 1978, five years after Postma, that the majority of the political parties in the Lower House of the Dutch Parliament asked the Minister of Health to establish a committee to develop policies in relation to euthanasia including possible legislative reform.132 Four years later, in 1982, a State Commission on Euthanasia was set up by Royal Decree for this purpose. In 1985 the Commission delivered its report. It recommended that the Penal Code be amended to reflect legal precedent so that a doctor who provided euthanasia in accordance with the due care guidelines would not be prosecuted.133 However, the due care guidelines put forward by the Commission were not entirely consistent with those laid down in Postma in 1973 and in Wertheim in 1981134 and likely added to existing confusion.

The commission was particularly concerned to ensure voluntariness of request, consultation and reporting. It recommended the creation of a new offence of

131 According to Griffiths et al, Dutch election outcomes are determined on the basis of proportional representation so a party’s share of the national vote determines its share of the seats in parliament. Voters are able to choose from a large number of parties. After 1980, the three largest religious parties united in the Christian Democratic Party (CDA) which dominates the political centre. There are two liberal parties, one to the left of the political centre (D66 founded in 1966) and the other to the right (VVD), and one social democratic party (PvdA). None of these parties has ever received a majority of the seats in the Lower House of Parliament to which the government is responsible. Hence the Dutch government is always based on a coalition: Griffiths et al, above n1 at 10.
132 Ten Have & Welie, above n4 at 52.
134 Id at 417.
breach of the due care requirements and the insertion of a clause in the Penal Code stating that health care workers who did not want to engage in euthanasia could not be directed to do so. The committee proposed guidelines for body disposal which would allow the government to verify that the due care guidelines had been complied with. Most importantly, the commission called upon parliament to make its position on euthanasia clear in light of widespread uncertainty regarding the scope of Article 293 of the Penal Code.135

The government did not act upon most of the committee’s recommendations. One year later, in 1986, it presented a draft Bill to parliament aimed at legalising euthanasia. However, the Bill was accompanied by a letter from the Minister of Justice and the Minister of Welfare, Health, and Cultural Affairs, stating that the government’s preference was that the legality of euthanasia continue to be decided by the courts on a case-by-case basis. The Bill was nevertheless presented for debate and referred to State Council for advice. State Council agreed that the courts should continue to decide cases of euthanasia on a case-by-case basis.136 Thus an opportunity was missed to clarify the status of euthanasia at law.

In 1989, the coalition government of the day comprising the Christian Democrats, who have always opposed euthanasia, and the Labour Party, fell. The new coalition government which comprised the Christian Democrats and the Socialists could not agree on a policy in relation to euthanasia. So, the parties agreed to wait until the results of the Remmelink Report (discussed in Part 4 below) were published. This happened in 1991.137

Various coalition governments tolerated the practice of euthanasia for 18 years before formally introducing a protocol for reporting. In 1991, following negotiations with the RDMA, doctors were informed that they should notify the coroner of all

135 Otlowski, above n4 at 418, 419.
136 Id at 422, 423.
137 Ibid.
cases of euthanasia. The government empowered the coroner to investigate each case of euthanasia and to report the outcome to the Public Prosecutor. The Public Prosecutor was instructed to refer each case of euthanasia to the Chief Prosecutor for a final decision. No cases were to be reported to the police for prosecution unless the prosecutor had examined the case and approved this. However, it was not until 1993, that the government stipulated what the reports should contain.

In 1994, in the aftermath of the decision in *Chabot*, the government reacted by stating that in the case of a patient with a psychological disorder, two independent doctors should be consulted by the treating doctor, one of whom should be a psychiatrist and that the patient should be examined by both of the independent doctors. In addition, all available treatment options should be considered and recommended. This direction was inconsistent with the decision in *Chabot* so it probably heightened confusion among Dutch medical practitioners.

The TLRASA did not come about as a result of careful, long-term planning. Before it was proclaimed, the Christian Democrats called upon the European Parliament to condemn the TLRASA and threatened to bring proceedings against the Netherlands in the European Court for breaching Articles 2 and 6 of the ECHR. In August 2001, the United Nations recommended that the Netherlands re-examine the TLRASA particularly in relation to a possible breach of Articles 2, 6.

---

138 Otlowski, above n4 at 397 citing B Sluyters, 'Euthanasia in the Netherlands' (1989) 57 Medico-Legal Journal 34 at 41. Prior to this, doctors reported to the police and at 424 stating that the police would interview the doctor and the coroner would view the body. If all was in order, the body would be released to the relatives. If not, the police investigation would continue. However, there were complaints from doctors that the investigation was intrusive and relatives were inappropriately questioned.

139 Id at 426: the reports had to state the patient’s history, who requested euthanasia, whether the request was express, whether there was consultation and the means used.

140 Id at 409.

141 See Chapter Three for the contents of Articles 2 and 6 of the European Covenant on Human Rights.

142 'Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, [namely the right to life] without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status …'
6\textsuperscript{143} and 7\textsuperscript{144} of the ICCPR.\textsuperscript{145} This seems to have prompted the Dutch Government, then comprising the Socialists and the Conservatives, to finally advance an agreed position in relation to euthanasia:

The Dutch Government does not believe that the new Act conflicts with its duty under international law to defend citizen's rights to life against violation by government or by individuals … what underlies … [the Act] … is respect for life.\textsuperscript{146}

Indeed, it is likely that a catalyst for the TLRASA was an earlier change in the composition of the Dutch Government. In 1994, the Christian Democrats who have always opposed the legalisation of euthanasia were voted out of office. They were not returned to office until July 2002,\textsuperscript{147} after the TLRASA had been passed and proclaimed.

To summarise thus far, it is clear from the foregoing discussion that the Netherlands is not a model for reform. The decriminalisation of euthanasia came about in a piecemeal manner rather than as a result of coordinated planning. Judicial decisions allowed the expansion of cases in which the conflict of duties defence could be raised in the absence of a regulatory framework and favoured lenient outcomes when the principles of due care were breached. In Postma in 1973, terminal illness was a requirement for euthanasia. By 1994, in Chabot, this requirement had been abandoned and incurable mental suffering in an otherwise healthy person was accepted as sufficient reason for euthanasia. During the mid-1990s, in Prins and Kadijk, the provision of euthanasia was extended to severely deformed neonates with less than 12 months to live. In 2000, being tired of life

\textsuperscript{143}‘Every human being has the inherent right to life. This right shall be protected by law. No one shall arbitrarily be deprived of his [sic] life.’
\textsuperscript{144}‘No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment …’
was accepted, at first instance, as a valid reason for euthanasia, in *Sutorius*. In 2003, no punishment was instituted by the court following a clear case of murder in *van Oijen*.

The RDMA supported the expansion of the categories that could justify the provision of euthanasia for over 20 years before initiating means by which euthanasing doctors could obtain independent consultation and support via SCEA and later, SCEN. Up until 1996, the RDMA does not appear to have taken measures to raise awareness of palliative care as an alternative to euthanasia even though the courts had highlighted the need to look for alternatives in *Postma, Wertheim, Chabot* and *Sutorius*. The RDMA condoned the actions of Dr Sutorius and Dr van Oijen yet it appears that Drs Sutorius and van Oijen believed that their behaviour, even though it fitted the definition of murder, was a private matter.\(^{148}\) In 2003, the RDMA sought to expand the circumstances in which euthanasia should be permitted to those who are tired of living even though this was contrary to the position that was adopted by the court in *Sutorius* and contrary to the view of the Minister for Health at the time that *Sutorius* was decided.

During the 30 years that euthanasia was tolerated in the Netherlands, prior to the TLRASA, various coalition governments took 18 years to introduce reporting guidelines, 20 years to stipulate what the reporting doctor’s report should contain, 26 years to establish committees to review cases of euthanasia to ensure that the due care guidelines had been complied with, 23 years to focus on raising awareness of palliative care and 30 years to unequivocally state a rationale for tolerating and later decriminalising euthanasia. In light of this, ten Have and Welie may be correct in surmising that Dutch doctors will likely continue to successfully raise the defence of conflict of duties when the due care guidelines, now contained

\(^{148}\) This was also the conclusion reached by Cohen-Almagor following an extensive qualitative study, from July 1999 to April 2002, of the views of Dutch doctors on euthanasia: Cohen-Almagor, above n4 at 110.
in the TLRASA, are breached in the future.\textsuperscript{149} If the authors are right, it is likely that the regulation of euthanasia will not be optimal.

Having discussed the attitudes and the responses of key groups in the Netherlands to euthanasia, I now turn to examine changing Dutch sensibilities toward death and dying in order to highlight the dominant themes and to theorise why the Netherlands is the only country in the world to have legalised AVE and DAS.

3. Dutch Society – Changing Sensibilities

The unusual situation that exists in the Netherlands prompts us to ask whether there are features that are unique to Dutch society that have allowed the courts, the medical profession and parliament to permit the provision of euthanasia in an increasing number of circumstances, only drawing the line so far at being tired of life. A number of commentators have suggested that the answer to this question lies in changing Dutch sensibilities.

Griffiths et al claim that Dutch society was traditionally characterised by deeply segregated according to social class and people of different religious persuasions lived in isolation from each other. However, sensibilities changed during the 1960s and 1970s when the Netherlands legalised marijuana, abortion and prostitution. During this time, increasing secularisation reduced the distance between the social classes. The political elite did not oppose these changes. In fact, in many cases, the political elite actually became the mouthpiece for social change.\textsuperscript{150}

Gomez is less generous in his assessment of the situation in the Netherlands. He refers to the Dutch position on euthanasia as ‘active deception.’\textsuperscript{151} According to Gomez, if any group is ascendant in the Netherlands it is the RDMA which tends

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{149} Ten Have & Welie, above n4 at 112.
\item\textsuperscript{150} Griffiths et al, above n1 at 10-13.
\item\textsuperscript{151} Gomez, above n5 at 128.
\end{enumerate}
\end{footnotesize}
to see the provision of euthanasia as a private matter between patient and doctor. Gomez claims that the RDMA was the driving force behind permissible euthanasia and that Dutch doctors have far too much power and control. He also locates the decline of religion as a causative factor, claiming that secular principles have become ascendant in the Netherlands along with a Utilitarian world view. According to Gomez (quoting the foreign secretary of the Dutch Voluntary Euthanasia Society in 1989) the Dutch psyche is also greatly influenced by Calvinism:

> Everybody in Holland is a Calvinist. The Protestants are Calvinists, but so are the Catholics. Even atheists like me are Calvinists. And the communists here, they’re the worst Calvinists of all. What does this mean? We like many rules but we don’t like being told what the rules mean.\(^{153}\)

Ten Have & Welie also assert that the creation of a codified exception to the criminalisation of euthanasia was brought about by the RDMA and that the level of control now exercised by Dutch doctors over the process of dying is unprecedented.\(^{154}\) Indeed, rather than Dutch people having gained greater control over the process of securing a good death, ten Have and Welie say that the range of options for people at the end of life have probably decreased as a result of the Dutch preoccupation with euthanasia.\(^{155}\) The authors claim that Dutch people adhere to strong libertarian ideals which favour almost absolute respect for the principle of autonomy – so much so that in the wider public debate it is taken for granted that the principle of autonomy provides a sufficient moral basis for euthanasia.\(^{156}\)

The authors also point to increasing secularisation of Dutch society in the tolerance of euthanasia and back this up with statistics. In 1960, 79 per cent of the Dutch were affiliated to a religion: 37 per cent were Catholic, 28 per cent were

---

\(^{152}\) Gomez, above n5 at 131.

\(^{153}\) Id at 95.

\(^{154}\) Ten Have & Welie, above n4 at 6.

\(^{155}\) Id at 7.
Dutch reformed, 14 per cent were Calvinist and 21 per cent regarded themselves as non-Church members. By 1996, only 46 per cent of the Dutch population was affiliated to a Church. By 1997, this figure had dropped to 43 per cent comprising: 21 per cent Catholic; 14 per cent Dutch reformed; and 8 per cent Calvinist.\textsuperscript{157}

The opposition to the legalisation of euthanasia that we see in the common law countries from organised religion and key groups such as medical associations, law reform bodies and parliamentarians has never existed to the same degree in the Netherlands. Indeed, following Postma, Baptist ministers in Northern Holland declared their support for the doctor’s actions.\textsuperscript{158} The people in Dr Postma’s village banded together in support of her. Furthermore, 18 doctors signed an open letter to the Minister for Justice stating that they had killed patients who had asked them to.\textsuperscript{159} Public opinion polls have revealed a sympathetic sensibility among the Dutch for those who assist dying people to die sooner.\textsuperscript{160}

Hendin claims that key members of the RDMA he interviewed admitted that cases of inappropriate euthanasia were de-emphasised to prevent playing into the hands of those who oppose euthanasia. On the basis of his research in Holland he claims that the Dutch in general, most lawyers, judges and prosecutors as well as key members of the Dutch Government support euthanasia.\textsuperscript{161} He claims that most of the doctors he interviewed were reluctant to criticise the situation in the Netherlands because of pressure not to do so and fear it may damage their career prospects.\textsuperscript{162} However, attitudes between medical practitioners are not as united as Hendin seems to suggest. The Dutch League of Physicians, Pro Life Doctors

\begin{itemize}
\item \textsuperscript{156} Ten Have & Welie, above n4 at 14. Paradoxically, AVE is performed ten times more often in the Netherlands than DAS. The authors do not explain why this is so: Id at 15.
\item \textsuperscript{157} Id at 39, 40. Compare the statistics for the United States of America and the United Kingdom in 1997. In the United States of America 94 per cent of the population were affiliated with a religion. In the United Kingdom, 76 per cent.
\item \textsuperscript{158} Id at 8, 11.
\item \textsuperscript{159} Sneiderman & Verhoeof, above n49 at 386.
\item \textsuperscript{160} Otlowski, above n4 at 395.
\item \textsuperscript{161} Hendin, above n5 at 7, 73.
\item \textsuperscript{162} Id at 105-107.
\end{itemize}
and the World Federation of Doctors who Respect Human Life are all opposed to
euthanasia in the Netherlands.\textsuperscript{163}

Indeed, Hendin’s account may be unreliable. Griffiths et al claim that Hendin’s
findings are ‘so filled with mistakes of law, of fact, and of interpretation, mostly
tendentious, that it is hard to be charitable and regard them as merely
negligent.’\textsuperscript{164} The authors allege that Dutch doctors whom Hendin interviewed
accused Hendin of misinterpreting the information they provided to him and of
failing to submit the manuscript to them for comment prior to publication.\textsuperscript{165}

Otlowski posits that a number of factors, in addition to secularisation and a
preference for personal autonomy, have led to the decriminalisation of euthanasia
in the Netherlands: the close and typically long-term relationship between Dutch
people and the family doctor; the openness of Dutch doctors; a degree of chance
in that the court in \textit{Postma} was prepared to take into account published articles on
euthanasia provided to it by the Foundation of Voluntary Euthanasia; and the
Dutch legal system with its absence of a minimum level of punishment which left
the courts free to impose very lenient sentences in cases of euthanasia.\textsuperscript{166}

Sneiderman and Verhoef point to tolerance of diversity and respect for personal
autonomy but add the Dutch cultural characteristic of pragmatism to the picture:

\begin{quote}
\ldots if the consensual activity in question cannot be suppressed, then better it
should be brought above ground and regulated. In short, there is a sense in
which the medical practice of euthanasia is part and parcel of Dutch policy
approaches that are invariably commented upon by outside observers: the
carefully demarcated red light districts; the open sale of pornography; and not
only coffee shops selling marijuana but also stores selling the equipment for
\end{quote}

\textsuperscript{163} Otlowski, above n4 at 415.
\textsuperscript{164} Griffiths et al, above n1 at 23, footnote 15.
\textsuperscript{165} Ibid.
\textsuperscript{166} Otlowski, above n4 at 448-450. Note that, according to Downes, leniency is not limited to cases of
euthanasia. The Dutch courts respond in a lenient manner in general to criminal matters: D Downes,
However, more recently, Downes has noted that Dutch society is becoming less tolerant of contentious
practices such as drug use, prostitution and euthanasia: see D Downes, ‘Visions of Penal Control in the
growing it. To its critics … the Netherlands stands indicted as a permissive society. Most of the Dutch don’t see it that way … it is better to react to human diversity with tolerance than intolerance; pragmatism is better than the no-win law enforcement war against consensual crimes; and respecting autonomy is better than trying to force people to refrain from conduct that can directly harm only themselves.\(^\text{167}\)

This alleged pragmatism is well illustrated by the circumstances surrounding the introduction of new reporting legislation in 1994 and by the case of Prins. The legislation, which amended the Burial Act, was criticised in Parliament because it made provision for the reporting of LAWER in addition to euthanasia and because it created a conflict between the provisions of the Penal Code and the Burial Act.\(^\text{168}\) The former criminalised euthanasia whilst the latter now told doctors how to report it. Cabinet responded to these criticisms by saying that there was evidence of LAWER in the Remmelink Report and the Association of Paediatricians had reported it being practised on severely handicapped babies so the new measures were needed.\(^\text{169}\) In the case of Kadijk, the Minister of Justice instructed the Public Prosecutor to prosecute Dr Kadijk so that the courts could lay down guidelines for doctors to follow in providing euthanasia to neonates.\(^\text{170}\)

By way of summary, two dominant themes emerge from the literature in relation to changing sensibilities in relation to death and dying in the Netherlands: increasing secularisation associated with a preference for personal autonomy over communitarian interests; and a pragmatic approach to contentious issues. It is likely that secularisation of the Dutch Coalition Government prior to the enactment of the TLRASA as a result of the Christian Democrats being voted out of office in the period before the TLRASA, also played an important role in the decriminalisation of euthanasia. However, other factors were also at play because although the Christian Democrats were voted back into office in July 2002 and in

---

\(^{167}\) Sneiderman & Verhorf, above n49 at 414.
\(^{169}\) Jochemsen, above n78 at 448.
\(^{170}\) Id at 451.
November 2006, they have not launched another attack on the TLRASA since their return to office.

Having considered how the unique situation in the Netherlands came about and having highlighted the dominant themes, I now turn to consider the Dutch studies in relation to the incidence of euthanasia in order to determine whether the Netherlands is the epitome of a slippery slope.

4. The Netherlands: the Epitome of a Slippery Slope?

As noted in the introduction to this chapter, some commentators in the euthanasia debate claim that the Netherlands is sliding down a slippery slope. According to Keown, there are two versions of the argument: the logical version and the empirical version. The logical version of the argument holds that acceptance of voluntary euthanasia by necessity leads to acceptance of non-voluntary euthanasia because the former rests on a judgement that some lives are not worth living and this judgement can be made in any situation – even if a person is incapable of requesting assistance to die. The second, empirical version of the argument holds that, even if a line can be drawn in principle between voluntary and non-voluntary euthanasia, a slide towards the latter is inevitable because it is impossible to adequately safeguard against just such an occurrence. In its most extreme form, the slippery slope argument is used to ground claims that legal recognition of a right to die will lead to widespread indiscriminate killing.

Due to the existence of the due care guidelines in the Netherlands, which forbid non-voluntary euthanasia and are designed to regulate AVE and AS, I only consider the empirical version of the slippery slope argument in this part. The

173 See for example, Hendin, above n5 at 224: ‘Euthanasia advocates appeal to the fearful in the name of ideals and compassion and autonomy even as they promote policies which despite their own best intentions can only result in coercion and cruelty.’
discussion in this part is also confined to the four major empirical studies in relation to the incidence of euthanasia in the Netherlands carried out in 1990, 1995, 2001 and 2005. The four studies are only discussed in so far as they relate to the incidence of contested practices: AVE; AS; and LAWER. At the end of this part I discuss some studies that have focused on levels of reporting because a failure to report euthanasia is a risk factor for the development of a slippery slope.

A. The Remmelink Report

In 1989, the Dutch Government established a Committee to determine the incidence of euthanasia. The Committee arranged for research to be carried out by an independent group at Erasmus University in Rotterdam led by the then Attorney General, Jan Remmelink. The product of that research, the Remmelink Report, was followed by the 1995 study, the 2001 study and the 2005 study, all three of which are discussed below. All three subsequent studies adopted the same research methodology and questions as the Remmelink Report and, like the

---

174 See Appendix 14 for a summary of the results obtained from all four studies.
175 I only consider the most reliable, large-scale studies that address the incidence of euthanasia. I do not consider the numerous smaller studies in relation to euthanasia such as: G van der Wal, J van Eijk, H Leenen & C Spreeuwenberg, 'Euthanasia and Assisted Suicide. I. How Often is it Practised by Family Doctors in the Netherlands?' (1992) 9 Family Practice 130; G van der Wal, J van Eijk, H Leenen & C Spreeuwenberg, 'Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?' (1992) 9 Family Practice 135.
176 Hereafter Remmelink Report.
177 Hereafter 1995 study.
178 Hereafter 2001 study. Note that a further study which focused on reporting and review but which also looked at the incidence of medical end-of-life decisions was commissioned by the Dutch Government in 2001 and was published, in Dutch, in 2003: G Van Der Wal et al, Medische Besluitvorming aan Het Einde van het Leven: De Praktijk en de Toetsing Procedure [Medical Decisionmaking at the End of Life: The Practice and the Review and Verification Procedure] (2003). The study also looked at the incidence of euthanasia in new categories such as children; persons tired of life, demented patients by advance directive, and issues such as terminal sedation, palliative care, demand for euthanasia and opinions of patients’ relatives and the public. I was able to obtain a copy of a summary of the study’s results, which had been translated into English, from the Dutch Voluntary Euthanasia Society. That was the only part of the study that had been translated into English: email from Mr Walburg de Jong, Press Officer, to Victoria Hiley (6 November 2006). I was unable to assess the reliability of the study’s conclusions in the absence of an English translation of the methodology that was used in the study. A negative account of the study is provided by Fenigsen, see: R Fenigsen, 'Dutch Euthanasia: The New Government Ordered Study' (2004) 20 Issues in Law and Medicine 73.
179 Hereafter 2005 study.
Remmelink Report, were funded by the Dutch Government and backed by the RDMA\textsuperscript{181} and anonymity was guaranteed.

The Remmelink researchers were asked to investigate the incidence of euthanasia, whether doctors were aware of the due care guidelines and what would improve reporting levels. They developed a methodology to determine the incidence of all medical decisions concerning the end of life.\textsuperscript{182} MDELs included: withdrawing or withholding treatment (including tube feeding); administering, supplying or prescribing drugs (including AS); AVE; LAWER and decisions not to resuscitate.\textsuperscript{183}

The Remmelink Report comprised three sub-studies: a 2 ½ hour interview with randomly selected subjects;\textsuperscript{184} an examination of death certificates over a period of time;\textsuperscript{185} and a prospective study in which doctors were asked to record their role in end-of-life decision-making over a period of time.\textsuperscript{186} In each sub-study the key questions were: What did the doctor do? What was his/her intention in so acting? Did the patient request the intervention? Was the patient able or not able to decide upon the intervention?\textsuperscript{187} The prospective study was not repeated in the subsequent studies. Consequently, I do not discuss it in this part.\textsuperscript{188}

\textsuperscript{181} Notably, due to a lack of clarity at the time in relation to reporting requirements and police involvement after euthanasia, the RDMA told the Government of the day that it would only support the study if guidelines were produced in relation to these matters: P van der Maas, J van Delden & L Pijnenborg, ‘Euthanasia and other Medical Decisions Concerning the End of Life’ (1992) 22 Health Policy Monographs at 17.

\textsuperscript{182} Hereafter MDELs.

\textsuperscript{183} Van der Maas et al, above n181 at 19, 20.

\textsuperscript{184} Hereafter interview study.

\textsuperscript{185} Hereafter death certificate study.

\textsuperscript{186} Hereafter prospective study.

\textsuperscript{187} Van der Maas et al, above n181 at 20.

\textsuperscript{188} The results of the prospective study accorded very closely with the results of the death certificate study, discussed below. The main differences between the two studies were that respondents in the prospective study were more inclined to state that a MDEL was carried out with the intention of shortening life even though fewer MDELs were reported. The authors put this down to chance variations and the fact that subjects in the prospective study were not able to discuss their actions and clarify categories of MDELs with an interviewer whereas subjects were able to do this in the interview study. There were no other marked differences between the two sub-studies: Van der Maas et al, above n181 at 159-163.
i. The Interview Study

Subjects for the interview study were drawn from each group of doctors in the Netherlands that has most involvement with end-of-life care: general practitioners; geriatricians; and specialists in the fields of oncology, haematology, nephrology, cardiology and pulmonology. Within these groups, subjects were randomly selected from registration lists provided they had practised for at least two years at the same location. The results from all three sub-studies were used to arrive at an average figure for the incidence of each MDEL. Results were weighted in order to extrapolate them to the whole of the Dutch population and regression analysis was used giving a confidence interval of 95 per cent.189

The cohort for the interview study comprised 150 general practitioners, 50 nursing home doctors and 210 specialists (a total of 410).190 Subjects were interviewed for approximately 2½ hours191 about the following: requests for AVE and AS and the most recent case of either; refusals of AVE and AS; LAWER; alleviation of pain and symptoms; withdrawing or withholding treatment on the explicit request of the patient; and do not resuscitate decisions. The interview looked at the subjects’ most recent involvement in MDELs. At most, 10 cases were discussed.192 Interviews were carried out by 35 trained doctors, five of whom held PhDs, in order to determine whether being interviewed by a medical doctor made any difference to the results. Subjects were not compensated for their time in interviews.193

The results of the interview study suggested that AVE and AS were already widely accepted practices by 1989 but that, when judged against total deaths, the incidence of both was relatively low. However, compliance with the due care guidelines was inadequate. Thus, 54 per cent of the subjects had engaged in AVE or AS at some time and 24 per cent in the last 24 months. Thirty-four per cent had

---

189  Van der Maas et al, above n181 at 27-31.
190  Id at 28, 29.
191  Id at 14.
192  Id at 32-33.
193  Id at 28-31, 35.
never done so but could conceive of it. Only 8 per cent would not provide AVE or AS but these would refer. Only 4 per cent would never refer or provide AVE or AS. The provision of euthanasia did not meet demand. Forty-four per cent of all requests received at some time were refused, the main reason being that alternatives were still available (33%). Seventy-two per cent of the cohort had reported the death as a natural death in breach of the due care guidelines. Eighty-four per cent had consulted with a colleague beforehand so that 16 per cent were in breach of this due care guideline. Fifty-five per cent of respondents said this was done to avoid the fuss of a judicial investigation, 25 per cent said it was done for fear of prosecution, 52 per cent stated it was to safeguard relatives from a judicial enquiry and 12 per cent did not consult because of bad experiences in the past. It is quite telling that eight general practitioners and 15 specialists said they perceived the death as natural even though it was not. Notably, 60 per cent failed to keep proper records.

Extrapolating from the figures from all three sub-studies, the researchers estimated that 1.7 per cent of deaths in 1990 (2,300 deaths out of a total of 128,786 deaths) were due to AVE and 0.8 per cent of all deaths were due to AS. These figures, assuming that subjects were honest in their answers, do not support the claim that the incidence of AVE or DAS in the Netherlands is extremely high or out of control. Subsequent studies, discussed later in this part, also do not support such a claim.

Extrapolating from the statistics generated in all three sub-studies in relation to LAWER, the authors estimated that there were 1,000 cases of LAWER in the Netherlands in 1990 representing 0.8 per cent of all deaths in that year. However, the methodology used to unearth this MDEL was flawed so the results are unreliable. The researchers did not enquire as to the subject’s intent each time

\[\text{\textsuperscript{194}}\text{ Van der Maas et al, above n181 at 40, 41, 45.}\]
\[\text{\textsuperscript{195}}\text{ Id at 44, 45, 48-50.}\]
\[\text{\textsuperscript{196}}\text{ Id at 178,179.}\]
\[\text{\textsuperscript{197}}\text{ Id at 181, 182.}\]
a LAWER was engaged in. In addition, the drug most often used in LAWER was morphine (76 per cent of 97 deaths before extrapolation) and the disease most frequently involved was cancer (70 per cent).\textsuperscript{198} As discussed in Chapter Two, it is accepted medical practice in the common law countries to use high doses of morphine at the end of life in the knowledge that this may shorten life. Thus, it is possible that subjects reported practices that are legitimated by the DDE in the common law countries as a LAWER.\textsuperscript{199}

In the context of LAWER, lack of consultation (48 per cent) and failure to report (only one subject reported the death as not being due to natural causes) emerged as significant issues.\textsuperscript{200} Other problems that emerged from the Remmelink Report were: a lack of detailed knowledge of the due care guidelines; a failure to consider the guidelines to be important; and a feeling among some subjects that doctors should not have to report euthanasia. Ninety eight per cent of subjects were aware of the due care requirements but when asked to list them only 42 per cent mentioned a voluntary request, 11 per cent explanation of alternatives, 18 per cent a long-standing desire to die and 37 per cent unbearable suffering. The highest figure was 66 per cent for a seriously considered request. Sixty seven per cent of subjects thought that consultation with a colleague was important, 59 per cent thought a written report was important and 64 per cent thought that no treatment alternatives was important. Twenty two per cent said that they would never, under any circumstances, be prepared to report a case of euthanasia to the coroner. Only 27 per cent said they always report.\textsuperscript{201}

\textit{ii. The Death Certificate Study}

The death certificate study involved examining a randomly selected sample of 8,500 death certificates selected from all deaths from July-November 1990 and

\textsuperscript{198} Van der Maas et al, above n181 at 57, 58, 60 – 67.
\textsuperscript{199} Attempts have been made in the Netherlands to justify the figures for LAWER. See, for example, P van der Maas, J van Delden & L Pijnenborg, ‘Euthanasia and other Medical Decisions Concerning the End of Life’ (1992) 22 Health Policy Monographs at 96, 97, 99. I do not discuss those publications in this part because I take the view that the figures for LAWER are unreliable.
\textsuperscript{200} Van der Maas et al, above n181 at 64, 65.
allotting each a number from 0-4 where 0 meant no chance of a MDEL, 1 a small chance, 2 a possibility, 3 a serious chance and 4 a high chance. Treating doctors for deaths in categories 1-4 were sent a short questionnaire about deaths they had been involved in.202

The responses indicated that no MDEL was performed in the majority of deaths (60.6 per cent of the 8,500 deaths). The largest category of MDELS was 17.9 per cent for intensifying alleviation of pain taking into account that this would probably hasten the end of life. In half of these cases there was an explicit intent to shorten life however this intent was surmised when subjects selected the purpose ‘to reduce or end suffering.’ 2.7 per cent of cases involved AVE or AS. 203 Compliance with the due care guidelines again emerged as an issue. There was prior discussion of AVE or AS in 83 per cent of cases. In the 27 per cent of cases in which consent was not obtained, this was said to be due to the patient not being able to make his or her wishes known.204

B. The 1995 Study

The aim of the 1995 study was to evaluate changes in the incidence of MDELS between 1990 and 1995. The 1995 study comprised only two sub-studies: a 2 ½ hour interview with a sample of 405 doctors randomly selected from the same practice groups as in the Remmelink Report and a death certificate study involving analysis of responses to questionnaires that were mailed out in relation to 6,060 deaths for the period 1 August – 1 December 1995 (total deaths 43,000). The questionnaire was designed to elicit what actions subjects took, their intention, whether there was a request from the patient for the action or some sort of discussion and whether the patient was competent; questions were identical to the

201 Van der Maas et al, above n181 at 95-99.
202 Id at 121-125.
203 Id at 128, 129.
204 Id at 130-135.
previous study.\textsuperscript{205} Response rates were 89 per cent and 77 per cent respectively. Ninety five per cent confidence intervals were achieved.\textsuperscript{206}

The results of the 1995 study revealed the following changes relevant to the slippery slope argument: an increase in the incidence of AVE from 1.7 per cent to 2.4 per cent in the death certificate study and an increase from 1.9 per cent to 2.3 per cent in the interview study. The rate of LAWER had decreased by 0.1 per cent and AS had remained constant. Willingness to engage in euthanasia was almost identical to the 1990 study.\textsuperscript{207} The results of the 1995 study do not support the existence of a slippery slope but, as the authors themselves concede, the results do not provide conclusive evidence either way.\textsuperscript{208}

C. The 2001 Study

The 2001 study looked at the incidence of MDELs in order to determine whether there had been any changes over the 10 year period since the Remmelink Report was published. The sub-studies carried out utilised the same methodology as the 1995 study and comprised a death certificate study and an interview study. Questions were identical to the previous two studies. The only difference between the 1995 study and the 2001 study was that the MDEL numbering categories in the 2001 death certificate sub-study were altered\textsuperscript{209} from 0-4 to 1-5.\textsuperscript{210}


\textsuperscript{207} Id at 1700.

\textsuperscript{208} Id at 1704, 1705.

\textsuperscript{209} There were still five categories used for the deaths in the sample and it was still the case that questionnaires were not sent out for deaths in the category in which a MELD was very unlikely (in this case category 1). The same selection methods were used as in the two previous studies so it is likely that this change in the numbering of categories did not interfere with comparison of these results with those from the earlier studies.

\textsuperscript{210} Onwuteaka-Philipsen et al, above n205 at 1.
The 2001 study did not show any significant increase in contested practices. The death certificate study showed that the rate of euthanasia increased from 1.7 per cent of all deaths in 1990 to 2.4% in 1995 and to 2.6% in 2001. In the interview study no increase was found in 2001. The frequency of DAS and LAWER remained virtually unchanged during all of the years studied. The only end-of-life decision that had clearly increased in 2001 was alleviation of symptoms with the use of morphine or other opiates with the possibility that life could be shortened as a result.\textsuperscript{211}

The authors of the 2001 study rightly conclude that the results show relative stability in the incidence of AVE, AS and LAWER over the period studied and probably reflect an incidence that is to be expected in a country in which euthanasia was, at that time, tolerated as this was prior to the decriminalisation of euthanasia.\textsuperscript{212}

Notably, data from Oregon, where AS has been legalised, also do not establish the presence of a slippery slope.\textsuperscript{213} European data shows a higher level of AVE and AS in the Netherlands than in England, Belgium, Denmark, Italy, Sweden and Switzerland.\textsuperscript{214} However, as Wolf points out, it is not possible to establish the existence of a slippery slope in the absence of detailed studies of the incidence of euthanasia in each jurisdiction that permits it.\textsuperscript{215} In order to ensure a clear and valid comparison, such studies would need to use identical definitions of AVE, DAS, LAWER and would need to distinguish between the provision of analgesia with the sole purpose of ending life and the provision of analgesia with the purpose of relieving pain, in the knowledge that this may shorten a patient’s life.

\textsuperscript{211} Onwuteaka-Philipsen et al, above n205 at 2, 4.
\textsuperscript{212} Id at 5.
\textsuperscript{214} See Appendix 15.
D. The 2005 Study

In 2005 a death certificate study was carried out that was largely similar to the previous three studies discussed above. All 43,959 deaths that occurred between August and November 2005 were assigned to one of five strata. Stratum 1 contained cases in which it was clear that a MDEL was not involved such as a sudden death from a car accident. Questionnaires were only sent out for deaths in which there was a chance of a MDEL. 6,860 questionnaires were mailed to the treating doctors. 5,342 were returned giving a response rate of 77.8 per cent.²¹⁶

The questions asked in relation to the type of end-of-life treatment decision that was made were identical to the previous studies outlined above (refraining from treatment, alleviation of symptoms, LAWER, AVE and DAS). However, the questionnaire also asked about the practice of terminal (palliative) sedation and subjects’ reasons for non-reporting²¹⁷ (reporting levels are discussed in subsection E below).

Percentages were weighted to adjust for differences between the five strata and differences in demographics. After this, percentages were extrapolated to cover a 12-month period involving 136,402 deaths in the Netherlands and weighting factors were applied. After all weighting factors and logistic-regression analysis had been applied and chi-squared analysis had been used to compare rates across years, only p values of less than 0.05 were considered to be of statistical significance.²¹⁸

The results of the 2005 study do not suggest that the practice of euthanasia is out of control in the Netherlands. In 2005, 1.7 per cent of all deaths were the result of euthanasia compared with 2.6 per cent in 2001, 2.4 per cent in 1995 and 1.7 per

²¹⁷ Id at 1959.
²¹⁸ Id at 1959, 1960.
cent in 1990. 0.4 per cent of all deaths were due to LAWER which was not significantly different from previous years. 8.2 per cent of all deaths in 2005 were due to terminal sedation.\textsuperscript{219}

As the authors point out, the results show a modest decrease in AVE and DAS since the TLRASA was enacted but a significant reversal of trends between 1990 and 2001. The authors conclude that the decrease in AVE and DAS since the TLRASA may be due a number of factors: changes in epidemiologic patterns; an increase in the use of palliative sedation and other means of alleviating symptoms near the end of life; and a decreased inclination among doctors to believe that opioids hasten death.\textsuperscript{220} This presumably means that fewer doctors are categorising pyramid pain relief, a practice that is sanctioned in the common law countries by the DDE, as a form of euthanasia.

**E. Reporting**\textsuperscript{221} **Since the Remmelink Report**

Reporting of euthanasia has improved in the Netherlands since the Remmelink Report but is still not optimal. In 1996 a study was carried out that assessed reporting in a number of ways. Firstly, by interviewing a random sample of 405 doctors who had not reported after euthanasia and 147 doctors who had reported. Secondly, by interviewing 116 coroners and 48 prosecutors about reporting of euthanasia. Thirdly, by reviewing 353 judicial files of reported cases of euthanasia, the minutes of the Assembly of Prosecutors General from 1991 to 1995 and all published court decisions from 1981 to 1995. The study found that reporting had increased from an estimated 18 per cent to 41 per cent during the period 1990 to 1995.\textsuperscript{222} Most of the doctors who were interviewed indicated concerns about the

\textsuperscript{219} Van der Heide et al, above n216 at 1960.

\textsuperscript{220} Id at 1961, 1962, 1964.

\textsuperscript{221} See Appendix 15 for a table showing reporting levels from 1990-2003.

In 1998, doctors were directed to report to the coroner after euthanasia instead of the Public Prosecutor thus making the process less legalistic in nature. A review of Dutch monitoring of euthanasia carried out in 2005 revealed that there was an increase in reporting, albeit small, to 54 per cent in 2001 but reporting had decreased from 2001 to 2003. Similarly, data published by the regional review committees suggest that reporting declined between 2000 and 2003. In 2000 there were 2,123 reports, in 2001 there were 2,054 reports, in 2002 there were 1,882 reports and, in 2003, there were 1,815 reports.

The 2005 study, discussed above, also looked at reporting after euthanasia. It showed an increase in reporting rates to 80.2 per cent for that year which is still not optimal. The researchers asked subjects who did not report, why they did not report. Very few subjects mentioned uncertainty over the legality of their actions. The main reason for not reporting was that, although the act in question fell within the definition of an end-of-life decision in the study, the subject did not categorise the act as such because it involved using opioids and/or sedatives. The authors theorise that this may be because Dutch doctors are aware of evidence that the life-shortening effects of such drugs are overstated.

223 Van der Maas et al, above n222 at 1710.
5. Conclusion

The results of the empirical studies, discussed above, do not support the claim that the Netherlands is the epitome of a slippery slope. On the other hand, the matters discussed in Parts 2 and 3 above do not support the argument that the Netherlands is a model for reform. The available information suggests that the Netherlands is neither. It suggests that: a high degree of secularisation; a strong preference for personal autonomy over communitarian interests; a sensibility of pragmatism when it comes to matters that are highly contested elsewhere; and a tendency to view the need to reduce human suffering as more important than the SLD all helped lead to the decriminalisation of euthanasia in the Netherlands.

Having concluded in this chapter that the Netherlands is not a model for reform and, having concluded in Chapters Two – Four, that legal and medical responses to changing sensibilities to death and dying in the common law countries are lacking, in Chapter Six I canvass options for reform. In the process I highlight the lessons that can be learned from the Netherlands, the need for more extensive debate of key issues in the euthanasia debate such as pain and suffering, and the need for a greater willingness to listen to the lived experience of those who are dying. At the same time, I revisit two issues that were traversed in earlier chapters: the defence of necessity (the common law equivalent of the Dutch conflict of duties defence); and palliative sedation.

---

CHAPTER SIX
RESPONDING TO CHANGING SENSIBILITIES IN THE CONTEXT OF THE RIGHT TO DIE DEBATE

So when they got to me I said that if I had a million dollars I’d get a ticket and go to Amsterdam. And I’d pay to have euthanasia. Well! That went down like a lead balloon … Anyway not long after this incident they bring the minutes of the meeting for me to see. And when you read about my suggestion (no names appeared for anyone) it simply read: one lady said she would take a trip to Holland! So I mean they couldn’t even put it on paper.¹

[Marion, nursing home resident, regarding comments she made during the discussion group ‘Chattery’ in which residents were asked what they would do if they won a million dollars].

1. Introduction

In this thesis I have utilised the notion of sensibilities in order to capture the shape of death and dying at the present time. In the common law countries today, the process of dying is likely to be prolonged, medicalised and sequestrated from the community. At the same time, by examining the results of opinion polls in relation to what I have referred to, for ease of reference, as the typical euthanasia scenario, I have shown that there is a sensibility of support, in the common law countries, for euthanasia to be available in certain circumstances. Linking these two domains of thought, I argued that the push for legal recognition of a right to die has likely come about in response to the medicalisation and the sequestration of the process of dying which tends to produce the unsatisfactory situation that Elias referred to as ‘the loneliness of the dying’.

By contrasting changing sensibilities with what I have inferred to be changing attitudes among key groups (the judiciary, law reform bodies, parliamentarians and medical practitioners) and with the actions of key individuals I have highlighted the shifting nature of the balance of power in the euthanasia debate. And, I have shown that the situation with regard to the call for a right to die is much more

complex than it initially appears to be. Attitudes within key groups, whilst often opposed to the legalisation of euthanasia, are far from settled and far from uniform. Sensibilities as measured in opinion polls appear to be more uniform in nature but are commonly based on a flawed understanding of what drives a desire to die sooner, focusing on physical pain instead of existential pain. And, as I indicated in Chapter Two, by adopting simplistic questions, opinion polls can produce misleading results.²

In light of this and in light of emerging demographic data, discussed in Chapter One, that suggest there will be a significant increase in the number of those aged 85 and above in the near future, I have argued for a re-examination of key institutions and groups in order to determine how well they are responding to changing sensibilities in relation to death and dying.

In this regard, in Chapters Two to Four, I assessed medical and legal responses to changing sensibilities. In Chapter Five, as a means of gaining greater perspective on practices that may be taken for granted in the common law countries, I considered the responses of counterpart key groups in the Netherlands. At the end of each chapter, I put forward suggestions for reform.

In the process, I have concluded that neither medicine nor law are responding in a sufficiently flexible manner to changing sensibilities in relation to death and dying in the context of the right to die debate. Absent special circumstances such as a powerful and successful champion for a right to die, as was the case with Marshall Peron in the Northern Territory and ERGO in Oregon, I have come to the view that the changes I suggested in the domain of law are unlikely to be made. Attitudes among the judiciary and other key groups such as law reform bodies and parliamentarians are in a state of flux. So far as the domain of medicine is concerned, I have concluded that the changes that I suggested are yet to be made.

² See Chapter Two, n147.
and may never eventuate because attitudes within medicine are similarly unsettled.

The conclusions I have reached thus far prompt me to ask, again, whether there is any better way forward in the euthanasia debate, in addition to the options that I canvassed in earlier chapters. Those options were: enlarging the matters that courts can take into account in end-of-life case law to include the petitioner’s or the deceased’s prognosis, beliefs about a good death and level of suffering; the interests of those in a close and caring relationship with the person who sought or is seeking assistance to die; and the need to exclude factors that may negate personal autonomy such as disability.³

In this, the final chapter of the thesis, I discuss an additional three options for increasing the flexibility of responses to changing sensibilities in relation to death and dying. The three options are: legalising euthanasia by way of carefully formulated legislation; permitting the defence of necessity to be raised following euthanasia; and extending existing practices in the medical subspecialty of palliative care.⁴ I consider each option before determining which is the most appropriate at the present time. I then conclude the chapter by highlighting some of the larger issues at stake in the euthanasia debate such as the need to recognise the fundamentally interdependent nature of human social life. I do so because, as Elias pointed out, we can only respond to changing sensibilities in an adequate manner if we resist the temptation to think of people as separate and autonomous.

³ See pages 88, 128, 130, 132 above.
⁴ I do not consider the option of creating a defence of mercy killing, which I defined in Chapter Two as killing by relatives or friends of the deceased, because this thesis predominantly focuses upon the provision of euthanasia by medical practitioners. I do not discuss the possibility of maintaining the status quo because I have concluded that existing approaches are unsatisfactory.
2. Options for Reform

A. Legalising Euthanasia via Legislation

Many of the commentators in the right to die debate argue that euthanasia should be legalised via legislation. The qualifying criteria for euthanasia contained in the ROTIA, which were set out in Chapter Two, show the very high degree of prescriptive control that is possible by way of legislation as opposed to case law. The limitations of case law emerged in Chapters Two, Three and Five; judge-made law is a blunt instrument, particularly when dealing with complex and highly contested claims such as the claim for a right to die.

Legalising euthanasia by way of legislation raises a number of important issues that were discussed in earlier chapters. Those issues are: the need to protect against possible abuse; the wisdom of applying a time limit within which death must occur; the need for more in-depth debate in relation to the role of existential pain in requests to die sooner; the need to recognise the limitations of the concept of personal autonomy; and the need to facilitate a dignified death. I discuss each of these issues, in turn, below.

Legal regulation of euthanasia is complex and multifaceted and its impact dependant on a number of variables such as judicial interpretation, juror sentiment and statutory clarity. However, if these factors could be adequately managed then I believe that euthanasia should be tightly regulated, primarily to reduce the

---

5 My comments in this part are primarily directed towards AVE because, as we saw in Chapter Two, it is AVE that is most often carried out by doctors whereas AS is usually engaged in by relatives or friends of the deceased.

potential for abuse of the practice by ensuring that important issues are addressed such as: that the request for euthanasia is truly autonomous and well-informed and that no other options are reasonably available that are workable for the person requesting euthanasia. In addition, tight regulation of euthanasia can assist in ensuring that the process of dying is dignified and in tempering its impact upon those who are closest to the person who has requested euthanasia.

i. Limiting the Potential for Abuse

As we saw in the previous chapter, there is no hard evidence of a slippery slope in the Netherlands where euthanasia was decriminalised in 2002 or in Oregon, where the legality of AS was confirmed in 1997. However, there will always be the potential for abuse when euthanasia is legalised. The risk of abuse is arguably greater in jurisdictions in which people do not have equal access to health care. In the Netherlands the health care system covers Dutch citizens for all costs arising out of genuine medical needs but that is not the case in some of the common law jurisdictions. In order to reduce the risk of abuse, governments of jurisdictions that are contemplating legalising euthanasia should first ensure that all people have equal access to health care.

The ROTIA, which was discussed in Chapter Two, is a rich source of ideas as to how to limit the potential for abuse of euthanasia. Subject to the outcome of further debate in relation to key issues such as what type(s) of existential pain ought to qualify a person for euthanasia (see below), I endorse the provisions in the ROTIA. The availability of euthanasia should be controlled in the following ways: by limiting the provision of euthanasia to medical practitioners; by requiring the person requesting euthanasia to be at least 18 years of age; by requiring him or

---

7 Note however, as Magnusson shows, that having no means of regulating euthanasia at all, in circumstances where it is known to occur, also gives rise to the potential for abuse: see R Magnusson, Angels of Death: Exploring the Euthanasia Underground (2002).
8 H ten Have & J Welie, Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice (2005) at 158.
9 See, for example, R Fowler, 'Sex and Age-Based Differences in the Delivery and Outcomes of Critical Care' (2007) 177 Canadian Medical Association Journal 1513-1519.
her to be suffering from a terminal illness; by requiring proof that he or she has been informed of all of the other available options such as palliative care; by providing for a 'cooling off' period; by requiring that a request for euthanasia be made in a verifiable form; and by requiring the person seeking euthanasia to be examined by a psychiatrist in order to identify conditions that might be treated such as depression. Whenever possible, every attempt should be made to resolve existential pain and to offer treatment for any psychiatric illness that is identified.

Additionally, euthanasia legislation should contain a statement, perhaps in the preamble, that euthanasia is a remedy of last resort when nothing else has provided the person seeking euthanasia with a level of relief that is acceptable to him or her and only after all of the legislative safeguards have been met.

The Regulations to the ROTIA, discussed in Chapter Two, are also a useful source of ideas as to how to decrease the risk of abuse of euthanasia. Euthanasia legislation should require the treating doctor to consult with another practitioner with expertise in the type of disease from which the person seeking euthanasia is suffering, prior to the provision of euthanasia, in order to confirm the diagnosis and to ensure that there is no other option that is acceptable to the patient. As is the case in the Netherlands and in Oregon, euthanasia legislation should state that a doctor who provides euthanasia must report the event to a Government-appointed body afterwards and provide a report showing compliance with the legislation, the procedure that was adopted, the outcome of the procedure and any complication that was experienced.

The Dutch experience with euthanasia highlights the need to ensure that consultant doctors are independent from treating doctors in order to limit the potential for abuse. This could be achieved by adopting measures similar or identical to the SCEN project discussed in Chapter Five. A further check on abuse could be created by limiting the provision of euthanasia to residents of the state in which the legislation is in force. In addition, as the situation in the Netherlands suggests, doctors should be educated about acceptable parameters for the provision of euthanasia prior to legalisation. Otherwise there is a risk that the
legislation may not be complied with and some doctors may develop an attitude that the provision of euthanasia is beyond the purview of the law. Others, who already have this attitude, will likely continue to think so.

In order to determine whether a slippery slope is developing, information should be gathered in relation to the incidence of euthanasia in a manner that permits meaningful comparisons to be made, locally, over time and between the jurisdictions that permit euthanasia. This could be achieved by utilising the approach in Oregon where data are collected each year on the number of cases of assisted dying, the number of persons who sought assistance but did not proceed, the reasons why assistance was sought and each person’s socioeconomic background and age.

The ODDA, which was discussed in detail in Chapter Two, contains a safeguard that a person who is seeking assisted dying must have a life expectancy of six months or less. Apart from the obvious problem of predicting life expectancy with this degree of accuracy, the case law discussed in Chapter Three suggests that the inclusion of this limitation can be problematic. This is a topic to which I now turn.

*ii. The Problem of Instituting a Precondition that Death Occur within a Specified Time*

Instituting a precondition that death occur within a specified time for euthanasia to be available is likely to produce uneven outcomes. Consider Dianne Pretty, discussed in Chapter Three, who suffered from motor neurone disease. Motor neurone disease is fatal but sufferers do not know when they will die. Mrs Pretty was terrified because she knew that she would likely suffocate to death after a long and debilitating illness. The issue in Mrs Pretty’s case was not how long she would live but the fact that she faced a prolonged period of existential pain. That is why she sought approval to be able to obtain AS at a time in the future. According to Dame Hale, one of the judges who decided Mrs Pretty’s case in the House of Lords, the refusal of her applications and appeals resulted in Mrs Pretty dying in the way in which she had most feared.
Yet, it is already the case, in relevant circumstances, that a person who wishes to die can bring about this result by refusing unwanted medical treatment whether or not the person is terminally ill. Consider again Ms B who was also discussed in Chapter Three. It will be recalled that Ms B, whilst dependant on a respirator, was not terminally ill. In contrast to Mrs Pretty, Ms B brought about her own death and the end of her existential pain by directing that the respirator that was keeping her alive be removed.

Accordingly, I contend that it would be unreasonable for euthanasia legislation to include a precondition that euthanasia only be available if a person is expected to die within a certain timeframe. This would be unfair given that many who wish to die can already achieve that end without the need to show that they are likely to die within a particular period of time.

### iii. The Need to Debate the Issue of Existential Pain

As we saw in Chapters Two and Four, the euthanasia debate in the common law countries is yet to acknowledge and discuss the role of existential pain in generating requests for assisted dying. In doing so it is important to consider the many different forms that existential pain can take, from a lack of quality of life to feelings of loneliness to a strong desire not to be dependant on others to feelings of helplessness, despair or fatigue to being tired of living.

Clearly, there is a need for the euthanasia debate to consider what types of existential pain ought to permit a person to obtain euthanasia. Revisiting two of the *dramatis personae* that we met in Chapter Five reveals how simple and yet how complex this process is likely to be. Due to widespread adherence to the SLD in either its religious or secular form, it is likely that consensus would quickly be reached that those who, like Edward Brongersma and Nancy Crick, are simply tired of living but otherwise well should not be euthanased. Similarly, it is likely that agreement would quickly be reached that any form of existential pain that can be treated should be provided the patient consents to this. However, the simplicity ends there.
Consider again, the case of Hilly Boscher, discussed in Chapter Five. As the reader will recall, Mrs Boscher was not terminally ill. She was in a state of profound existential distress; grief stricken because of the death of both of her sons. Mrs Boscher’s sons gave her life meaning, they were her *raison d’être* so with both of them dead there was no longer any reason for her to go on living. How should we, in the common law countries, deal with this particularly difficult situation when we are yet to establish a uniform strategy for treating intractable existential distress at the end of life?\(^\text{10}\) The issue of what types of existential pain ought to qualify a person for euthanasia must be considered and canvassed at length before euthanasia legislation is enacted.

**iv. Recognising the Limits of Personal Autonomy**

In Chapter One I noted that one of the driving forces behind the call for legal recognition of a right to die is the notion of personal autonomy. Proponents of a right to die typically consider personal autonomy to be a great deal more important than communitarian interests. As we saw in Chapter Five, many commentators attribute the legalisation of euthanasia in the Netherlands to a strong and widespread belief in the importance of personal autonomy. This belief increased as Dutch society became less affiliated with religion. It is likely that, if the trend toward increasing secularisation continues in the common law countries, the privileging of personal autonomy will become more pervasive, in the future, and there will be greater interest in euthanasia as an option at the end of life as a result.

In Chapter Three, following discussion of the cases of *Latimer* and *Re A*, I pointed out that the principle of personal autonomy is not the fixed, immutable concept that many proponents of a right to die assume it to be. On the contrary, for many people who are terminally ill, particularly those suffering from a disability,

advanced old age, depression or other forms of psychiatric illness, personal autonomy may be in very short supply. This is yet to be recognised and comprehensively addressed in the euthanasia debate.

Once people are aware of the limitations of the concept of personal autonomy we will be in a better position to debate how best to ensure that a request for euthanasia is autonomous and not driven by other factors. In this regard, one need only consider again the Dutch documentary *Death on Request*, which was discussed in Chapter Five. In watching the documentary, I got the distinct impression that Cees’ wife, Antoinette, was the driving force behind Cees’ ‘request’ for euthanasia. In light of this, in addition to the limitations outlined above, euthanasia legislation should make provision for unbiased counselling prior to the provision of assistance to die in order to confirm that a request for euthanasia is in fact an autonomous one.

An additional limitation associated with the concept of personal autonomy is a tendency to view personal autonomy only from the perspective of the person seeking assistance to die. In fact, the principle of personal autonomy attaches to all human beings and beliefs about personal autonomy are likely to be just as important to members of the healthcare team who care for a person seeking euthanasia. Hence, euthanasia legislation should provide that health care workers cannot be compelled to provide euthanasia if this is contrary to their beliefs.

v. *Ensuring that the Process of Human Dying is Dignified*

Whilst proponents and opponents of legalised euthanasia agree that the process of human dying should be dignified, debate continues to rage over the true definition of key terms such as dignity. It is difficult to resolve this issue other than as a result of sensibilities continuing to change, over time, to the point where the majority of people come to see assisted dying as a dignified way of dying.

If this occurs, euthanasia legislation should state that its aim is to promote a death that is dignified. This could be defined to mean that euthanasia must be carried out in a manner that is technically correct, that complies with the relevant legislation,
that does not result in any disfigurement to the body and that does not cause undue distress to those who are in a caring and close relationship with the person seeking euthanasia.

It is likely that the issue of legalising euthanasia by legislation will continue to be revisited in the common law countries in the future. This is why I discuss it in this part. However, I do not consider this option to be a realistic one at the present time. Discussion in Chapters One, Two and Four revealed that attitudes in the common law countries among key groups are not sufficiently united to justify legalising euthanasia at the present time. Opinion polls suggest a widespread community sensibility of support for legalised euthanasia but, as discussion in Chapter Two showed, polls are typically based on a flawed understanding of the factors that drive a desire to die sooner because they tend to focus on physical pain. Consequently, such polls should not be relied upon as a mandate for the legalisation of euthanasia. Given that, at the present time, there is no equivalent to Mr Perron or ERGO in the other common law jurisdictions, community sensibilities must become more uniformly in favour of legalised euthanasia, and should be based upon a recognition and understanding of the role of existential pain in requests for assistance to die, before they should be relied upon as a reason to legalise euthanasia.

B. Permitting the Defence of Necessity to be Raised

The discussion of case law in Chapter Five prompts us to ask whether the common law countries should follow the lead of the Netherlands by permitting doctors to raise the defence of necessity in order to justify or to excuse having provided euthanasia.11 As we saw in Chapter Five, necessity (the conflict of duties defence) was the mechanism whereby euthanasia was decriminalised in the Netherlands.

The various elements of the defence of necessity were set out in Chapter Three. To recap, in England, three requirements must be met before a defendant can raise the defence of necessity: s/he carried out an act that was needed to avoid inevitable and irreparable evil; s/he did no more than was reasonably necessary for the purpose to be achieved; and the evil inflicted was not disproportionate to the evil avoided.\(^{12}\) In Canada, three similar qualifying conditions must be met before the defence of necessity can be raised: there was a situation involving imminent peril or danger; the accused had no reasonable legal alternative to the course of action that s/he took; and there was proportionality between the harm inflicted and the harm avoided.\(^ {13}\) It is likely that the courts in the other common law jurisdictions would adopt one of these formulations if the defence of necessity were raised in a prosecution for murder following AVE.\(^ {14}\)

The possibility of permitting the defence of necessity to be raised in a prosecution for unlawful killing after a typical euthanasia scenario is not entirely fanciful. As we saw in Chapter Three, there is English and American case law that holds that necessity cannot be pleaded in defence of a charge of murder. However this authority dates back to the 1800s\(^ {15}\) and has been challenged. It was challenged in America during Hurricane Katrina in 2007. In England, it was challenged in 1987 in the Zeebrugge ferry disaster and again, in 2001, in the case of *Re A*.

In the Zeebrugge ferry disaster the coroner held that it was reasonable to cause another person’s death in the pursuit of self-preservation or the preservation of other lives. In *Re A* the defence of necessity was raised, among other factors, in order to justify an operation that would kill an infant. Following Hurricane Katrina, a Grand Jury refused to indict a doctor who had prescribed pain relief in doses that

\(^{12}\) *Re A Children (Conjoined Twins: Surgical Separation)* [2001] 147 Fam at 240.

\(^{13}\) *R v Latimer* [1997] 1 SCR 217 adopting the test of necessity in *Perka* [1984] 2 SCR 232.

\(^{14}\) There is an additional requirement in the United States of America that the legislature must not have expressly or by implication denied the use of the defence in the context in which an accused seeks to raise it: C Stewart, *The Right to Die and the Common Law* (PhD thesis, University of Sydney, 2002) at 296.

\(^{15}\) *R v Dudley and Stephens* (1884) 14 QBD 272; *United States v Holmes* (1842) 26 Fed Cas 360.
were sufficient to kill the recipient. Thus the case law in relation to necessity and unlawful killing in England and in the United States of America is far from settled.

As discussed in Chapter Three, in Canada, the defence of necessity was removed from the jury in *Latimer* on the grounds that its constituent elements were not made out. Mr Latimer’s decision to kill his disabled daughter Tracy was disproportionate to the evil he was trying to avoid (the physical pain that Tracy would suffer if she had the operation and existential pain in the sense of her perceived poor quality of life). There were other options available to him such as placing Tracy in a group home. However, *Latimer* was not a typical case of euthanasia. Tracy was physically and mentally disabled, she was a minor, she did not ask to be assisted to die, Mr Latimer was not a medical practitioner and he did not use medically-recognised means to end Tracy’s life. Thus, in a typical euthanasia scenario in Canada in the future, *Latimer* might be distinguished.

Given that it is theoretically possible to raise the defence of necessity in the common law countries following a typical case of euthanasia, we need to consider whether this should be permitted. From the foregoing discussion it can be seen that the common element in the defence of necessity in the common law jurisdictions is the requirement that the accused’s act be proportionate to the evil or the harm that he or she was trying to avoid. The Dutch case law in relation to euthanasia suggests that the chances that this requirement will be met in a typical case of euthanasia are remote. In all of the cases discussed in Chapter Five the accused had an alternative to euthanasia namely, palliative care.

It is for this reason that I consider that the defence of necessity should not be permitted to be raised in defence of a charge of homicide or AS following the provision of euthanasia in the common law countries. Providing euthanasia when palliative care is available, even if this extends to the application of palliative sedation (a matter that is discussed below), is not proportionate. Having so concluded, I now turn to consider the last option for reform; extending existing practices in palliative care.
C. Extending Existing Practices in Palliative Care

As noted in Chapter Four, palliative sedation (lowering a person’s consciousness in order to relieve suffering) is a contested issue in end-of-life care in the common law jurisdictions.\(^\text{16}\) Indeed, at the present time, its use is uncommon.\(^\text{17}\) This was reflected in the results of the original research that I carried out among palliative care experts, discussed in Chapter Four, which is why I did not pursue the topic of palliative sedation at that time. However, a number of leading commentators in the euthanasia debate have recently advanced compelling arguments in favour of the more liberal use of palliative sedation near the end of life.\(^\text{18}\) Various justifications are put forward in support of this.

Magnusson argues that palliative sedation at the end of life should be justified by the notion of the devil’s choice; a choice between relieving suffering and hastening death. Magnusson includes in his discussion the practice of giving increasing doses of pain relief in the knowledge that this may shorten the recipient’s life (pyramid pain relief).\(^\text{19}\) As I noted in Chapters Two and Three, pyramid pain relief is legitimated in the common law countries by beliefs that are consistent with the DDE.

According to Magnusson, the devil’s choice should apply in situations where there is no ‘right choice’ because all of the available options are perverse.\(^\text{20}\) Thus, the devil’s choice should come into play when:

First of all, the ethical parameters within which the choice takes place are not of the chooser’s making, and are perversely constrained or limited. All the available options are not only not wanted, but are morally perverse, to a

\(^{16}\) See references cited in Chapter Four at footnote 81.

\(^{17}\) Smith, above n10 citing P Rousseau, ‘Existential Suffering and Palliative Sedation’ and B Lo & G Rubenfield, ‘Palliative Sedation in Dying Patients’ (2005) 294 *Journal of the American Medical Association* 1810 at 1815 respectively.

\(^{18}\) For a contrary view see M Kelly, ‘Dying with Dignity: Dissecting “Palliative Care” for “Existential Pain”’ paper presented at the Congress of the International Academy of Law and Mental Health, Padua (26 June 2007).


\(^{20}\) Ibid.
greater or lesser degree. Secondly, avoiding evil by opting out or failing to choose, is itself a choice. It is not possible not to choose, since the physician is morally and legally charged with the care of the patient, and doing nothing ensures its own tragic consequences. In a very real sense, the physician is trapped within a narrow set of more or less perverse alternatives.\textsuperscript{21}

Magnusson posits that liability for shortening life by palliative sedation could be avoided by the use of the defence of medical necessity, recognised by common law doctrine or through legislation. In keeping with the defence, the doctor would be morally responsible for the patient’s death but his or her actions would be justified by the circumstances. However, in order to invoke the devil’s choice, two conditions would have to be satisfied. Firstly, the doctor’s desire to help the patient must be reflected in the use of sedatives and analgesics that are appropriate as opposed to drugs that are inappropriate such as a bolus dose of potassium chloride. Secondly, the dosages given must be proportionate to the patient’s level of suffering.\textsuperscript{22}

Magnusson rejects the use of the DDE as sufficient justification for palliative sedation for three main reasons: the vulnerability of patients at the end of life; the power that doctors have over their patients; and the fact that the DDE does not recognise the true nature of the choice that the doctor makes in a typical case of hastening death; a choice based on the need to provide adequate relief from suffering.\textsuperscript{23}

Stewart also argues for more widespread use of palliative sedation (by which he also means pyramid pain relief) at the end of life but he considers that this should be justified by a reformulation of the DDE. Stewart’s reformulation moves away from intention and causation and argues instead for a justification rooted in the

\textsuperscript{21} Magnusson, above n19. Magnusson points out that the devil’s choice could also apply when life support measures are withdrawn from suffering, severely damaged neonates or permanently unconscious patients and when curative measures are futile: Id at 559.

\textsuperscript{22} Id at 566, 567.

\textsuperscript{23} Id at 565, 566.
right to self-determination, consent and the doctrine of necessity. 24 The relevant considerations in applying the reformulation would be the patient’s state of being, the doctor’s duty to relieve pain and proportionality. 25 Stewart argues that DDE reasoning, properly articulated, satisfies the three elements of the defence of necessity: the acceleration of death is done to avoid the evil of refractory symptoms where the doctor has a duty to relieve pain; all other options have been exhausted by the time palliative sedation is provided so there is no reasonable alternative to it; and the palliation of the patient’s pain is proportionate to the evil of a long and painful dying process. 26

Stewart concurs with Magnusson that the defence should not be available when there are alternatives or when a drug is used that has no analgesic or sedative effect. However he asserts, in addition, that the protection from liability that the defence provides should extend to other health care workers whenever they are responsible for administering the medication that might lead to the patient’s earlier death. 27

Smith agrees that palliative sedation (in the sense in which I use the phrase; lowering of consciousness in order to reduce suffering) should be embraced more widely in the care of the dying. He argues that this should be justified by each person’s right to exercise a good or dignified death derived from the principle of self-determination. Smith claims that the right to a good death is strengthened by common decency, human dignity, mercy and compassion at the end of life. The right to die with dignity stems from the right to life and justifies the relief of suffering. 28

24 Stewart also advances, but rejects, other separate bases such as: statutory recognition of terminal sedation; recognition of a right to be free from pain; and, a consent based defence: Stewart, above n14 at 273, 291-295.
25 Stewart, above n14 at 299.
26 Id at 296, 297.
27 Ibid.
28 Smith, above n10 at 1, 4.
In Smith’s view, palliative sedation should form an integral part of palliative care for those who are suffering from existential pain or profound psychological distress and who are in a futile situation. It should be provided within an ethic of care that is constantly adjusted to meet the patient’s particular circumstances and which is informed, equally, by the principle of mercy and the principle of beneficence. According to Smith, the more liberal use of palliative sedation should be achieved by legislation.29

I agree with each of these commentators that palliative sedation should be more freely available near the end of life. Of the three options for reform addressed in this chapter, I consider that palliative sedation is the one that is likely to cause the least difficulties. I believe that palliative sedation should be available when the patient requests it and the patient’s pain, whether physical or existential in origin, does not respond to treatment to a level that is satisfactory to him or her. I concur with Smith that the patient and his or her doctor should work together to determine the type of care that should be instituted and that this process should be an ongoing one. Along with Magnusson and Stewart, I am of the view that treatment should only comprise drugs that are appropriate and proportionate to the level of suffering being experienced by the patient. And, I am of the same opinion as Stewart that protection from liability should extend to those who administer palliative sedation as well as the medical practitioner who prescribes it.

However, contrary to Magnusson and Stewart, I consider that pyramid pain relief and palliative sedation should be dealt with as separate categories. In analysing and making recommendations concerning end-of-life care, it is important to advance solutions that reflect clinical practice and community sensibilities. The practice of pyramid pain relief, as the case law discussed in Chapters Two and Three reveals, has become an accepted part of patient care. In light of this, rather than rely upon the DDE – a depiction of pyramid pain relief that is inaccurate and can be contrary to clinical reality, the common law jurisdictions should proceed to

29  Smith, above n10 at 1.
enact legislation, as has already occurred in South Australia and Queensland, confirming the acceptability of pyramid pain relief on the basis of public policy. In short, doctors should be able to provide adequate pain relief at the end of life, at the patient's request or where indicated, without fear of being prosecuted for murder or manslaughter.

By contrast, palliative sedation is not widely accepted within the practice of medicine or in the community. In light of the problems with the DDE outlined in detail in Chapter Two, I do not consider the DDE to be a suitable basis upon which to justify freer use of palliative sedation. Moreover, to rely upon the doctrine in this context may be contrary to clinical reality because some commentators argue that there is no clear evidence that palliative sedation, when given in an appropriate manner, shortens life.30

On the other hand, the defence of necessity does provide a convincing basis upon which to justify the broader use of palliative sedation in circumstances where there is no definitive evidence as to whether or not palliative sedation can shorten life. As Magnusson and Stewart point out, the provision of palliative sedation meets the elements of the defence. By the time that palliative sedation is provided there is no alternative available to relieve the patient's suffering and it is a lesser evil than letting the patient continue to suffer. However, in light of widespread adherence to the SLD in the common law countries and the lack of a community sensibility of support for it, I believe that an attempt to justify the broader use of palliative sedation on the basis of necessity would be vigorously and successfully opposed.

Turning now to Smith's argument, I do not agree that palliative sedation should be justified by notions such as dignity or the right to a dignified death. In the case of the latter, as we saw in Chapter Three, there is no recognised right to die let alone a recognised right to die with dignity. With regard to the former, as I noted in Chapter Four and above, debate continues to rage over the correct definition of

pivotal terms in the euthanasia debate such as dignity. How then can we defend the more liberal use of palliative sedation at the end of life?

To answer this question we need to revisit the situation in the Netherlands. As we saw in Chapter Five, palliative sedation (in the sense in which I use the phrase) is gradually becoming an alternative to AVE and AS in the Netherlands. A high level of interest in it resulted in calls for it to be included in the TLRASA. Instead, the Dutch Government instructed the RDMA to develop a national guideline for administering it.31

Given that palliative sedation is not widely practised in the common law countries, steps would first have to be taken to make patients aware of what it involves and how it could be of benefit to them. If this were to result in a greater demand for palliative sedation as an option near the end of life, then I consider that the governments of the common law countries should follow the lead of the Netherlands by directing that a guideline be developed for its safe and effective use. The following principles contained in the Dutch protocol should form the basis for debate:32 the level of sedation must be determined by symptom control and not by level of consciousness; sedation may be given continuously until death or, for intermittent periods up to the time of death; the drug of choice should be a sedative such as midazolam which lowers consciousness (morphine does not lower consciousness); midazolam may be used in conjunction with morphine, the latter for pain and dyspnoea33 (difficulty breathing); prior to commencing palliative sedation there must be consultation with the patient, his or her family and the medical staff in order to ensure that palliative sedation is indicated, the patient wants it and that patient and family understand exactly what the process entails; palliative sedation may only be administered without the patient’s consent when

31 Legemaate et al, above n30 at 62
32 The focus, at this stage, should be on debate of these issues because, unlike the situation in the Netherlands, doctors in the common law countries do not have clear protection from liability via any mechanism such as the conflict of duties defence.
33 Legemaate et al, above n30 at 62, 63.
death is imminent, the patient is unable to ask for it and there is evidence that the patient’s level of physical or existential pain is acute.34

Putting the issue of debate on the contents of a national protocol aside, contrary to the Dutch protocol, I do not consider that palliative sedation should only be available when death is about to occur. I concur with Smith that it should be available from the time that a person is admitted to a palliative care facility. Palliative sedation should be available when a person is experiencing existential or physical pain that is not responding to treatment to a level that is satisfactory to him or her. Notably, the main indications for palliative sedation in the Netherlands are physical pain, dyspnoea and delirium.35 The Dutch protocol does not specifically target the problem of existential pain and it has been criticised for this.36 In light of the findings of the studies in relation to why people seek to die sooner, discussed in Chapter Four, it is not clear why the Dutch protocol does not address the issue of existential pain.37

Having concluded that, of the three options canvassed in this part, the most appropriate is the broader use of palliative sedation, I now conclude the chapter by considering some of the larger issues at stake in the euthanasia debate.

3. The Larger Issues at Stake in the Euthanasia Debate

In Chapter One in the context of discussion in relation to changing sensibilities toward death and dying, I noted that Elias was particularly concerned to draw attention to the loneliness that typifies the experience of dying for many people.

34 Legemaate et al, above n30 at 63, 66, 67.
35 Id at 63.
36 Id at 72.
37 Notably, in the Remmelink Report published in 1991, the reason that was most often given for euthanasia was ‘loss of dignity’: P van der Maas, J van Delden & L Pijnenborg, ‘Euthanasia and other Medical Decisions Concerning the End of Life’ (1992) 22 Health Policy Monographs at 44,45.
today. As Smith so aptly describes it: ‘By and large, dying is a messy business … Dying is ugly and dirty [in a world that is intolerant of such qualities].’

The trend of sequestrating and medicalising the process of dying can exacerbate the loneliness of the dying by interrupting what Elias referred to as the fundamentally interconnected nature of human social life. Elias noted that the dying often experience a profound sense of loneliness when they find that they are no longer surrounded by companions to whom they can relate and who feel empathy toward them. Many dying people, as Wendell Moller points out, suffer a ‘social death’ or a death of the self before the death of the body because of a loss of close personal relationships.

According to sociologist Allan Kellehear, the loneliness of the dying is frequently compounded by feelings of bitterness and helplessness in circumstances of economic difficulty and/or of physical decline. If the dying person is elderly, he or she may also feel devalued and alienated. Dr Diego De Leo, the head of the Australian Institute for Suicide Research and Prevention at Griffith University in Brisbane suggests why:

[The desire to die sooner] … may well reflect contemporary society’s failure to retain a sociable place for its elders … Even healthy older people may feel so emotionally excluded … that their lives are meaningless.

At a societal level, there is a pressing need to challenge the negative way in which dying, illness and aging are perceived. Fortunately, moves are already under way to safeguard the interconnectedness between those who are dying and those to

---

38 Smith, above n10 at 29 citing S Nuland, How we Die: Reflections on Life’s Final Chapter (1995) at 142, 255.
42 M Metherell & R Pollard, 'News and Features – Handmaiden of Death', The Sydney Morning Herald (Sydney), 27 November 2002, 13. Magnusson echoes this sentiment: ‘It is important to underscore the value of older people to society and to recognise that there is ... value in all of us feeling our lives are important’: Ibid.
whom they are close. Programs have been, and are being, developed to permit people to die at home when they want to and when this is possible.\footnote{A Rosenquist, K Bergman & P Strang, ‘Optimizing Hospital-Based Home Care for Dying Cancer Patients: A Population-Based Study’ (1999) 13 *Palliative Medicine* 393; B Ferrell, R Virani & M Grant, ‘Improving End-of-Life Care Education in Home Care’ (1998) 1 *Journal of Palliative Medicine* 11.}

However, more does need to be done. A powerful way of fostering a feeling of connectedness and a sense of acceptance within those who are dying is the simple action of listening, an issue that was canvassed at length at the end of Chapter Four. However, listening should occur in a way which permits free and open expression of feelings. Too often, as the quote at the beginning of this chapter reveals, health care workers edit or ignore what those who are closer to death have to say about their feelings and beliefs.

Permitting those who are dying to discuss contested issues such as euthanasia can help to dispel fears about dying.\footnote{Magnusson, above n7 at 80.} According to Dr Nitschke, most people who are interested in euthanasia are interested in it as an option at the end of life.\footnote{This proposition is supported by a recent study of 379 dying Canadians. Whilst 238 (62.8\%) thought AVE and DAS should be legalised, only 22 (5.8\%) thought they would initiate a request for euthanasia: K Wilson, C M’Pherson & P Allard, ‘Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care’ (2007) 26 *Health Psychology* 314-323.}

Thank you for continuing to explore this important pill. There are times when I feel unwell and I panic. I haven’t gone to a workshop, I haven’t stored drugs to end my life. As I am so well, I don’t think about it. But *how relieved* I’d be if you had such a pill …

My disease is such that when it gets into my internal organs I will live three months only. For now, it is only on my skin, and tumours have been radiated from my right upper buttock. So it’s the ‘real thing’. I’m going to try and live to the end, but I won’t cop agony or leave such a memory on my sons who are now seventeen and ten. I believe in the right to choose as my bumper sticker says.

Thank you for being there. Your being there really helps me sleep at night. You are like a lifeline thrown to me on a dark night as I flounder in the endless sea. God bless you. I hope I won’t need your help for another ten-plus years, but keep going.

– Daryl, forty-one years, diagnosis: mycosis fungoides, Tasmania.\footnote{Thank you for continuing to explore this important pill. There are times when I feel unwell and I panic. I haven’t gone to a workshop, I haven’t stored drugs to end my life. As I am so well, I don’t think about it. But *how relieved* I’d be if you had such a pill …

My disease is such that when it gets into my internal organs I will live three months only. For now, it is only on my skin, and tumours have been radiated from my right upper buttock. So it’s the ‘real thing’. I’m going to try and live to the end, but I won’t cop agony or leave such a memory on my sons who are now seventeen and ten. I believe in the right to choose as my bumper sticker says.

Thank you for being there. Your being there really helps me sleep at night. You are like a lifeline thrown to me on a dark night as I flounder in the endless sea. God bless you. I hope I won’t need your help for another ten-plus years, but keep going.

– Daryl, forty-one years, diagnosis: mycosis fungoides, Tasmania.}
In addition to challenging negative attitudes and sensibilities in relation to death and dying we need to ensure that the health and economic needs of those who are dying are met to a level that is acceptable. In order to facilitate greater flexibility in responses to changing sensibilities toward death and dying we also need to devote more attention to determining why some people who are dying seek to die sooner.\textsuperscript{47} There has been scant research carried out in relation to this question. Emerging evidence suggests that Elias was right all along in emphasising the overarching importance of the need for a sense of connectedness in human social life.\textsuperscript{48} It is likely that this need becomes even more pronounced near the end of life.

\begin{footnotesize}
\begin{itemize}
\item Y Mak, G Elwyn \& I Finlay, 'Patients' Voices are Needed in Debates on Euthanasia' (2003) 327 \textit{British Medical Journal} 213.
\end{itemize}
\end{footnotesize}
BIBLIOGRAPHY

Audiovisual

Nederhorst, M., *Death on Request* (1994)

Books


Williams, R., *Keywords: A Vocabulary of Culture and Society* (London, Fontana Press: 1987)


**Book Sections**


Electronic Sources

Amendola, F., Necessity or Choice of Evils at § 57 <http://www.westlaw.com.au>

Australian Broadcasting Commission News, 'MP Pushes for Voluntary Euthanasia Bill' <http://www.abc.net.au>

Australian Broadcasting Commission, ‘Ockham's Razor’ (23 July 2006) <http://www.abc.net.au>


Bickerton, I., ‘Balkenende Claims Victory in Dutch Election’ <http://www.ft.com>

CNN News, 'Dr Death' <www.cnn.com/us/9904/13/kevorkian.03>


Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, *Fifth Annual Report on Oregon's Death with Dignity Act* <http://www.dhs.state.or.us/publichealth/chs/pas/year5/ar-index.cfm>

Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, *Fourth Annual Report on Oregon's Death with Dignity Act* <http://www.dhs.state.or.us/publichealth/chs/pas/year4/ar-index.cfm>

Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, *Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide* <http://www.dhs.state.or.us/publichealth/chs/pas/year3/ar-index.cfm>

Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, *Oregon's Death with Dignity Act: The Second Year's Experience* <http://www.dhs.state.or.us/publichealth/chs/pas/year2/ar-index.cfm>

Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, *Oregon's Death with Dignity Act: The First Year's Experience* <http://www.dhs.state.or.us/publichealth/chs/pas/year1/ar-index.cfm>

Editorial, 'In the Courts: Louisiana has Closed Investigation of New Orleans MD' <http://www.advisoryboardcompany.com/>

Editorial, 'Majority of US Adults Favour Euthanasia and Assisted Suicide by more than Two-to-One Most People with Living Wills do not want to go on Life-Support Systems' <http://www.prnewswire.com/>


Hamlon, K., 'Failed Attempts to Legalise Euthanasia/ Assisted Suicide in the United States' <http://www.internationaltaskforce.org/>


New York State Task Force on Life & the Law, ‘When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context’ <http://wings.buffalo.edu/faculty/research/bioethics/WDIS.html>

Palliative Care Australia, Position Statement of Voluntary Euthanasia, Palliative Care Practice and End-of-Life Decisions <http://www.pallcare.org.au>


Robinson, B., ‘Kevorkian Sentenced to 10 to 25 Years for Murder’ <www.courttv.com/trials/kevorkian/041399_pc_ctv.html>

Scoop, 'NZMA's Anti-Euthanasia Stance is Good News' <http://scoop.co.nz>

The American Medical Association, Voluntary Active Euthanasia <http://www.ama-assn.org>


The Canadian Medical Association, Euthanasia and Assisted Suicide (Update 2007) <http://www.cma.ca>

The New Zealand Medical Association, 'Euthanasia and Doctor-Assisted Suicide' <www.nzma.org.nz>


Journal Articles


Arlidge, A., 'The Trial of Dr David Moor' [2002] Criminal Law Review 31

Armstrong, D., 'Silence and Truth in Death and Dying' (1987) 24 Social Science and Medicine 651


Barr, P., 'Relation of Neonatologists' End-of-Life Decisions to their Personal Fear of Death' (2007) 1 Archives of Disease in Childhood F1


Baszanger, I., 'Pain: Its Experience and Treatment' (1989) 29 Social Science and Medicine 425

Baugham, W. et al, 'Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations' (1973) 48 Notre Dame Lawyer 1202


Beachamp, T. & Davidson, A., 'The Definition of Euthanasia' (1979) 4 Journal of Medicine and Philosophy 294

Beecher, H., 'Relationship of Significance of Wound to Pain Experienced' (1956) 161 Journal of the American Medical Association 1609


Benzein, E. & Berg, A., 'The Level of and Relationship between Hope, Hopelessness and Fatigue in Patients and Family Members in Palliative Care' (2005) 19 Palliative Medicine 234


Billings, A., 'What is Palliative Care?' (1988) 1 Journal of Palliative Medicine 73


Bishop, J., 'Euthanasia, Efficiency, and the Historical Distinction between Killing a Patient and Allowing a Patient to Die' (2006) 32 Law, Ethics, and Medicine 220


Brownstein, E., 'Pain Relief and Causation of Death in the Context of Palliative Care' (2001) 8 Journal of Law and Medicine 152


Callahan, D., 'Can we Return Death to Disease? (Mercy, Murder & Morality: Perspectives on Euthanasia' (1989) 19 The Hastings Centre Report S4


Carrick, D., 'Legal Euthanasia not Quite Dead in the Top End' (1997) 32 Australian Lawyer 12


Cherny, N., Coyle, N. & Foley, K. 'The Treatment of Suffering: When Patients Request Elective Death' (1994) 10 *Journal of Palliative Care* 71


Chochinov, H., 'The Senate Report on End-of-Life Care: The Ball is in our Court' (2001) 164 *Canadian Medical Association Journal* 794


Clark, P., 'Physician Participation in Executions: Care Giver or Executioner?' (2006) 10 *Journal of Law, Medicine and Ethics* 10


Cuperus-Bosma, J., 'Assessment of Physician-Assisted Death by Members of the Public Prosecution in the Netherlands' (1995) 25 *Journal of Medical Ethics* 8


de Wachter, M., 'Active Euthanasia in the Netherlands' (1989) 262 *Journal of the American Medical Association* 3316


Emanuel, E., 'Depression, Euthanasia, and Improving End-of-Life Care' (2005) 23 Journal of Clinical Oncology 6456


Ferrell, B., Virani, R. & Grant, M., 'Improving End-of-Life Care Education in Home Care' (1998) 1 Journal of Palliative Medicine 11

Fletcher, G., 'Prolonging Life' (1967) 42 Washington Law Review 999

Fowler, R., 'Sex and Age-Based Differences in the Delivery and Outcomes of Critical Care' (2007) 177 Canadian Medical Association Journal 1513
Frank, A., 'Can we Research Suffering?' (2001) 11 Qualitative Health Research 353


Gunning, K., 'Euthanasia' (1991) 338 The Lancet 1010


Haig, R., 'Management of Depression in Patients with Advanced Cancer' (1992) 156 Medical Journal of Australia 499

Hale, Dame B., 'A Pretty Pass: When is there a Right to Die?' (2003) 32 Common Law World Review 1

Halttunen, K., 'Humanitarianism and the Pornography of Pain in Anglo-American Culture' (1995) 100 American Historical Review 303


265
Heavin, H., 'Perspectives on the Latimer Trial' (2001) 64 Saskatchewan Law Review 613

Hendin, H., 'Euthanasia Consultants or Facilitators?' (1999) 170 Medical Journal of Australia 351

Holden, J., 'Demographics, Attitudes and Afterlife Beliefs of Right-to-Life and Right to die Organisation Members' (1992) 133 Journal of Social Psychology 521

Hunt, R., 'Intention, the Law, and Clinical Decision-Making in Terminal Care' (2001) 175 Medical Journal of Australia 516


Jansen-Van der Weide, M. et al, 'Quality of Consultation and the Project "Support and Consultation on Euthanasia in the Netherlands" (SCEN)' (2007) 80 Health Policy 97


Kastenbaum, R., 'Reconstructing Death in Postmodern Society' (1993) 27 Omega 75

Kearney, M., 'Palliative Medicine: Just Another Speciality?' (1992) 6 Palliative Medicine 275


Kennedy, I. & Grubb, A., 'The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment' [1976] Criminal Law Review 217


Kissane, D., Street, A. & Nitschke, P., 'Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act' (1998) 352 The Lancet 1097


Kompanje, E., van Zuylen, L. & van der Rijt, K., 'Morphine is not a Sedative and Does not Shorten Life' (2006) 166 Archives of Internal Medicine 2047

Kselman, T., 'Death in the Western World: Michel Vovelle's Ambivalent Epic La Mort et L'Occident de 1300 à nos Jours' (2004) 9 Mortality 168


Lamb, T., 'Euthanasia, Suicide, Natural Death' (1993) 4 HIV/AIDS Legal Link 9

Lanham, D., 'Euthanasia, Painkilling, Murder and Manslaughter' (1994) 1 Journal of Law and Medicine 146


Leenen, H., 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands' (1987) 8 *Health Policy* 197


Legemaate, J., 'Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands' (1995) 4 *Cambridge Quarterly of Health Care Ethics* 112


Lipton, J. & Mariachi, J., 'Ethnicity and the Pain Experience' (1984) 19 *Social Science and Medicine* 1279


Magnusson, R., 'The Devil's Choice: Re-Thinking Law, Ethics and Symptom Relief in Palliative Care' (2006) *Journal of Law, Medicine & Ethics* 559


Mak, Y. & Elwyn, G., 'Voices of the Terminally Ill: Uncovering the Meaning of Desire for Euthanasia' (2005) 19 *Palliative Medicine* 343

Mak, Y., Elwyn, G. & Finlay, I., 'Patients' Voices are Needed in Debates on Euthanasia' (2003) 327 *British Medical Journal* 213


Morris, N., 'The Sanctity of Life in the Criminal Law' (1958) 4 University of Western Australia Law Review 114


Ontwuteaka-Philipsen, B. & van der Wal, G., 'Support and Consultation for General Practitioners Concerning Euthanasia: the SCEA Project' (2001) 56 Health Policy 33

Ontwuteaka-Philipsen, B., 'Consultation with Another Physician on Euthanasia and Assisted Suicide in the Netherlands' (2000) 51 Social Science and Medicine 429


Pellonpaa, M., 'European Court of Human Rights: Case of Pretty v the United Kingdom' (2002) 18 Issues in Law and Medicine 67


Price, D., 'Euthanasia, Pain Relief and Double Effect' (1997) 17 *Legal Studies* 323


Regnard, C., 'Double Effect is a Myth Leading a Double Life' (2007) 334 *British Medical Journal* 440


Rigter, H., 'Euthanasia across the North Sea' (1988) 297 *British Medical Journal* 1593


Sanders, J., 'Euthanasia: None Dare Call it Murder' (1969) 60 The Journal of Criminal Law, Criminology & Police Science 351


Saunders, C., 'Voluntary Euthanasia' (1992) 6 Palliative Medicine 1


Scott, P., 'Autonomy, Power and Control in Palliative Care' (1999) 8 Cambridge Quarterly of Health Care Ethics 139


Seale, C., 'Heroic Death' (1995) 29 Sociology 597


Seymour, J., Janssens, R. & Broeckaert, B., 'Relieving Suffering at the End of Life: Practitioners' Perspectives on Palliative Sedation from Three European Countries' (2007) 64 Social Science & Medicine 1679
Shapiro, R., 'Willingness to Perform Euthanasia' (1994) 154 Archives of Internal Medicine 575

Sheldon, T., 'Killing or Caring?' (2006) 330 British Medical Journal 560


Sheldon, T., 'The Netherlands Regulates Ending the Lives of Severely Ill Neonates' (2005) 331 British Medical Journal 1357


Sheldon, T., 'Dutch Doctors are given Guidance on Sedation' (2005) 331 British Medical Journal 1422

Sheldon, T., 'Dutch Murder Case Leads to Talks with Attorney General' (2005) 331 British Medical Journal 473


Sheldon, T., 'Two Test Cases in Holland Clarify Law on Murder and Palliative Care' (2004) 329 British Medical Journal 1206


Sheldon, T., 'Court Upholds Murder Verdict on Doctor who Ended Woman's Life' (2003) 326 British Medical Journal 1351


Sheldon, T., 'Reported Euthanasia Cases in Holland Fall for Second Year' (2002) 324 British Medical Journal 1354


273
Sheldon, T., 'Doctor Convicted of Helping Patient to Commit Suicide may be Retried' (2002) 325 British Medical Journal 924


Sheldon, T., 'Existential Suffering not a Justification for Euthanasia' (2001) 323 British Medical Journal 1384


Sheldon, T., 'Netherlands Gives more Protection to Doctors in Euthanasia Cases' (2000) 321 British Medical Journal 1433


Sheldon, T., 'Dutch GP in Euthanasia Case will not go to Prison' (1997) 314 British Medical Journal 1145


Sheldon, T., 'Dutch GP on Murder Charge over Euthanasia Claim' (1996) 312 British Medical Journal 1116

Sheldon, T., 'Euthanasia Reporting is Increasing but is still Low' (1996) 313 British Medical Journal 1423

Sheldon, T., 'Dutch Appeal Court Dismisses Case Against Doctor' (1995) 311 British Medical Journal 1322


274

Smith, C., 'What about Legalised Assisted Suicide?' (1993) 8 Issues in Law and Medicine 503


Smith, J., 'A Comment on Moor's Case' [2000] Criminal Law Review 41


Somerville, M., 'Pain and Suffering at the Interfaces of Medicine and Law' (1986) 36 University of Toronto Law Journal 286

Spanjer, M., 'Dutch Psychiatrist Reprimanded for Assisting Suicide' (1995) 345 The Lancet 914

Spanjer, M., 'Mental Suffering as Justification for Euthanasia in the Netherlands' (1994) 343 The Lancet 1630


Sulmasy, D. & Pellegrino, E., 'The Rule of Double Effect: Clearing up the Double Talk' (1999) 159 Archives of Internal Medicine 545


Taylor, B., 'Hospice Nurses Tell their Stories About a Good Death: The Value of Storytelling as a Qualitative Health Research Method' (1997) 3 Australian Review of Health and Social Science 97


Van der Maas, P., et al, 'Euthanasia and Other Medical Decisions Concerning the End of Life' (1991) 338 The Lancet 669

Van der Wal, G. & Ontwuteaka-Philipsen, B., 'Cases of Euthanasia and Assisted Suicide Reported to the Public Prosecutor in North Holland over 10 Years' (1996) 312 British Medical Journal 612


Van der Wal, G., 'Euthanasia in the Netherlands' (1994) 308 British Medical Journal 1346


276
Van der Wal G., *et al.*, 'Euthanasia and Assisted Suicide. I. How often is it Practiced by Family Doctors in the Netherlands?' (1992) 9 *Family Practice* 130

Vranken, M., 'Schools of Thought on Pain' (1989) 29 *Social Science and Medicine* 435


Wakefield, M. & Ashby, M., 'Attitudes of Surviving Relatives to Terminal Care in South Australia' (1993) 8 *Journal of Pain and Symptom Management* 529

Walter, T., 'Historical and Cultural Variants on the Good Death' (2003) 327 *British Medical Journal* 218

Walter, T., 'Modern Death: Taboo or not Taboo?' (1991) 25 *Sociology* 293

Walters, G., 'Is there Such a Thing as a Good Death?' (2004) 18 *Palliative Medicine* 404

Ward, B. & Tate, P., 'Attitudes Among NHS Doctors to Euthanasia' (1994) 308 *British Medical Journal* 1332

Weisstub, D., 'Ethical and Legal Reflections on Euthanasia' (1997) 18 *Health Law in Canada* 20


Wilson, K., *et al.*, 'Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care' (2007) 26 *Health Psychology* 314

Wolf, S., 'Assessing Physician Compliance with the Rules for Euthanasia and Assisted Suicide' (2005) 165 *Archives of Internal Medicine* 1677

Won, S., 'About 2,000 Dutch Patients Choose Euthanasia Annually Forum Told' (1991) 145 *Canadian Medical Association Journal* 1341


Young, R. & King, A., 'Legal Aspects of Withdrawal of Therapy' (2003) 31 *Anaesthetic Intensive Care* 501


Zborowski, M., 'Cultural Components in Response to Pain' (1952) 8 *Journal of Social Issues* 16


Zinn, C., 'Doctor Sets Up 'How to Die' Workshops in New Zealand' (2001) 322 *British Medical Journal* 315


Zylicz, Z., 'Euthanasia' (1991) 338 *The Lancet* 1150

**Legal**

**Acts, Charters & Regulations**

*Bill of Rights Act* 1990 (NZ)

*Charter of Human Rights and Responsibilities Act* 2006 (Vic)

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

*Controlled Substances Act* 1970 (USA)

*Crimes Act* 1900 (NSW)

*Crimes Act* 1900 (ACT)

*Crimes Act* 1958 (Vic)

*Crimes Act* 1961 (NZ)

*Crimes (Sentencing) Procedure Act* 1999 (NSW)

*Criminal Code Act* 1924 (Tas)
Criminal Code Act 1899 (Qld)
Criminal Justice Act 2003 (UK)
Criminal Law Consolidation Act 1935 (SA)
Euthanasia Laws Act 1997 (Cth)
Homicide Act 1957 (UK)
Medical Treatment Act 1988 (Vic)
Medical Treatment Act 1994 (ACT)
Natural Death Act 1983 (SA)
Natural Death Act 1988 (NT)
New York Penal Law
Self-Government Act 1978 (NT)
Sentencing Act 2002 (NZ)
Sentencing Act 1997 (Tas)
Sentencing Act (NT)
Sentencing (Crime of Murder) and Parole Reform Act 2003 (NT)
The Bill of Rights 1990 (NZ)
The Criminal Code Amendment (Suicide and Related Offences) Act 2006 (Cth)
The Human Rights Act 2003 (ACT)
The Human Rights Act 1998 (UK)
The Oregon Death with Dignity Act 1997
The Rights of the Terminally Ill Act 1996 (NT)
The Rights of the Terminally Ill Regulations 1996 (NT)
The Suicide Act 1961 (UK)
The Termination on Request and Assisted Suicide (Review Procedures) Act 2002 (Neth)
Bills

AB 651 (Compassion in Dying Act) (Cal)

Bill C-407 (Can)

Criminal Code (Euthanasia) Bill 1998 (NT)
Criminal Code (Euthanasia) Bill 1997 (NT)
Euthanasia Laws Bill 1996 (NT)
HB 168 (Death with Dignity Act) (Ver)
Rights of the Terminally Ill Bill 2003 (NT)
Rights of the Terminally Ill Bill 2001 (NT)
The Assisted Dying Bill 2003 (NZ)
The Assisted Dying for the Terminally Ill Bill 2005 (UK)
The Dignity in Dying Bill 2005 (SA)
The Dignity in Dying Bill 2003 (SA)
The Dignity in Dying Bill 2001 (SA)
The Euthanasia Laws Bill 1996 (Cth)
The Rights of the Terminally Ill Bill 2003 (NT)
The Rights of the Terminally Ill Bill 2001 (NT)
The Voluntary Euthanasia Bill 1996 (SA)
The Voluntary Euthanasia Bill 2002 (WA)
The Voluntary Euthanasia Bill 2000 (WA)
The Voluntary Euthanasia Bill 1998 (WA)
The Voluntary Euthanasia Bill 1997 (WA)
The Voluntary Euthanasia Trial (Referendum) Bill 2003 (NSW)
The Voluntary Euthanasia Trial (Referendum) Bill 2002 (NSW)
The Voluntary and Natural Death Bill 1994 (ACT)
Case Law

Airedale NHS Trust v Bland [1993] 1 All ER 821

Attorney General v Able & Ors [1984] 1 All ER 277

Bouvia v Superior Court of Los Angeles County 179 Cal App 3d 1127 (1986)

Chabot Case, Nederlandse Jurisprudentie 1994, No. 656

Christopher John Wake and Djiniyini Gondarra v Northern Territory of Australia & Ors (1996) NTR 1

Compassion in Dying v State of Washington 79 F 3d 790 (1996) en banc

Cruzan v Director, Missouri Department of Health 111 L Ed 2d 224 (1990)

Furman v Georgia 408 US 238 (972)

Gonzales v Oregon, Supreme Court of the United States, No. 04-623, 17 January 2006

Gonzales v Oregon (2004) 368 F 3d 1118

In re F (mental patient: sterilization) [1989] 2 WLR 1025

Kadijk Case District Court of Gronigen, 13 November 1995; High Court of Leeuwarden, 4 April 1996

Ms B v An NHS Hospital Trust [2002] 2 All ER 449

Nancy B v Hôtel-Dieu de Québec (1992) 86 DLR (4th) 385

People v Hassman (Unreported., The New York Times (20 December 1986) 1)

People v Kevorkian, Oakland Circuit Court, LC No. 98-163675-FC (1999)

People v Sander (Unreported., New York Times (10 March 1950) 1)

People of the State of Michigan v Jack Kevorkian No. 221758, Court of Appeal of Michigan, 248 Mich App 373 (2001)

Perka v The Queen (1984) 42 CR (3d) 113 (SCC)

Postma Case, Nederlandse Jurisprudentie, No. 183, 1973

Prins Case, District Court at Alkmaar, 26 April 1995

Pretty v The United Kingdom, Application No. 2346/02, European Court of Human Rights (4th Section) [2002] 2 FLR 45
Quill v Vacco 80 F 3d 790 (9th Circuit, 1996)

R v Adams [1957] Criminal Law Reports 365

R v Carr (Unreported., Leeds Crown Court, Mars-Jones J, 29 November 1986)

R v Chard, (Unreported., The Times (23 September 1993))

R v Cox 12 BMLR 3

R v Dudley & Stephens [1881-1885] All ER Rep 61

R v Hoddy (Unreported., District Court of New South Wales, Solomon J, 28 November 1995)

R v Larkin (Unreported., Supreme Court of Victoria, Nicholson J, 14 April 1983)

R v Latimer [2001] 1 SCR 3

R v Latimer [1997] 1 SCR 217

R v Latimer (1995) 99 CCC (3d) 481 Saskatchewan Court of Appeal

R v Latimer [1988] Saskatchewan D Crim 15

R v Lodwig (Unreported., Central Criminal Court, Leonard J, 15 March 1990)

R v Loughnan [1981] VR 443

R v Martin 3 NZLR [2004] 69

R v Martineau [1990] 2 SCR 633

R v Mataya 19 WCB (2d) 118 (Ontario Court, General Division) (1983)

R v Maxwell [2003] VSC 278

R v Moor (Unreported., Crown Court, Hooper J, 11 May 1999)

R v Morrison NSR (2d) 201 (Nova Scotia Supreme Court) (1998)

R v Morrison [1998] NSJ No. 75, Case No. 720188 (Nova Scotia Provincial Court)

R v Nedrick [1997] 1 Criminal Appeal Reports 97

R (on the application of Pretty) v DPP [2002] 1 All ER 1

R (on the application of Pretty) v DPP [2001] EWHC Admin 788

R v Woollin [1999] 1 AC 82

Re A Children (Conjoined Twins: Surgical Separation) [2001] 147 (Fam)
Re B (adult refusal of medical treatment) [2002] EWHC 429 (Fam)

Re Z [2004] EWHC 2917 (Fam)


Secretary, Department of Community Services (NT) v JWB and SMB [1992] 66 ALJR 300

Schoonheim Case, Nederlandse Jurisprudentie, No. 106, 27 November 1984

Smith v Auckland Hospital Board [1965] NZLR 191

Spratt v Hermes (1965) 114 CLR 226

State v Francis 152 SC 17 (1929)

State of Oregon & Ors v John Ashcroft & Ors 368 F 3d 1118 (United States Court of Appeal, 9th Circuit, No. 02-35587) (2001)

Sutorius Case, District Court of Haarlem, 30 October 2000

The Queen v Lesley Jane Martin, New Zealand Court of Appeal, CA 199/04, 14 February 2005

United States v Holmes 26 Fed Cas 360 (1842)

Vacco v Quill 521 US 793 (1997)

Van Oijen Case, District Court of Amsterdam, 24 November 1998; High Court of Amsterdam, 17 May 1999; Supreme Court, 26 September 2000; District Court of Amsterdam, 21 February 2001; High Court of Amsterdam, 3 June 2003

Washington v Glucksberg, 117 S Ct 2258 (1997)

Wertheim Case, Nederlandse Jurisprudentie, No. 63, 1982

Codes

California Penal Code (Cal)

Civil Code of Lower Canada

Criminal Code 1913 (WA)

Criminal Code 1983 (NT)

Criminal Code (Can)
Criminal Code (Qld)
Penal Code 1886 (Neth)

**Human Rights Instruments**

Bill of Rights 1688 (UK)
Charter of Human Rights and Freedoms 1983 (Can)
European Convention for the Protection of Human Rights and Fundamental Freedoms 1950
International Covenant on Civil and Political Rights 1976
International Covenant on Economic, Social and Cultural Rights 1973
The Bill of Rights 1791 (USA)
The Charter of Rights and Freedoms 1983 (Can)
Universal Declaration of Human Rights 1948
United Nations Declaration of Human Rights 1948

**Newspaper Articles**

Alcorn, G., 'Now More Want to Die', *The Age* (27 September 1997) 1
Alcorn, G., 'A Painful Search for that Elusive Signature', *The Age* (7 January 1997) 4
Alcorn, G., 'Sixty Wanted to Join Queue for Euthanasia', *The Sydney Morning Herald* (26 March 1997) 1
Alcorn, G., 'Vatican Urges Euthanasia Battle', *The Age* (9 January 1997) 3
Alcorn, G., 'How the Northern Territory Act Came to Life', *The Sydney Morning Herald* (26 March 1997) 6
Alcorn, G., 'Northern Territory Clarifies Euthanasia Checks Rule', *The Age* (7 January 1997) 1
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Source</th>
<th>Date</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcorn, G.</td>
<td>'Death at Your Fingertips'</td>
<td>The Sydney Morning Herald</td>
<td>(17 April 1996)</td>
<td>15</td>
</tr>
<tr>
<td>Alcorn, G.</td>
<td>'Death Throes'</td>
<td>The Sydney Morning Herald</td>
<td>(23 August 1996)</td>
<td>13</td>
</tr>
<tr>
<td>Alcorn, G.</td>
<td>'The Fight to End a Life'</td>
<td>The Sydney Morning Herald</td>
<td>(27 September 1996)</td>
<td>10</td>
</tr>
<tr>
<td>Alcorn, G.</td>
<td>'Mercy Death Splits Nation'</td>
<td>The Sydney Morning Herald</td>
<td>(27 September 1996)</td>
<td>1</td>
</tr>
<tr>
<td>Altman, L.</td>
<td>'Jury Declines to Indict Doctor who Said he Aided in a Suicide'</td>
<td>The New York Times</td>
<td>(27 July 1991)</td>
<td>1</td>
</tr>
<tr>
<td>Arlington, K.</td>
<td>'Judge Rejects 'Cruel' Jail Call over Son's Loving Death; Mercy Kill Parents Walk Free'</td>
<td>The Mercury</td>
<td>(5 April 2007)</td>
<td>18</td>
</tr>
<tr>
<td>Article</td>
<td></td>
<td>Yorkshire Evening Post</td>
<td>(18 November 1986)</td>
<td>1</td>
</tr>
<tr>
<td>Bain, H.</td>
<td>'Euthanasia Campaigner Joins Labor Ranks'</td>
<td>Sunday Star-Times</td>
<td>(29 January 2006)</td>
<td>9</td>
</tr>
<tr>
<td>Barks Hoffman, K.</td>
<td>'Assisted Suicide still Illegal in 49 States: Kevorkian Leaving Prison after Eight Years, but his Cause has made Little Progress'</td>
<td>The Grand Rapids Press</td>
<td>(27 May 2007)</td>
<td>B3</td>
</tr>
<tr>
<td>Binning, E.</td>
<td>'Dr Death on Recruiting Mission'</td>
<td>New Zealand Herald</td>
<td>(16 December 2004)</td>
<td>A05</td>
</tr>
<tr>
<td>Blakeney, S.</td>
<td>'Tears Fight Back the Facts to Carry the Day'</td>
<td>The Australian</td>
<td>(17 October 1996)</td>
<td>4</td>
</tr>
<tr>
<td>Boniface, H.</td>
<td>'Euthanasia Challenge'</td>
<td>Gold Coast Sun</td>
<td>(2 January 2008)</td>
<td>18</td>
</tr>
<tr>
<td>Bonoguore, T.</td>
<td>'Do-it-Yourself Suicide Pill Goes on Show'</td>
<td>The Globe and Mail</td>
<td>(8 September 2006)</td>
<td>6</td>
</tr>
<tr>
<td>Boreham, G.</td>
<td>'Death by Choice: Premier Defends the Right to 'A Beautiful Death&quot;</td>
<td>The Age</td>
<td>(7 January 1997)</td>
<td>4</td>
</tr>
<tr>
<td>Brough, J.</td>
<td>'Thumbs Down for Palliative Care Funding'</td>
<td>The Sydney Morning Herald</td>
<td>(26 March 1997)</td>
<td>1</td>
</tr>
<tr>
<td>Brough, J. &amp; Alcorn, G.</td>
<td>'Patients Appeal to Sir William'</td>
<td>The Sydney Morning Herald</td>
<td>(25 March 1997)</td>
<td>6</td>
</tr>
<tr>
<td>Cadzow, J.</td>
<td>'A Troubled Place in the Sun'</td>
<td>The Good Weekend Magazine</td>
<td>(10 August 1991)</td>
<td>10</td>
</tr>
</tbody>
</table>

Carruthers, F., 'Members Argue Obligation to Protect Life', *The Australian* (17 October 1996) 4

Ceresa, M., 'Final Hours of a Five-Year Struggle', *The Australian* (27 September 1997) 1

Ceresa, M., 'MPs Defeat Bid to Reject Euthanasia', *The Australian* (23 August 1996) 4


Chan, G., 'Bill Won't Punish Doctors Involved in Euthanasia', *The Australian* (27 September 1996) 7


Chorneau, T., 'California/ New Poll Results Support Option to Allow Life-Ending Medication/ 70% of all Adults Indicate in Favor of Euthanasia', *San Francisco Chronicle* (15 March 2006) B2

Colburn, D., 'Other States see Path in Ruling on Assisted Suicide', *The Oregonian* (22 January 2006) A1

Cooper, M., 'I Helped Cancer Man Die: Doctor', *Geelong Advertiser* (21 June 2007) 1

Cribb, J., 'Euthanasia a Right: Oliphant', *The Australian* (26 May 1995) 4

Cummings, M., 'Martin Applauds Euthanasia Book Ban', *Manawatu Standard* (11 June 2007) 1

Davey, M., ‘Parole does not Silence Dr Death; but Kevorkian says he will Keep Promise to not Aid more Suicides', *The New York Times* (4 June 2007) A3

Debelle, P., 'MP Defiant on Suicide', *The Age* (31 August 2006) 3

Dent, B., 'Why I Choose to Die', *The Australian* (27 September 1996) 1
Dent, B., 'Why I Need to Die', The Sydney Morning Herald (27 September 1996) 11

Dougherty, K., 'Legalized Euthanasia has Potential for "Ethical Slips" Couillard Warns; Most Quebecers Advocate Assisted Suicide', The Gazette (11 June 2007) A9

Dow, S., 'Putting Faith in Euthanasia', The Age (7 June 1995) 4


Editorial, 'Rudd Becomes PM, Ratifies Kyoto', The Sydney Morning Herald (3 December 2007) 1

Editorial, 'Authorities Eager to Stop 'Suicide Tourism'', Irish Times (13 November 2007) 3

Editorial, 'Suicide: Californians against Assisted Suicide: For the Third Time in Three Years, Assisted Suicide Fails to get Support in the Assembly', Biotech Week (27 June 2007) 976

Editorial, 'Martin Sad to be Struck Off Nursing Register', Taranaki Daily News (1 March 2007) 2

Editorial, 'Charting the Impact of the Charter; Canadians Love their Charter of Rights and Freedoms – Even if they Don't Know Much About It', The Ottawa Citizen (15 April 2007) A6


Editorial, 'No Suicide' The Sun (30 June 2006) 9

Editorial, 'Escaping a Fatal Mistake', The New Zealand Herald (7 June 2005) E05

Editorial, 'Martin "Moves On" After Rebuff', Dominion Post (16 June 2005) 3


Editorial, 'BMA: No Suicide', The Sun (30 June 2006) 9

Editorial, 'Euthanasia by Doctors Favoured', New Zealand Herald (29 January 2003) 12
Editorial, 'Tired of Living, so Lisette Took her Life', *The Adelaide Advertiser* (27 November 2002) 1

Editorial, 'Suicide Bid Woman Dies', *The Adelaide Advertiser* (30 July 2002) 21

Editorial, 'The Crick Suicide A Farewell to Pain …' *Courier-Mail* (24 May 2002) 8

Editorial, 'Siamese Twin and Parents Fly Home to Malta', *Yorkshire Post* (18 June 2001) 3

Editorial, 'Strong Support for Euthanasia, Poll Shows - High Profile Cases have Changed Attitudes: Pollster', *The Toronto Star* (2 July 2001) A06

Editorial, 'Dr Death Recruiting', *The Daily Telegraph* (31 January 2001) 12

Editorial, 'Vatican Hits Death Move', *Herald-Sun* (29 November 2000) 33

Editorial, 'Kevorkian had no Right to Act as Executioner' *Buffalo News* (30 March 1999) B2


Editorial, 'Euthanasia $50 Fine May be Legal', *The Sydney Morning Herald* (12 August 1997) 8


Editorial, 'Power to Allow Discontinuance of Treatment to Insensate Patient', *The Times* (20 May 1996) 33

Editorial, 'Euthanasia a Right Court Rules', *The Sydney Morning Herald* (8 March 1996) 8

Editorial, 'Act Clears Final Hurdle in Northern Territory', *The Sydney Morning Herald* (21 February 1996) 2


Editorial, 'Doctor was a Mass Murderer, Former Police Chief Says', *The Times* (11 July 1983) 3


Faroque, F., 'The House Call that Lasted Two Weeks', *The Age* (27 January 2001) 5

Faust, B., 'Give Patients Free Will over Life and Death', *Weekend Australian* (10-11 June 1995) 26


Fife-Yeomans, J., 'Patients Face a Legal Minefield across the Nation', *The Australian* (27 September 1996) 7

Ford, R., 'Life may Mean Just 3 Years for "Mercy Killing" Husband', *The Times* (25 May 2007) 7

Geissinger, S., 'Doctor-Assisted Suicide Bill Dies in Committee after Debate', *The Oakland Tribune* (28 June 2006) 1

Glascott, K., 'Push the Button and Die Peacefully', *The Australian* (27 September 1997) 7


Gorman, R., 'Teenager Cleared of Aiding Suicide', *The Times* (23 September 1993) 3

Green, A. & Colburn, D., 'Justices Back Oregon Suicide Law', *The Oregonian* (18 January 2006) 1


Griffith, C., Doneman, P. & Hedley, T., 'You are not Terminally Ill: What Specialists Told Nancy Crick', *Adelaide Advertiser* (29 May 2002) 1

Guilliatt, R., 'Signature that Signed Away a Life', *The Sydney Morning Herald* (27 September 1996) 11


Henzell, D., 'Martin Case Boosts Support for Euthanasia', *Sunday Star-Times* (2 May 2004) 5

Heslop, K., 'Euthanasia Around the World', *The Observer* (19 September 2004) 9


Hodgkinson, N., 'Euthanasia: A Judge Warns Doctor Not to Play God', *The Sunday Times* (30 November 1986) 1

Hosnall, M., 'Doctor is Struck Off for Trying to Help Friend to Die', *The Times* (28 September 2007) 1


Judd, T., 'Pretty Loses Lords Challenge over Right to Die', *The Independent* (30 November 2001) 13


Lane, B., 'High Court Defers to MPs on Euthanasia', *The Weekend Australian* (16-17 November 1996) 9


Manne, R., 'How Data on Death Became a Numbers Game', *The Australian* (17 February 1997) 11

Martindale, M. & Price, D., 'Dr Death's Freedom Rekindles Debate: as Kevorkian is Paroled Today, Widow of Man he was Convicted of Killing Admires his Stand', *The Detroit News* (1 June 2007) 1

McCaffrey, M., 'Right to die Activist: I will Assist More Irish Suicides', *Sunday Tribune* (1 July 2007) N03


290
Moore, T., "'Dr Death" Returns to Life; Profile; The Face', *The Times* (15 December 2006) 2
Nader, C., 'State Liberal MP to Push Death Law', *The Age* (21 June 2007) 11
Nason, D., 'Dent was a Man of Courage: Perron', *The Australian* (27 September 1996) 7
Nicklin, L., 'This Will Kill You', *The Bulletin* (9 September 1990) 40
O' Neill, J., 'Assisted Suicide should be Legal: Poll; Survey shows Canadians Support Euthanasia', *Calgary Herald* (10 June 2007) A7
Osman, A., 'Women Cry 'Thank God' as Dr Arthur is Cleared', *The Times* (6 November 1981) 1
Perron, M., 'Freedom of Speech is Dead where Euthanasia is Concerned', *The Sydney Morning Herald* (5 January 2006) 11
Pilkington, E. & Arbor, A., 'International "Dr Death" Swaps Prison for Lecture Circuit: Euthanasia Champion Released after Eight Years: Block Placed on Advising on, or Attending, Suicides', *Guardian* (1 June 2007) 21
Riley, M., 'Euthanasia Stirs Emotions of MPs', *The Sydney Morning Herald* (17 October 1996) 5
Roberts, G., Metherall, M. & Pollard, R., 'Inside Dr Nitschke's Travelling Death Show', *The Sydney Morning Herald* (27 November 2002) 1

Rothwell, N., 'My Father Decided to Die in Dignity for a Cause he Believed In', *The Australian* (27 September 1996) 1

Sandham, S. & Brough, J., 'Family at War as Dent Rushed to Hospital', *The Sydney Morning Herald* (5 December 1996) 10


Scott, J., 'Suicide Last Hope for Dignified Death', *The Weekend Australian* (28-29 September 1996) 8


Skehan, C., 'Euthanasia Compromise Rejected', *The Sydney Morning Herald* (28 October 1996) 3


Sullivan, R., 'The Difficult Years are Over', *The Age* (7 January 1997) 1

Sweet, M., 'Call for Caution over Depressed Patients' Wishes', *The Sydney Morning Herald* (22 October 1996) 3

Tan-Van Baren, C., 'Suicide Man's Son Recants Support for Bill', *The West Australian* (4 December 1996) 10

Templeton, Sarah-Kate, 'Doctors: Let us Kill Disabled Babies', *The Sunday Times* (5 November 2006) 1

Tibbetts, J., 'Liberals Open to Assisted Suicide: Cotler: Government Still Opposes Bloc Bill; Current Law May be Out of Step with Times, Justice Minister Says While Urging Caution', *Montreal Gazette* (3 November 2005) A14

Toohey, P. & Shine, K., 'Suicide Planned for Two Decades', *The Australian* (27 November 2002) 5

Tyler, T., 'Doctor Jailed After Losing Court Appeal - Ruling Upholds Two-Year Sentence for Assisting Suicide', The Toronto Star (29 April 1999) 1

Valpy, M., 'Assisted Suicide Debate Muted. Academics Say; Poll Finds 60% Favour Legalization', The Globe and Mail (28 September 2004) A9

Vitez, M., 'Debate on Euthanasia Left Kevorkian Behind Quite a Few Years Ago', Houston Chronicle (18 April 1999) 2


Walsh, Kerry-Anne, 'Vote … 1 Choice', The Bulletin (17 September 1996) 18

Whinnett, E., 'Mercy Kill Debate Set to Go Ahead' Sun Herald (25 January 2008) 23

Wilkinson, P., 'Doctor Cleared of Murdering Patient with Pain-Killing Jab', The Times (16 March 1990) 3

Papers


Smith, G III., 'Pain Management, Palliative Care and Self-Determination', Paper presented at the Congress of the International Academy of Law and Mental Health (Padua, 26 June 2007)


Policies and Position Statements


General Board of the Royal Dutch Medical Association, Vision on Euthanasia (1995)


**Reports**


House of Lords Select Committee, *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill* (2005)

House of Lords Select Committee on Medical Ethics, *Report of the Select Committee on Medical Ethics* (1994)


**Theses**