

# APPENDICES

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## APPENDIX 1

### Health care workers' attitudes to active voluntary euthanasia<sup>1</sup>

**Table 1: Health care workers' attitudes to active voluntary euthanasia: selected Australian studies**

Study	In-principle support	Compliance with patient requests	Law reform
<p><b>Kuhse &amp; Singer<sup>2</sup></b> 869 Victorian doctors (1988) Sample: 1893 (46% response rate)</p>	<p>It is sometimes right for a doctor to take active steps to end a patient's life at the patients request: 62% to 34% in favour</p>	<p>40% of doctors (354) asked by patient to hasten death; 29% (107) of 369 doctors had taken active steps to end a patient's life</p>	<p>60% in favour of pro-euthanasia law reform</p>
<p><b>Kuhse &amp; Singer<sup>3</sup></b> 951 Victorian nurses (1992) Sample: 1942 (49% response rate)</p>	<p>75% to 25% in favour of Australia adopting the Netherlands situation permitting active voluntary euthanasia in certain circumstances</p>	<p>55% of nurses (502) asked by patient to hasten death, 333 nurses received requests for direct assistance; 5% (of 333) took active steps to hasten death without a doctor's request; 25% (of 502) were requested by a doctor to take active measures to end a patient's life and 85% of this number complied</p>	<p>78% of respondents in favour of pro-euthanasia law reform</p>
<p><b>Stevens &amp; Hassan<sup>4</sup></b> 298 South Australian doctors (1994) Sample: 494 (60% usable returns)</p>	<p>Is it ever right to bring about the death of a patient by active steps? 18% said yes, 26% said yes but only if requested by the patient</p>	<p>33% of doctors asked by patients to hasten death by taking active steps; 19% (56) had complied with the request</p>	<p>45% in favour of legalisation of active euthanasia (39% opposed)</p>

Study	In-principle support	Compliance with patient requests	Law reform
<p><b>Baume &amp; O'Malley<sup>5</sup></b></p> <p>1268 New South Wales and ACT doctors (1994)</p> <p>Sample: 1667 (76% response rate)</p>	<p>59% agreement that it is sometimes right for a doctor to take active steps to bring about a patient's death</p>	<p>46.4% of doctors asked by patient to hasten death; of those asked, 28% had complied with the request (12.3% overall); 7% had provided the means for suicide</p>	<p>58% in favour of changing the law to permit active voluntary euthanasia</p>
<p><b>Steinberg, Najman, Cartwright<sup>6</sup></b></p> <p>159 Queensland general practitioners (1997)</p> <p>Sample: 387 (67% response rate)</p>	<p>52% did not agree that active euthanasia would undermine trust between doctor and patient; 48% agreed</p>	<p>43% of doctors had been asked by patients to administer something to end their life</p>	<p>33% favoured law reform to allow active voluntary euthanasia; 36% favoured a law allowing physician assisted suicide</p>
<p><b>Neil et al<sup>7</sup></b></p> <p>854 of doctors registered and resident in Victoria (2007)</p> <p>Sample: 1,817 (47% response rate)</p>	<p>35% had given drugs with the intent of shortening life.</p>		<p>53% were frequently in support of legalised euthanasia.</p>

<sup>1</sup> Tables adapted from Roger S Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (2002) at 39-42, 137.

<sup>2</sup> H Kuhse and P Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *The Medical Journal of Australia* 623-627.

<sup>3</sup> H Kuhse and P Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices' (1992) 21 *Australian Nurses Journal* 21-22.

<sup>4</sup> C Stevens and R Hassan, 'Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia' (1994) 20 *Journal of Medical Ethics* 41-46.

<sup>5</sup> P Baume and E O' Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (1994) 161 *The Medical Journal of Australia* 137-144.

<sup>6</sup> M A Steinberg et al, 'End-of-Life Decision-Making: Community and Medical Practitioners' Perspectives' (1997) 166 *The Medical Journal of Australia* 131-134.

<sup>7</sup> D A Neil et al, 'End-of-Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)' (2007) 33 *Journal of Medical Ethics* 721-725

**Table 2: Physicians' attitudes to assisted suicide and active voluntary euthanasia: selected American studies**

Study	Willingness to assist	Compliance with patient requests	Attitudes toward law reform
<p><b>Meier, Emmons, Wallenstein et al<sup>8</sup></b>  (1998, national survey: 1902 physicians from 10 specialties)  Sample: 3102  (61% response rate)</p>	<p>11% would be prepared to (illegally) prescribe medication to assist a suicide; 36% would do so if it were legal  7% would be prepared to (illegally) give a lethal injection; 24% would do so if it were legal</p>	<p>18.3% (32) had received requests for medication to assist in suicide; 16% (of 320) had written "lethal prescription" (3.3% of sample) 11.1% (196) had received a request for a lethal injection; 4.7% of sample (59) had given at least 1 lethal injection</p>	
<p><b>Lee, Nelson, Tilden et al<sup>9</sup></b>  (1996: 2761) Oregon physicians  Sample: 3944  (70% response rate)</p>	<p>46% (1257) would be prepared to prescribe a lethal dose of medication to assist a suicide if it were legal; 52% would not be willing</p>	<p>21% (570) had received a request for a prescription for a lethal dose of medication within the past year; 7% (187) had written a "lethal prescription"</p>	<p>60% believed that physician-assisted suicide should be legal in some cases</p>
<p><b>Bachman et al<sup>10</sup></b>  (1996: 1119 Michigan physicians)  Sample: 1518  (74% response rate)</p>	<p>If physician-assisted suicide were legal 35% willing to participate if asked; 22% willing to participate in either PAS or euthanasia; 13% only in PAS; 52% would participate in neither</p>		<p>40% favoured the legalisation of physician-assisted suicide; 37% preferred no law (no government regulation); 17% favoured prohibition</p>
<p><b>Doukas et al<sup>11</sup></b>  (1995: 154 Michigan oncologists)  Sample: 250  (62% response rate)</p>		<p>38% had been asked to provide assistance in suicide; 18% had provided assistance. 43% had been asked to administer medication to cause the patient's death; 4% had done so</p>	<p>21% favoured the legalisation of physician-assisted death; 44% were unsure, and 35% opposed legalisation.</p>

Study	Willingness to assist	Compliance with patient requests	Attitudes toward law reform
<p><b>Slome, Mitchell, Charlebois<sup>12</sup></b> (1997: 118 San Francisco AIDS physicians)  Sample: 228  (52% response rate)</p>	<p>48% would be likely to assist an AIDS patient to suicide, based on a case vignette</p>	<p>53% had assisted a patient to suicide at least once (mean number of times: 4.2)</p>	

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<sup>8</sup> D E Meier et al, 'A National Survey of Physician-Assisted Suicide and Euthanasia in the United States' (1998) 338 *The New England Journal of Medicine* 1193-1201.

<sup>9</sup> Melinda Lee et al, 'Legalizing Assisted Suicide: Views of Physicians in Oregon' (1996) 334(5) *The New England Journal of Medicine* 310-315.

<sup>10</sup> J G Bachman et al, 'Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia' 334 (5) (1996) *The New England Journal of Medicine* 303-309.

<sup>11</sup> David J Doukas et al, 'Attitudes of Michigan Physicians to Legalizing Physician-Assisted Suicide and Voluntary Euthanasia' (1995) 13 *Journal of Clinical Oncology* 1055-1061.

<sup>12</sup> L R Slome et al, 'Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease' (1997) 336 417-421.

**Table 3: Frequency of involvement in episodes of assisted death, as estimated by the ‘top dozen’ interviewees in Roger Magnusson’s study**

Name & occupation	Dominant form of assistance	Total number of times involved (estimated in interview)	Total number of times involved (estimated in questionnaire)	Number of anecdotes told in interview illustrating direct involvement
Jane GP	‘Hands on’-lethal injection at patient’s home	50-60 with AIDS patients	50-100	5
Merril GP	‘Indirect facilitation’-prescribes drugs, oversees drug overdose (has given lethal injection)	Perhaps twice a year for 20 years	N/A	0
Kyle GP	‘Indirect facilitation’-prescribes drugs for overdose	15 times	N/A	1
Russell Hospital physician	‘Indirect facilitation’-prescribe drugs for stockpiling, provide syringes for euthanasia	30-40 times	~10 times	3
Harvey GP	‘Hands on’-lethal injection at patient’s home	A dozen times	7 times	2
Tony GP	‘Hands on’-steady escalation of morphine, or sudden withdrawal of cortisone drugs	N/A	10-12	3
Peter Community nurse	‘Hands on’-frequently lethal injection	5-6 lethal injections at patient’s home	AIDS patients (20-25 times); terminally ill non AIDS (4 times); able-bodied HIV (3 times)	4
Bill Hospice nurse	Mixed-act as intermediary between patient and doctor; obtained drugs for overdose; educating patient; assisting at scene; lethal overdose (once)	‘Immemorable’	‘Greater than 50 certainly’	2

<b>Name &amp; occupation</b>	<b>Dominant form of assistance</b>	<b>Total number of times involved (estimated in interview)</b>	<b>Total number of times involved (estimated in questionnaire)</b>	<b>Number of anecdotes told in interview illustrating direct involvement</b>
Erin Community nurse	Mixed-procuring drugs, counselling the process, administering drugs	4 times in past year	20-40 (AIDS patients), and that number again with terminally ill non-AIDS	3
Michelle Community nurse	Mixed-liaison role, obtaining drugs, active at scene, lethal injections	6-8 times in 4 years	6 times	3
Stanley Therapist	'Active at scene'-coaching, create rituals; assist drug ingestion	'A couple of dozen probably'	A dozen (AIDS patients); 5-6 (terminally ill non-AIDS)	1
Mark Therapist	Mixed-active at scene, lethal injection	5-6	5	4

## APPENDIX 2

### Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002<sup>1</sup>

#### CHAPTER I DEFINITIONS

##### Article 1

For the purposes of this Act, the following definitions shall apply:

- (a) Our [meaning Queen Beatrix's] Ministers: the Minister of Justice and the Minister of Health, Welfare and Sport;
- (b) Assistance with suicide: intentionally helping another person to commit suicide or providing him with the means to do so as referred to in Article 294, paragraph 2, second sentence, of the Criminal Code;
- (c) Attending physician: the physician who, according to the notification, has terminated life on request or has provided assistance with suicide;
- (d) Independent physician: the physician who has been consulted about the attending physician's intention to terminate life on request or to provide assistance with suicide;
- (e) Care providers: the persons referred to in Article 446, paragraph 1, of Book 7 of the Civil Code;
- (f) Committee: a regional review committee as referred to in Article 3;
- (g) Regional inspector: a regional inspector employed by the Health Care Inspectorate of the Public Health Supervisory Service.

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<sup>1</sup> Adapted from Appendix II, Henk ten Have & Jos Welie, *Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice* (2005) at 211-219.

## CHAPTER II REQUIREMENTS OF DUE CARE

### Article 2

1. In order to comply with the due care criteria referred to in Article 293, paragraph 2, of the Criminal Code, the attending physician must:
  - (a) be satisfied that the patient has made a voluntary and carefully considered request;
  - (b) be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;
  - (c) have informed the patient about his situation and his prospects;
  - (d) have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
  - (e) have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in (a) to (d) above; and
  - (f) have terminated the patient's life or provided assistance with suicide with due medical care and attention.
2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the attending physician may comply with this request. The due care criteria referred to in subsection 1 shall apply *mutatis mutandis*.
3. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who has/have responsibility for him, or else his guardian, has or have been involved in the decision-making process.
4. If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending

physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are able to agree to the termination of life or to assisted suicide. Subsection 2 shall apply *mutatis mutandis*.

## **CHAPTER III REGIONAL REVIEW COMMITTEES FOR THE TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE**

### *Division 1: Establishment, composition and appointment*

#### **Article 3**

1. There shall be regional committees to review reported cases of the termination of life on request or assisted suicide as referred to in Article 293, paragraph 2, and Article 294, paragraph 2, second sentence, of the Criminal Code.
2. A committee shall consist of an odd number of members, including in any event one legal expert who shall also chair the committee, one physician and one expert on ethical or moral issues [the meaning or purpose of life]. A committee shall also comprise alternate members from each of the categories mentioned in the first sentence.

#### **Article 4**

1. The chair, the members and the alternate members shall be appointed by Our Ministers for a period of six years. They may be reappointed once for a period of six years.
2. A committee shall have a secretary and one or more deputy secretaries, all of whom shall be legal experts appointed by Our Ministers. The secretary shall attend the committee's meetings in an advisory capacity.
3. The secretary shall be accountable to the committee alone in respect of his work for the committee.

### *Division 2: Resignation and dismissal*

#### **Article 5**

The chair, the members and the alternate members may tender their resignation to Our Ministers at any time.

## **Article 6**

The chair, the members, and the alternate members may be dismissed by Our Ministers on the grounds of unsuitability or incompetence or other compelling reasons.

### *Division 3: Remuneration*

## **Article 7**

The chair, the members and the alternate members shall be paid an attendance fee and a travel and subsistence allowance in accordance with current government regulations, insofar as these expenses are not covered in any other way from the public purse.

### *Division 4: Duties and responsibilities*

## **Article 8**

1. The committee shall assess, on the basis of the report referred to in Article 7, subsection 2 of the Burial and Cremation Act, whether an attending physician, in terminating life on request or in assisting with suicide, acted in accordance with the due care criteria set out in Article 2.
2. The committee may request the attending physician to supplement his report either orally or in writing, if this is necessary for a proper assessment of the attending physician's conduct.
3. The committee may obtain information from the municipal pathologist, the independent physician or the relevant care providers, if this is necessary for a proper assessment of the attending physician's conduct.

## **Article 9**

1. The committee shall notify the attending physician within six weeks of receiving the report referred to in Article 8, subsection 1, of its findings, giving reasons.
2. The committee shall notify the Board of Procurators General of the Public Prosecution Service and the regional health care inspector of its findings:
  - (a) If the attending physician, in the committee's opinion, did not act in accordance with the due care criteria set out in Article 2; or

- (b) If a situation occurs as referred to in Article 12, last sentence, of the Burial and Cremation Act. The committee shall notify the attending physician accordingly.
- 3. The time limit defined in the first subsection may be extended once for a maximum of six weeks. The committee shall notify the attending physician accordingly.
- 4. The committee is empowered to explain its findings to the attending physician orally. This oral examination may be provided at the request of the committee or the attending physician.

#### **Article 10**

The committee is obliged to provide the public prosecutor with all the information that he may require:

- (1) for the purpose of assessing the attending physician's conduct in a case as referred to in Article 9, subsection 2; or
- (2) for the purposes of a criminal investigation.

The committee shall notify the attending physician that it has supplied information to the public prosecutor.

#### *Division 6: Procedures*

#### **Article 11**

The committee shall be responsible for making a record of all reported cases of termination of life on request or assisted suicide. Our Ministers may lay down further rules on this point by ministerial order.

#### **Article 12**

- 1. The committee shall adopt its findings by a simple majority of votes.
- 2. The committee may adopt findings only if all its members have taken part in the vote.

### **Article 13**

The chairs of the regional review committees shall meet at least twice a year in order to discuss the methods and operations of the committees. A representative of the Board of Procurators General and a representative of the Health Care Inspectorate of the Public Health Supervisory Service shall be invited to attend these meetings.

#### *Division 7: Confidentiality and disqualification*

### **Article 14**

The members and alternate members of the committee are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties, unless they are required by a statutory regulation to disclose the information in question or unless the need to disclose the information in question is a logical consequence of their responsibilities.

### **Article 15**

A member of the committee sitting to review a particular case shall disqualify himself and may be challenged if there are any facts or circumstances which could jeopardise the impartiality of his judgment.

### **Article 16**

Any member or alternate member or the secretary of the committee shall refrain from giving any opinion on an intention expressed by an attending physician to terminate life on request or to provide assistance with suicide.

#### *Division 8: Reporting requirements*

### **Article 17**

1. By 1 April of each year, the committees shall submit to Our Ministers a joint report on their activities during the preceding calendar year. Our Ministers may lay down the format of such a report by ministerial order.
2. The report referred to in subsection 1 shall state in any event:

- (a) The number of cases of termination of life on request and assisted suicide of which the committee has been notified and which the committee has assessed;
- (b) The nature of these cases;
- (c) The committee's findings and its reasons.

#### **Article 18**

Each year, when they present their budgets to the States General, Our Ministers shall report on the operation of the committees on the basis of the report referred to in Article 17, subsection 1.

#### **Article 19**

1. On the recommendation of Our Ministers, rules shall be laid down by order in council on:
  - (a) the number of committees and their powers;
  - (b) their locations.
2. Further rules may be laid down by Our Ministers by or pursuant to order in council with regard to:
  - (a) the size and composition of the committees;
  - (b) their working methods and reporting procedures.

### **CHAPTER IV AMENDMENTS TO OTHER LEGISLATION**

#### **Article 20**

The Criminal Code shall be amended as follows:

A

Article 293 shall read as follows:

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 twelve 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.

B

Article 294 shall read as follows:

Article 294

1. Any person who intentionally incites another 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 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 *mutatis mutandis*.

## **Article 21**

The Burial and Cremation Act shall be amended as follows.

A

Article 7 shall read as follows:

Article 7

1. The person who conducted the post-mortem examination shall issue a death certificate if he is satisfied that the death was due to natural causes.
2. If death was the result of the termination of life on request or assisted suicide as referred to in Article 293, paragraph 2, or Article 294, paragraph 2, second

sentence, of the Criminal Code respectively, the attending physician shall not issue a death certificate and shall immediately notify the municipal pathologist or one of the municipal pathologists of the cause of death by completing a report form. The attending physician shall enclose with the form a detailed report on compliance with the due care criteria set out in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

3. If the attending physician decides, in cases other than those referred to in subsection 2, that he is unable to issue a death certificate, he shall immediately notify the municipal pathologist or one of the municipal pathologists accordingly by completing a report form.

## B

Article 9 shall read as follows:

### Article 9

1. The form and layout of the models for the death certificates to be issued by the attending physician and the municipal pathologist shall be laid down by order in council.
2. The form and layout of the models for the notification and the detailed report as referred to in Article 7, subsection 2, for the notification as referred to in Article 7, subsection 3 and for the forms referred to in Article 10, subsections 1 and 2, shall be laid down by order in council on the recommendation of Our Minister of Justice and Our Minister of Health, Welfare and Sport.

## C

Article 10 shall read as follows:

### Article 10

1. If the municipal pathologist decides that he is unable to issue a death certificate, he shall immediately notify the public prosecutor by completing a form and shall immediately notify the Registrar of Births, Deaths and Marriages.
2. Without prejudice to subsection 1, the municipal pathologist shall, if notified as referred to in Article 7, subsection 2, report without delay to the regional review

committees referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act by completing a form. He shall enclose a detailed report as referred to in Article 7, subsection 2.

D

The following sentence shall be added to Article 12: If the public prosecutor decides, in cases as referred to in Article 7, subsection 2, that he is unable to issue a certificate of no objection to burial or cremation, he shall immediately notify the municipal pathologist [coroner] and the regional review committee as referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

E

In Article 81, first point, “7, subsection 1” shall be replaced by: 7, subsections 1 and 2

#### **Article 22**

The General Administrative Law Act shall be amended as follows.

In Article 1:6, the full stop at the end of point (d) shall be replaced by a semi-colon, and a fifth point shall be inserted as follows:

decisions and actions to implement the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

### **CHAPTER V CONCLUDING PROVISIONS**

#### **Article 23**

This Act shall enter into force on a date to be determined by Royal Decree.

#### **Article 24**

This Act may be cited as the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

We order and command that this Act shall be published in the Bulletin of Acts and Decrees and that all ministries, authorities, bodies and officials whom it may concern shall diligently implement it.

Done at on

The Minister of Justice,

The Minister of Health, Welfare and Sport,

Lower House, 1998-1999 session, 26 691, Nos. 1-2

## APPENDIX 3

### Physical and fault elements of murder in Australia<sup>1</sup>

Jurisdiction and Law	Physical Element	Fault Element
<b>ACT</b> <i>Crimes Act 1900</i>	Causes the death of another person: section 12(1)	Intending to cause death, reckless indifference to the probability of causing death: sections 12(1)(a) & (b)
<b>NSW</b> <i>Crimes Act 1900</i>	Act or omission causing death: section 18(1)(a) Constructive murder: section 18(1)(a)	Intent to kill or inflict grievous bodily harm, reckless indifference to human life: section 18(1)(a)
<b>QLD</b> <i>Criminal Code</i>	Causes the death of another: sections 291, 293 & 300 Constructive murder: section 302	Intends to cause death or grievous bodily harm: section 302(1)(a)
<b>SA</b> Common law <i>Criminal Code Consolidation Act 1935</i>	Unlawfully kills "any reasonable creature in being" Constructive murder: section 12A	Intention to cause death or grievous bodily harm Foreseeability of death as a probable consequence of action
<b>TAS</b> <i>Criminal Code</i>	Culpable homicide: sections 156(2), 157 & 158 Constructive murder: section 157(1)(d)	Intention to cause death or grievous bodily harm Intention to cause bodily harm which the offender knew to be likely to cause death Unlawful act or omission which the offender knew or ought to have known to be likely to cause death: sections 156 & 157
<b>VIC</b> Common law <i>Crimes Act 1958</i>	Unlawfully kills 'any reasonable creature in being' Constructive murder: section 3A	Intention to cause death or grievous bodily harm Foreseeability of death as a probable consequence of action
<b>WA</b> <i>Criminal Code</i>	Unlawfully kills another: sections 268 & 269	Constructive murder: section 279(2) Intends to cause death or grievous bodily harm: section 279(1).

<sup>1</sup> Table taken from Simon Bronitt & Bernadette M<sup>c</sup>Sherry, *Principles of Criminal Law* (2<sup>nd</sup> ed, 2005), Table 1 at 454.

## APPENDIX 4

### Incidence of assisted suicide in Oregon

**Table 1: Summary of the findings of yearly reports in relation to the incidence of doctor-assisted suicide in Oregon from 1998 – 2006<sup>1</sup>**

Year	Prescriptions written	Deaths from prescription	Died from illness	Did not ingest	Still alive at 31 December	Deaths from prescription in a previous year	Total Deaths from PAS	Percentage per 10,000 deaths in Oregon
1998	23	15	6	8	2	NA*	21	5.5
1999	33	26	5	7	2	1	27	9.2
2000	39	26	8	13	5	1	27	9.1
2001	44	19	14	25	11	2	21	7.0
2002	58	36	16	22	6	2	38	12.2
2003	67	39	18	28	10	3	42	13.6
2004	60	35	13	25	12	2	37	12.3
2005	64	32	15	32	17	6	38	12.0
2006	65	35	19	16	11	11	46	14.7

\* Not available.

<sup>1</sup> Table developed from: Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Oregon's Death with Dignity Act: The First Year's Experience' (1999) <<http://www.dhs.state.or.us/publichealth/chs/pas/year1/ar-index.cfm>> at 4; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Oregon's Death with Dignity Act: The Second Year's Experience' (2000) <<http://www.dhs.state.or.us/publichealth/chs/pas/year2/ar-index.cfm>> at 9; 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' (2001) <<http://www.dhs.state.or.us/publichealth/chs/pas/year3/ar-index.cfm>> at 9; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Fourth Annual Report on Oregon's Death with Dignity Act' (2002) <<http://www.dhs.state.or.us/publichealth/chs/pas/year4/ar-index.cfm>> at 9; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Fifth Annual Report on Oregon's Death with Dignity Act' (2003) <<http://www.dhs.state.or.us/publichealth/chs/pas/year5/ar-index.cfm>> at 4,11; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Sixth Annual Report on Oregon's Death with Dignity Act' (2005) <http://www.dhs.state.or.us/publichealth/chs/pas/ar-index.cfm> at 4; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Eighth Annual Report on Oregon's Death with Dignity Act' (2006) <<http://www.oregon.gov/DHS/ph/pas/index.shtml>> at 4; Department of Human Resources Oregon Health Division Centre for Disease Prevention and Epidemiology, 'Ninth Annual Report on Oregon's Death with Dignity Act' (2007) <<http://www.oregon.gov/dhs/ph/pas>>

## APPENDIX 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

#### 1. AUSTRALIA

##### A. MURDER

- (i) *R v Stephens, Hayes & Vinson* (Magistrate's Court, Perth, Magistrate Packingham, 2000); (Supreme Court of Western Australia, 2001)

#### Facts and charges laid

Dr Daryl Stephens, a urologist, was charged with the wilful murder of his patient, 48-year-old Freeda Hayes, on 4 April 2000 at the Murdoch Community Hospice in Perth. Mrs Hayes was suffering from cancer of the kidneys and had secondary tumours throughout her nervous system. She was in 'exquisite' pain and had asked numerous times that her life be ended. Mrs Hayes' brother, Warren Hayes, and her sister, Lena Vinson, were present when she died. Dr Stephens had been in to see her earlier that day but was not present when she died. Mr Hayes and Mrs Vinson were also charged with wilful murder.

#### Preliminary hearing

A preliminary hearing was set down for 27 November 2000 before Magistrate Packingham in the Perth Magistrate's Court. The Magistrate found that a properly instructed jury could find that between 7.10pm and 8pm on 4 February 2000 atracurium, midazolam and morphine were administered to Freeda Hayes for the purpose of providing her with a peaceful departure from life. But on the evidence presented, a reasonable jury could not exclude every reasonable hypothesis except the guilt of the defendants. Accordingly, he discharged the defendants.

In early 2001, the Director of Public Prosecutions reinstated the charge of wilful murder against all three defendants and added an alternative charge of assisted suicide.

### **The hearing – evidence**

Mr Neil Campbell, forensic scientist, gave evidence that atracurium was found in Mrs Hayes' body as well as midazolam after her death. She had not been given these drugs by the hospital. However he was shown blood results from Royal Melbourne Hospital and Murdoch Hospice which showed different levels to each other of these drugs.

Nurse Helen Guthrie gave evidence that Mrs Hayes felt let down by the medical profession and wished she were dead.

Nurse Anthea Crawford gave evidence that Mrs Hayes had an intravenous drip because she was dehydrated and also said that Mrs Hayes had a great fear of suffocation.

Dr Mark Bell gave evidence that he had seen a black bag outside Mrs Hayes room on the evening in question but he could not say to whom it belonged. He confirmed that Mrs Hayes was fed up and that she also had signs of heart failure and had numerous pleural effusions in her left lung which were drained so she could still breathe.

Nurse Diane Grennan gave evidence that on the evening in question she went into Mrs Hayes room and found the drip running too fast. She went to slow it down and Dr Stephens tried to stop her. He then let her pass and she slowed the drip down. She conceded that she had not seen anyone give Mrs Hayes an injection and that the drip was positional (it would run faster when Mrs Hayes' arm was in some positions).

Nurse Julieanne Willsmore gave evidence that Mrs Hayes would have been able to draw up and administer an injection to herself.

Nurse Gillian Abbiss gave evidence that Warren Hayes telephoned his son Craig Hayes and asked him to come into the hospital and also said that Mr Hayes seemed 'cool' after his sister had died.

Dr Douglas Bridge, palliative care doctor at Murdoch, gave evidence that Mrs Hayes was almost the most despairing patient he had ever met and that he was shocked when Mrs Hayes died because he wasn't expecting it. He said he would have liked to have seen evidence of a pulmonary embolus or a stroke to explain her sudden death.

George Nesbitt, police officer, introduced a video tape interview of Mr Hayes in which the latter made no admissions except to say at the end of the interview that if he knew who had given the drugs to his sister he would not say so.

A video interview with Lena Vinson was shown in which she made no admissions but looked distraught.

Dr Karen Margolius, a forensic pathologist, gave evidence that there was no sign of a pulmonary embolus in Mrs Hayes and nor had she died of a stroke.

Dr Joyce, also a forensic pathologist, gave evidence that there was also methadone in Mrs Hayes' body and he was unable to explain its presence.

Dr Ronald Cohen, a histopathologist, gave evidence that it was almost impossible to pinpoint the cause of Mrs Hayes' death with absolute accuracy.

Dr Peter Bremner, a thoracic physician, gave evidence that Mrs Hayes had so much fluid drained from her lungs in the lead up to her death that it was inconceivable that there was no fluid found by Dr Margolius.

Craig Vinson, Mr Hayes' son, gave evidence that he had gone to see Mrs Hayes on the evening she died. He arrived after Dr Stephens had left and whilst Mr Hayes and Mrs Vinson were still present and that Mrs Hayes was still alive.

## **Outcome**

Dr Stephens, Mr Hayes and Mrs Vinson were all acquitted.

## **Source**

Robin Bowles, *What Happened to Freeda Hayes?* (2002)

### **(ii) *R v Maxwell* [2003] VSC 278**

#### **Facts and charges laid**

Alexander Maxwell pleaded guilty to aiding or abetting his wife, Margaret Maxwell, to commit suicide on 19 October 2002. The only issue therefore was what sentence should be imposed.

The matter was determined by Coldrey J.

His Honour noted the following relevant facts:

1. Mrs Maxwell was the dominant partner in the relationship.
2. In 1994, she was diagnosed with cancer of the left breast.
3. She was advised by Professor Sali, a surgeon, of the need to have surgery but she persisted with natural therapies only until 2001 when her general practitioner finally convinced her to have a mastectomy.
4. In January 2002, Professor Sali performed a left mastectomy on her.
5. After the surgery she developed a cough and was advised to have a CT scan but declined.
6. In September 2002, she was aware that the cancer had spread and was inoperable and she threatened to stop eating and drinking.
7. Mr Maxwell loved his wife dearly. He had helped her to find natural therapy because that was what she wanted. He convinced her not to starve herself to death but in return she extracted a promise that he would help her to die when she asked him to.

8. By October 2002, Mrs Maxwell's condition was terminal but she declined palliative care. At this time, Mr Maxwell again convinced her not to give up.
9. On 19 October 2002, Mrs Maxwell told her husband she had had enough she had read *Final Exit* and now wanted Mr Maxwell to honour his promise to help her.
10. Mr Maxwell hired a bottle of helium gas, got a plastic bag and a length of hose and gathered together Mrs Maxwell's various pain relief tablets.
11. Also on 19 October 2002, Mr Maxwell used the drugs and equipment to help Mrs Maxwell commit suicide.
12. After Mrs Maxwell had died, Mr Maxwell contacted the funeral parlour who contacted the police as a routine measure because Mrs Maxwell's treating doctor was not available.
13. Mrs Maxwell was 59 years old when she died. A post-mortem showed widespread cancer in her chest wall, lymph nodes, both lungs, ribs, lumbar spine and pituitary gland. She weighed only 40 kilograms.

### **The decision**

Justice Coldrey referred to his earlier judgement in *R v Hood* in which he had said:

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 a potentially lethal medication to a terminally ill person, perhaps a loved one who is in extreme pain and who wishes to end that suffering at the earliest possibility.

Mr Maxwell was placed at the latter end of the spectrum. The Judge also noted that he had shown considerable remorse, had no prior convictions, there was no reason to expect he would repeat his conduct and he had previously led an unblemished life.

## **The outcome**

A sentence of imprisonment of 18 months was imposed which was wholly suspended.

## **2. ENGLAND**

### **A. ATTEMPTED MURDER**

#### **(i) *R v Carr* (unreported, Leeds Crown Court, Mars-Jones J, 29 November 1986)**

#### **Facts and charges laid**

Dr John Douglas Carr, a general practitioner, was charged with attempted murder after he reportedly gave a patient, 63 year-old Ronald Mawson, an overdose of pain killers.

#### **Trial and issues**

The matter was heard before a jury and one judge, Mars-Jones J, in the Leeds Crown Court.

The issue in the case was whether Dr Carr had intended to kill Mr Mawson or only to relieve his pain.

#### **The evidence**

No details were available.

#### **Arguments raised**

The Prosecution alleged that Dr Carr had given Mr Mawson 1,000 mgs of morphine instead of 150 micrograms together with phenobarbitone to help Mr Mawson to die.

The defence argued that the overdose was a 'ghastly mistake.'

## **Directions**

Mars-Jones J's summing up to the jury was reportedly hostile to Dr Carr. He said:

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, 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.

## **Outcome**

Dr Carr was acquitted.

## **Source**

N Hodgkinson, 'A Judge warns Doctors must not "Play God"' *The Sunday Times* (30 November 1986) 1

**(ii) R v Cox 12 BMLR 38 (Winchester County Court, Ognall J, 1991)**

## **Facts and charges laid**

The accused was Dr Nigel Cox, a consultant rheumatologist at Royal Hampshire Hospital. Dr Cox was indicted on charge of the attempted murder of his patient of 13 years, Lillian Boyes, on 16 August 1991. Ms Boyes was in great pain before she died. Dr Cox was not charged with murder because Ms Boyes' body had already been cremated at the time that the charges were laid.

## **Type of trial and issues**

The matter was heard before a jury and one judge, Justice Ognall in the Winchester County Court.

The issue in the case was whether Dr Cox had the *mens rea* (criminal intent) to attempt to murder Ms Boyes or not.

## **The evidence**

There was a note in medical records that Dr Cox injected Ms Boyes with two undiluted ampoules of potassium chloride.

The nursing staff gave evidence, which was uncontroverted, that the dose was a lethal dose.

The evidence taken together suggested that Ms Boyes passed away from seconds to less than a few minutes from the time of the injection was given to her.

The toxicologist who gave evidence for the Crown stated that potassium chloride should never be injected neat in that amount and if injected neat in that amount was certain to kill. His evidence was uncontroverted. However, he conceded that it was not possible to know the exact level of the drug in Ms Boyes' blood stream at the time of death because blood was not taken from her within 20 minutes of the time of her death.

It was common ground that:

1. potassium chloride has no curative properties;
2. it is not an analgesic;
3. if injected undiluted it is lethal;
4. any doctor would know this;
5. to inject two ampoules would cause Ms Boyes' death in seconds or minutes
6. there was no clinical use for the potassium chloride in Ms Boyes' case;
7. Ms Boyes was terminally ill; and
8. the use of potassium chloride by Cox could only have been to hasten death.

## **Directions**

The judge directed the jury as follows:

There can be no doubt that the use of drugs to reduce pain and suffering will often be fully 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 her death, then he is guilty. In using the words 'hasten her death' I do so quite deliberately. It matters not by how much or by how little her death was hastened or intended to be hastened. You may recall Staff Nurse Creasey agreeing with Mr Kentridge QC that at the time Lillian Boyes received the first injection, not the potassium chloride, but the earlier one of diamorphine and diazepam; that at the time she received that first injection from Dr Cox that morning, she, 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.

### **Arguments raised**

The Crown argued that Dr Cox's primary intention could only have been to bring about Ms Boyes' death.

The defence argued that although Dr Cox's methods were unorthodox, his primary intention had been to relieve Ms Boyes' suffering.

### **Outcome**

Dr Cox was convicted of attempted murder but the 12-month sentence he received was suspended. The General Medical Council admonished Dr Cox but declined to suspend his registration.

### **Source**

*R v Cox* (1992) 12 BMLR 38

## **B. MURDER**

### **(i) R v Adams [1957] Crim L R 365**

#### **Facts and charges laid**

On 19 December 1956 Dr John Bodkin Adams was arrested and charged with the murder of his patient of 13 years, Mrs Morrell. Mrs Morrell who was 81 years old died on 13 November 1950.

#### **Type of trial and issues**

The matter was heard before a jury and one judge, Justice Devlin. The issue in the trial was Dr Adams' intent – whether he intended to kill Mrs Morrell or only to relieve her pain.

#### **The evidence**

According to the arresting officers, Dr Adam's first words were "Murder? Can you prove it?"

Nurse Stronach gave evidence that she gave Mrs Morrell morphine every night on Dr Adam's orders but Dr Adams would also attend and give Mrs Morrell an injection. She did not know what it was because Mrs Morrell would ask the nurses to leave the room.

She gave evidence that Mrs Morrell was semi-conscious and rambling shortly before she died. On cross-examination, based on the actual records of the time, it was established that Mrs Morrell had eaten lunch that day and thus it was highly unlikely that she was semi-conscious and rambling.

Sister Mason-Ellis agreed in cross-examination that Mrs Morrell was not in a coma on her last day alive.

Sister Randall insisted that on Mrs Morrell's last day alive she had given her two injections of paraldehyde but the second injection was not recorded in the notes. It was pointed out to her that she had earlier said that Mrs Morrell was in a coma two

or three days before she died and this could not be right but she refused to withdraw her earlier evidence.

Nurse Hughes also gave evidence that Mrs Morrell was semi-comatose in the last few days which was contrary to the nursing notes.

The Crown then called Dr Arthur Doutwaite, a senior physician to give evidence. He stated that the combination of drugs given to Mrs Morrell before she died (heroin, morphine and paraldehyde) could only have been given with an intent to kill and were not indicated. Further he said there was nothing to justify Dr Adams writing "cerebral thrombosis" on the death certificate as the cause of death. On being shown earlier nursing notes for previous admissions for Mrs Morrell Dr Doutwaite conceded that other doctors had used such drugs for her in the past. He also conceded that Mrs Morrell would have developed a tolerance to the drugs given.

The next Crown witness, Dr Michael Ashby, a consultant neurologist, gave evidence that there was nothing in the nurses' notes to indicate that Mrs Morrell was in pain or discomfort near the time of her death and that he thought the quantity of drugs given just before her death killed her.

However, on cross-examination he conceded that he could not be sure that Mrs Morrell did not die of natural causes.

Dr John Harman, consulting physician, was called to give evidence for the defence. He said that he did not think the dosage of the drugs given were freak doses nor were they unusual drugs to give. He would have done exactly as Dr Adams had done.

In cross-examination he denied that the dosages contributed either directly or indirectly to Mrs Morrell's death.

Hubert Sogno, Mrs Morrell's solicitor gave evidence that Mrs Morrell had altered a will a few times in favour of Dr Adams. In cross examination he stated that after Mrs Morrell's death Dr Adams received an oak chest containing silver and a Rolls

Royce from Mrs Morrell's son – Mrs Morrell had in fact written Dr Adams out of her will before her death.

Detective-Superintendent Herbert Hannam gave evidence that when he questioned Dr Adams about initially saying he had not been a beneficiary under Mrs Morrell's will, Dr Adams replied 'It was not done wickedly. We all want a cremation to go off smoothly for the dear relatives. If I said I was getting money under the will they might be suspicious, and I like cremations and burials to go smoothly ...'

### **Arguments raised**

The Prosecution argued that Dr Adams' intent had been to kill Mrs Morrell.

The defence argued that Dr Adams had not intended to kill Mrs Morrell, he had intended to relieve her pain.

### **Directions**

Justice Devlin directed the jury that:

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 ... 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.

### **Outcome**

Dr Adams was acquitted. The Attorney-General considered that the public interest did not require that Dr Adams be tried on a second indictment of the murder of a Mrs Hullett and he therefore entered a *nolle prosequi* for the indictment.

### **Source**

H Palmer, 'Dr Adams' Trial for Murder' [1957] *Criminal Law Review* 365-377

**(ii) *R v Ludwig* (unreported, Central Criminal Court, Leonard J, 15 March 1990)**

**Facts and charges laid**

Dr Stephen Ludwig, a 30-year-old junior doctor at Battle Hospital in Berkshire was charged with murder after he allegedly gave a patient who was terminally ill with cancer of the pancreas, Mr Sprately, a large dose of potassium chloride and lignocaine. Mr Sprately was allegedly constantly 'writhing in pain' and his wife and two sisters had asked Dr Ludwig to 'do something to help him.'

**Type of trial and issues**

The matter was heard before a jury and one judge, Justice Leonard, in the Central Criminal Court.

The issue in the case was what had caused Mr Sprately's death: the morphine and lignocaine, an overly high dose of morphine or the spread of the cancer which was confirmed on autopsy.

**The evidence**

At the hearing, Counsel for the Prosecution informed the court that its main witness was no longer convinced that Mr Sprately died from a potassium overdose and thought it possible that he could have died of natural causes.

The defence had found two eminent doctors who were willing to testify as to their experimental work in using potassium to potentiate the pain relieving effects of lignocaine – the early results of which were encouraging.

A nurse gave evidence that Dr Ludwig said to her before giving the injection of potassium and morphine to Mr Sprately:

I'm going to send somebody up out there.

At the same time, he drew a finger across his throat and pointed upwards.

## **Arguments raised**

The defence argued that the comments made by Dr Ludwig to the nurse were 'a form of scatological aside intended to lighten the atmosphere at a time of great emotional strain' and that Dr Ludwig was a man of 'integrity, courage and endurance' and that his intention had been to kill the pain and not the patient. Also raised were the long hours that Dr Ludwig had been working at the time.

The Prosecution conceded that it was not possible to say what caused Mr Spratley's death, whether it was the potassium and lignocaine, the morphine or Mr Spratley's disease.

## **Directions**

As it was clear that the Prosecution had abandoned its case against Dr Ludwig, Leonard J ordered that a formal not guilty verdict be recorded.

## **Outcome**

Dr Ludwig was acquitted.

## **Source**

P Wilkinson, 'Doctor cleared of Mercy Killing Jab' *The Times* (16 March 1990) 3

**(iii) *R v Moor (David)* (Unreported, Crown Court, Hooper J, 11 May 1999)**

## **Facts and charges laid**

The accused was Dr David Moor a general practitioner in Newcastle. He was charged with the murder of one of his patients, George Liddell.

Mr Liddell was an 85 year old widower. He had been diagnosed with cancer of the bowel. He had a section of his bowel surgically removed but a small amount of invasion was found at autopsy. Mr Liddell was nursed at home but became depressed and immobile and suffered considerable pain. Although he was not diagnosed as terminally ill he appeared so to the nursing staff. He told more than

one person he did not want to go on and the nurses told this to Dr Moor. Mr Liddell was on regular doses of morphine via a syringe driver. When that ran out and Dr Moor thought Mr Liddell was close to death he gave Mr Liddell a large bolus injection of morphine. Mr Liddell died about 20 minutes after receiving the injection.

Dr Moor was interviewed about terminal illness and pain relief and stated that he had given large overdoses of morphine to help patients die a pain free death. As a result he received some negative publicity. In one tabloid he was described as Britain's greatest serial killer. Initially, Dr Moor denied giving the bolus dose of morphine but in a statement he subsequently prepared for the police some months after the fact he admitted giving it.

### **Type of trial and issues**

The matter was heard before a jury and one judge, Justice Hooper in the County Court.

One issue in the case was whether Dr Moor had intended to kill Mr Liddell or whether he intended only to relieve Mr Liddell's pain. Another issue in the case was whether Mr Liddell died as a result of the dose of morphine or because of a terminal heart condition or some other cause.

### **The evidence**

The Crown's toxicologists gave evidence that a post-mortem sample of blood revealed levels of morphine up to six times higher than the dose Dr Moor had admitted to having given.

The Crown pathologist stated that Mr Liddell was not terminally and no cause could be found for the pain he complained of.

A defence expert agreed Mr Liddell was not terminally ill but stated that the cancer found on post-mortem could have caused the pain. Also he had a heart condition, undiagnosed by the Crown pathologist that could have been the cause of his death.

The defence challenged the reliability of the blood evidence because it was not labelled as to the site from which it was taken and the area chosen was not ligated. Also the effects of non-refrigeration of the body on the post-mortem distribution of the morphine was not dealt with (there is little information on this issue) or the effect that Mr Liddell's impaired renal function would have on clearance of the drug.

After the judge's directions were given (see below) the Prosecution relied heavily on the lies Dr Moor had told, his statements to the media and the fact that he gave the bolus dose when Mr Liddell was already semi-conscious and a virtual admission as to intent as conceded by him in evidence:

Judge: You said in evidence that when you have the final injection you intended to put Mr Liddell to sleep. Did you think he would wake from that sleep?

Moor: No.

Judge: Death was therefore virtually certain?

Moor: Highly probable.

The Prosecution did not dispute that Dr Moor believed that Mr Liddell was terminally ill and in extremis.

### **Directions**

The judge directed the jury to disregard the Crown pathologist's evidence of reasonable health because the manifest weight of the evidence was that Mr Liddell appeared to be terminally ill. He also directed the jury not to rely on the post-mortem morphine levels which seemed unreliable.

The judge directed the jury as follows.

1. Has the prosecution satisfied you so that you are sure that the intramuscular injection given by Dr Moor to Mr Liddell contained significantly more than 60 mg of morphine...If the answer to question 1 is

'No' your verdict must be 'not guilty'. If the answer to question 1 is 'yes', go to question 2.

2. Has the prosecution satisfied you so that you are sure that the defendant caused the death of Mr Liddell? If the answer to question 2 is 'No', your verdict must be 'not guilty'. If the answer to question 2 is 'Yes' go to question 3.
3. Has the prosecution satisfied you so that you are sure that Dr Moor's purpose in giving the intramuscular injection was not to give treatment which he believed in the circumstances (as he understood them) to be proper treatment to relieve Mr Liddell's pain and suffering? If the answer to question 3 is 'No', your verdict must be 'not guilty'. If the answer to question 3 is 'Yes' go to question 4.
4. Has the prosecution satisfied you so that you are sure that the defendant when he gave the intramuscular injection intended to kill Mr Liddell. If the answer to question 4 is 'No' your verdict must be 'not guilty'. If the answer to question 4 is 'Yes' then your verdict must be one of 'guilty'.

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.

### **Outcome**

Dr Moor was acquitted.

### **Source**

Arlidge, Anthony, 'The Trial of Dr David Moor' (2000) *Criminal Law Review* 31-40

### **3. THE UNITED STATES OF AMERICA**

#### **A. MURDER**

##### **(i) *People v Sander*, Unreported, *New York Times* (10 March 1950) 1**

#### **Facts and charges laid**

Dr Herman Sander was charged with the murder of a patient who was terminally ill, Mrs Abbie Borroto. It was alleged that he injected 40 mls of air into a vein in Mrs Borroto's arm and that she died shortly afterwards.

It was alleged that Dr Sander had also confessed to giving the injection of air, to a nurse and to the arresting authorities.

#### **The evidence**

Dr Sander made a note of having given the injection in the medical records as well as that Mrs Borroto died a few minutes later.

An expert pathologist gave evidence for the defence that Mrs Borroto's death was most likely caused by disease rather than the injection of air.

#### **Arguments raised**

The defence argued that the prosecution had failed to show beyond a reasonable doubt that Mrs Borroto was still alive at the time the injection of air was given, that there was intent to kill, that the vein was 'open' to the heart, that an embolus formed or was a cause of death.

Note that euthanasia as a defence or issue in the case was never raised.

#### **Outcome**

The jury acquitted Dr Sander because of a lack of evidence of causation.

## **Source**

T Sachs, 'Criminal Law – Proof of the Corpus Delicti by the use of Extra-Judicial Confessions' 48 (1950) *Michigan Law Review* 1197-1199; T Sachs, 'Criminal Law – Humanitarian Motive as a Defence to Homicide' 48 (1950) *Michigan Law Review* 1199-1201

## **4. CANADA**

### **A. MURDER**

#### **(i) *R v Morrison* (2d) 201 (Nova Scotia Supreme Court) (1998)**

### **Charges Laid**

Dr Nancy Morrison was arrested on 6 May 1997 and charged with the murder of Paul Mills, a patient of hers who had died in the intensive care unit of Queen Elizabeth II Health Sciences Unit in Nova Scotia six months earlier.

### **Facts of the case**

Paul Mills was a 65-year-old man who had had a total of ten operations for cancer of the oesophagus from April – October 1996. A section of his stomach was removed and inserted to replace his oesophagus. The tissue died (necrosis) and he developed a massive infection that would not respond to antibiotics. He had about ten intravenous lines in situ and a hole in the chest which could not be closed which constantly oozed pus. In mid October whilst being encouraged to cough up sputum he said 'I just want to die.' On 15 October 1996 he was admitted to ICU and placed on a ventilator. He was heavily sedated and on narcotics for pain and could not breathe for himself. Two days later his family agreed to a 'do not resuscitate' order being entered into his medical notes.

On 6 November 1996 the medical team informed the family that there was nothing further that could be done for Mr Mills and it was agreed that the ventilator should be removed which happened later that day.

## **The evidence**

One of the ICU nurses, Elizabeth Bland-McInnes gave evidence that she had never seen anyone suffer so much as Mr Mills whilst he was dying after the ventilator was removed. He was constantly gasping for air. She informed Dr Morrison of this and said the only thing that would stop it was potassium chloride. She did not mean by this that she wanted Dr Morrison to give Mr Mills potassium chloride and she was shocked when Dr Morrison did so. Mr Mills was receiving very large doses of narcotic analgesia and sedative hypnotics that did not seem to be relieving his distress. Mr Mills died within a minute of receiving the potassium chloride.

Dr Bethune, Mr Mill's thoracic (chest) surgeon gave evidence that Mr Mills' infection was untreatable.

The medical records showed that Mr Mills received more than 800mg of Dilaudid (a synthetic opiate), more than 230 mg of Versed (a sedative hypnotic and anti anxiety agent) and 40 mg of morphine.

An ICU resident, Dr Cohen, gave evidence that Mr Mills' blood pressure was so low that it was not possible to say whether he was aware and/or in pain.

Nurse Bland-McInnes reported the matter to the nurse manager and there was an internal investigation. Dr Morrison admitted giving the potassium chloride and her hospital privileges were suspended for three months. The matter only came to the attention of the police when a doctor reviewing the investigation reported it as a case of AVE.

Dr Geoffrey Barker, a specialist in intensive care medicine, gave evidence that the amounts of Dilaudid and Versed given to Mr Mills were 'in the lethal range.' Given that Mr Mills was not getting relief he would have checked the intravenous line to make sure that it had not come out of the vein. This would be one possible reason why Mr Mills was so distressed.

A pathologist who examined Mr Mills after the body was exhumed gave evidence that there were no traces of Dilaudid or Versed in Mr Mills' liver though there

should have been given the large doses that were given. He conceded that a reason for this could be that the intravenous line was no longer in the vein and the drugs were not getting directly into Mr Mills' bloodstream.

### **Arguments**

The defence argued that the intravenous line was not in Mr Mills' vein so, not only did he not receive the Dilaudid and Versed but he also could not have received the potassium chloride. As a result the causation requirement for murder could not be met and it was irrelevant what Dr Morrison had intended in giving the potassium chloride.

### **The outcome**

Randall PCJ accepted the causation argument and discharged Dr Morrison ruling that there was no case to go to the jury.

The prosecution appealed but the appeal was denied by Justice Hamilton in the Nova Scotia Supreme Court. The prosecution could have charged Dr Morrison with manslaughter or appealed the decision of Justice Hamilton but did neither.

Dr Morrison was reprimanded by the provincial College of Physicians and Surgeons in 1999.

### **Source**

*R v Morrison* [1998] NSJ No 75, Case No. 720188 (Nova Scotia Provincial Court);

*R v Morrison* [1998] NSJ 441 SH No. 147941 (Nova Scotia Supreme Court)

### **(ii) *R v Alberto De La Rocha, unreported***

### **Facts and charges laid**

Dr De La Rocha was charged with second degree murder and administering a noxious substance to Mary Graham (40mg of morphine and 20 mg of potassium chloride) with intent to end her life.

An agreement was struck in Court between the Counsel in the matter that the doctor would plead guilty to the second charge and so the first charge was dropped. Hence the decision turned on the question of sentencing.

### **The evidence**

An agreed statement of facts was read in evidence. It was agreed that specific deterrence and rehabilitation were not issues. General deterrence was an issue.

At the end of August 1991 Mrs Graham noticed a lump on her neck. By October 7 the lump had increased and Mrs Graham was having difficulty breathing and swallowing. Dr de la Rocha was called in. He viewed the x rays and noted two lumps and arranged for a biopsy on 15 October 1991. During the biopsy Mrs Graham's difficulty breathing became so acute that she had to be intubated. The examination revealed that she had a tumour on the tongue and a large tumour in one bronchus (lung). Mrs Graham asked the nurse to remove the ventilator. The following morning, Mrs Graham was not answering to her name, did not open her eyes or respond to stimuli. One of her sons arrived and asked that she be kept alive until the other son arrived.

Dr de la Rocha extubated Mrs Graham and she breathed normally on her own. He gave 40 mg of morphine and she stopped breathing but still had a heart rate. He then asked for potassium chloride. The family were present. The nurse refused to get it so he got it himself and gave Mrs Graham 20mg. It was not clear whether Mrs Graham was breathing before the potassium chloride was given but she died soon after.

### **Directions**

The judge said that he was not convinced that Dr de la Rocha intended euthanasia when he gave the potassium chloride. The evidence was not clear cut but suggested that she had received the potassium chloride after she stopped breathing.

His Honour took into account the character evidence in support of Dr de la Rocha and the fact that he had no prior convictions. Although he went so far as to say:

As I say, the result may have been different were I persuaded that this was a case where the accused....believed in euthanasia. It is true that he said that....I am not convinced that it was anything more than a retrospective, post mortem expression of views on the matter.

## **5. NEW ZEALAND**

### **A. ATTEMPTED MURDER**

#### **(i) *R v Martin* 3 NZLR [2004] 69**

##### **Facts and charges laid**

New Zealand nurse, Leslie Martin, was charged with the attempted murder of her mother either by administering morphine or by suffocating her with a pillow.

Leslie Martin wrote a book after her mother died called *To Die Like a Dog* advocating euthanasia. In it she admitted to killing her mother who was terminally ill.

At the trial, Ms Martin sought to raise the defence of double effect and also to lead evidence that she was in a state of cognitive dissonance when she wrote the book which led to her memory of events being distorted.

In an interlocutory application, the crown sought to prevent her doing so.

##### **Interlocutory Hearing**

The crown argued that:

1. The doctrine of double effect intrudes upon the sanctity of life and the right to life;
2. only a doctor can assess the effects of pain killing drugs; and
3. the extent to which the doctrine of double effect might apply outside the context of palliative care was not relevant in Martin's case.

The defence argued that the doctrine should not be restricted to doctors for the following reasons:

1. Anyone can meet the conditions that make up the doctrine.
2. The criminal law provides a further safeguard.
3. Doctors are often unavailable for example, in rural areas or in the middle of the night.
4. Pain relief needs to be titrated to the patient's needs – doctors are not regularly available to do this.

### **The outcome of the interlocutory hearing**

Justice Wild held that:

1. the doctrine of double effect is only available to doctors. The doctrine emerges from the cases of *Airedale NHS Trust v Bland* [1993] 2 WLR 316 (HL); *Auckland Area Health Board v Attorney-General* [1993] NZLR 235 and *R v Cox* (1992) BMLR 38. All those cases involved doctors. There will not be adequate safeguards if the doctrine is extended beyond doctors. And it would be an unwarranted intrusion on the sanctity of life doctrine.
2. Ms Martin was permitted to lead evidence of cognitive dissonance.

### **Outcome of the hearing**

Martin's intent to kill her mother was evident in many statements made by her including in her book *To Die Like a Dog*. She was convicted of attempted murder.

An appeal to the Supreme Court was subsequently denied on the same grounds.

### **Sentencing**

Justice Wild convicted Martin of attempted murder. Mitigating factors were that she had an unblemished record, she had acted out of love, she was open about what she had done and her mother was terminally ill at the relevant time and had asked

to be assisted to die. Aggravating factors were that her act was premeditated and deliberate, she had breached the trust reposed in her by the general practitioner who supplied the morphine, she did not seek outside help and did not consult with the rest of the family or her mother's friends. He also noted that Martin had at no time shown remorse and was an advocate of euthanasia. A discount could not be allowed because Martin had not pleaded guilty and had shown no remorse.

### **Outcome**

Martin was sentenced to 15 months in gaol with liberty to apply for home detention.

Her subsequent appeal against conviction and sentence in November 2004 was dismissed in February 2005.

### **Source**

*R v Martin* 3 [2004] NZLR 69; *R v Martin*, High Court of New Zealand, Wanganui Registry, CRI 2003 083 432, 30 April 2004; *R v Martin*, Court of Appeal of New Zealand, CA 199/04, 14 February 2005, Anderson P, McGrath & O'Reagan JJ

## **APPENDIX 6**

### **Letter to research subjects**

31 May 2000

Dear Doctor,

#### **Research in relation to the attitudes of Australian palliative care experts to active voluntary euthanasia and doctor-assisted suicide**

I am a candidate for the degree of Doctor of Juridical Science at the Faculty of Law, University of Sydney. I obtained your name and address from the Palliative Care Institute.

I realise that, as a medical practitioner, you are a busy person but I would be grateful if you would take the time to read this letter and consider whether you would be prepared to take part in the research which I am undertaking.

The anonymity of those who take part in the study is guaranteed unless such information were required by law. Participation in the study involves a 15-minute interview at a time and place to suit you.

You may find the following information useful:

#### **Full title of the project**

“Qualitative research into the attitudes of Australian palliative care specialists to active voluntary euthanasia and doctor-assisted suicide”

#### **Name of chief investigator, department and institution**

Victoria Hiley, Faculty of Law, University of Sydney.

The research is being supervised by Associate Professor Julie Stubbs, Faculty of Law at the University of Sydney. She can be contacted on 9351 2222.

#### **Contact numbers**

My contact numbers are 0414 726 919 (mobile) and 9233 7299 (work).

#### **Purpose of the study**

To gather empirical data to be incorporated into a thesis in relation to active voluntary euthanasia and doctor-assisted suicide.

#### **What is asked of the subject?**

A 15-minute face-to-face interview involving 10 short questions.

## **Risks and benefits**

I do not foresee any risks to those who participate. The benefit is the opportunity to voice how you feel about this important issue and to hopefully further our understanding of the euthanasia debate.

## **Data storage/confidentiality**

Data will be recorded on paper during the interview, it will then be recorded on computer disc. Both must be kept for at least 5 years after publication of the thesis but they will be kept in a secure place to which only I have access. Data will not be recorded on hard disc. At the end of the 5 year period all of the data will be destroyed. Doctor's names will not be recorded on any of the notes taken or on the computer disc. Consent forms will be stored separately from interview notes.

## **Essential information**

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

## **Further action**

If you would like to take part in the study please telephone me on 0414 726 919. I will organise a time and place to meet that suits you. I will bring a standard consent form to the interview as this is a requirement of the Ethics Committee. The consent form states that you have read and understood this information sheet and you understand the purpose of the study.

This information sheet is for you to keep.

I look forward to hearing from you.

**Victoria Hiley**

## APPENDIX 7

### Consent to take part in research

I have read and understood the Information Sheet in relation to the research to be conducted by Victoria Hiley and I understand that the purpose of the study is to elicit the attitudes of Australian palliative care specialists to active voluntary euthanasia and doctor-assisted suicide.

I am aware that the data generated from the interview will be used in Ms Hiley's doctoral thesis but that the anonymity of those who take part in the study will be preserved unless such information were required by law.

.....  
(signed)

.....  
(date)

## APPENDIX 8

### Interview questions

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?
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?

## APPENDIX 9 – Table of results

Q	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5	Subject 6	Subject 7	Subject 8	Subject 9	Subject 10	Subject 11	Subject 12	Subject 13
1	9 yrs	5 yrs	14 yrs	10 yrs	10 yrs	Still in training	2 yrs	5 yrs	13 yrs	15 yrs	8 yrs	3 yrs	14 yrs
2	85%	95 - 99%	80%	90 - 95%	98 – 99%	85-90%	98%	98%	95%	95%	90-95%	98%	90%
3	15-20% due to nerve pain or psychiatric pain.  Nerve blocks and sedation	1-5% due to nerve pain and raised intracranial pressure. For 1% nothing works due to emotional pain.	20% due to nerve or bone pain. In 1% nothing works. In 10% the cause is existential pain. Counselling and station	5% due to nerve pain. 5% due to psychiatric distress. In 5% of cases nothing works.  Otherwise nerve blocks and sedation	1-2% due to nerve or bone pain. There is psychiatric overlay in 100% of cases.  Sedation and counselling.	10-15% due to nerve pain and bone pain. 1% due to psychiatric issues.  Nerve blocks and counselling	2% due to rapid onset disease and anxiety.  Counselling and resetting of goals.	1-2% due to nerve pain or psychiatric problem.  Uses nerve blocks, sedation. There are usually issues such as fear of dying, anguish, and inability to accept end of life. One or two patients per year cannot be helped.	In HIV medicine pain is not an issue. 5% of patients have existential pain  Sedation and counselling	5% due to nerve pain and threshold issues such as depression, isolation, lack of support.  Counselling and sedation.	5% due to nerve pain. Nerve blocks, anti epilepsy drugs, epidurals and morphine. 5 % due to depression, anxiety, social problems, unresolved issues.	2% due to incident pain and/or anguish.  Narcotic analgesia and counselling.	10% for organic reasons. Small percentage due to mental suffering.  Analgesia, counselling and putting the patient "in control".
4	Never	No	No	No	No	No	Never	No	No	No	No	No	No
5	Yes, but would not help.	No, but would not help.	Yes, but would not help.	Yes, but not help.	Yes, but would not help.	Frequently, but would not help.	Yes, for AVE but would not help.	Yes but would never assist.	Yes, but would never assist.	Yes, but would never assist.	Yes but would not assist.	Rarely. Would never assist.	Frequently but has never assisted.
6	Yes.  To care and help and to offer support, to "be there".	Yes.  To do no harm, to do as much good as possible.	Yes.  To diagnose, to treat and to take the patient's wishes into account. Palliation	Yes.  To achieve health.	Yes.  Prevention, cure, to comfort but not to prolong life. But not to end suffering.	Yes.  To provide compassion, comfort and care and to relieve suffering.	Yes.  To comfort, care, diagnose and investigate and prevent disease.	Yes.  To alleviate pain, to care, to cure, to palliate and to preserve dignity and comfort.	Yes.  To do no harm and to involve the patient in decision making not to prolong life unnecessarily	Yes.  To cure, sometimes to relieve and comfort always. To promote health even when dying	No.  To improve quality of life and to treat illness.	Not necessarily.  To cure. The goal of palliative care is to relieve suffering.	No.  To cure or improve.
7	No.	No.	Probably not.	Yes.	In time – yes.	Yes.	Yes.	No.	Yes.	Yes.	Yes.	No.	No.

Q	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5	Subject 6	Subject 7	Subject 8	Subject 9	Subject 10	Subject 11	Subject 12	Subject 13
8	Multi-disciplinary approach (MDA)	MDA	MDA	MDA	MDA	MDA	MDA	MDA	MDA	MDA	MDA	MDA	MDA
9	Yes.	No.	Possibly.	Yes.	No.	No .	No.	No.	Yes.	No.	No.	No.	No.
10	People would become disenchanted with palliative care. Abuse.	It would be impossible to draw the line as to who should be euthanised. People may die who could be helped.	Less effort to palliate people with the risk that inexperienced people would start making. Worries people would take the easy way out.	People may die who might have changed their minds.	Palliative carers may be forced to engage in euthanasia. Some may die who could be treated.	It would divide nurses and doctors. People would fear palliative carers. People could be forced into it	It would lead to genocide. Patients would lose trust in doctors and doctors may be forced to practice medicine to suit the patient.	A loss of respect for life. Minorities would be killed. People would no longer try to help.	Doctors would be expected to provide euthanasia. People may be euthanased instead of alternatives being found.	Worries about temptation to kill because it is cheaper.	Decrease in trust in the medical profession.	A decreased trust in the medical profession. Disastrous for palliative care because people would equate palliative care with euthanasia.	More pressure on palliative carers to get into the debate
G	F	M	F	M	M	F	F	F	F	M	F	M	M

## APPENDIX 10 – Due Care Guidelines, 1973-2002<sup>1</sup>

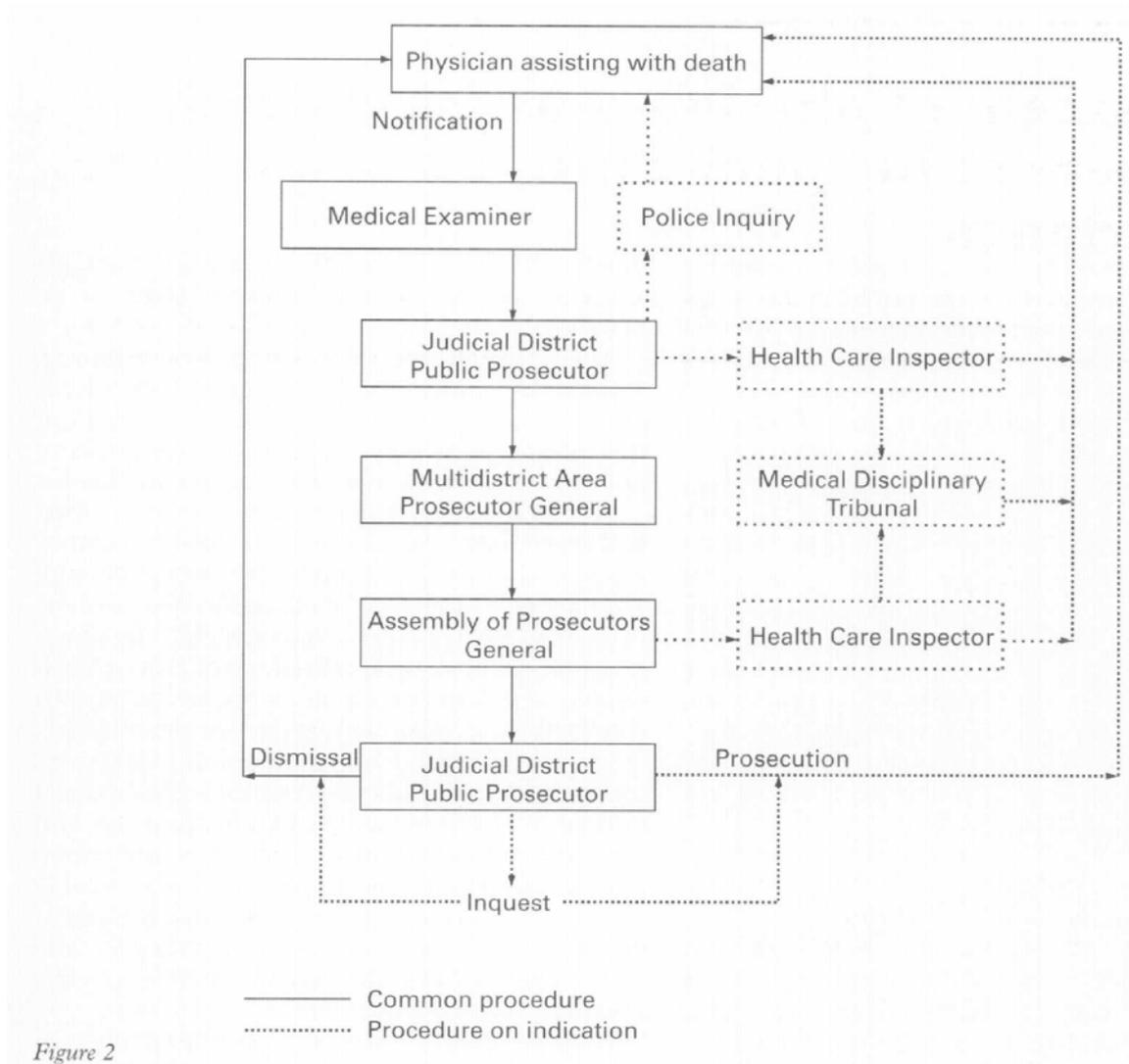
<i>Postma, 1973</i>	<i>Wertheim, 1981</i>	<i>Schoonheim, 1984</i>	<i>Chabot, 1994</i>	<i>Dutch Government, 1994</i>	<i>RDMA, 1995</i>	<i>Prins &amp; Kadjik, 1996</i>	<i>TLRSA, April 2002</i>
<p>1. The patient is terminally ill as a result of disease or accident;</p> <p>2. The patient is of the view that his/her physical or mental suffering is severe or unbearable;</p> <p>3. The patient expresses a wish to have his/her life ended;</p> <p>4. The patient has entered is about to enter the terminal phase; and</p> <p>5. The pain relief is provided by a doctor or in consultation with a doctor.</p> <p>NB: Dr Postma criticised for not seeking other options to euthanasia.</p> <p>Conflict of duties defence rejected.</p>	<p>1. The patient repeatedly and explicitly expresses a desire to die;</p> <p>2. The patient's decision to die is well-informed, free and enduring;</p> <p>3. The patient must be suffering from severe mental or physical pain with no prospect of relief;</p> <p>4. All other options for care have been exhausted or refused by the patient;</p> <p>5. Euthanasia must be carried out by a qualified doctor;</p> <p>6. The doctor must consult with at least one other doctor;</p> <p>7. The treating doctor must inform the local Coroner of the death as a euthanasia death;</p> <p>8. The patient has entered or is about to enter the terminal phase;</p> <p>9. The patient is terminally ill as a result of disease or accident.</p> <p>NB: AS by a layperson, conflict of duties defence not raised.</p>	<p>The criteria set out in <i>Postma</i> and <i>Wertheim</i> plus consideration of the following:</p> <ol style="list-style-type: none"> <li>Whether, and if so to what extent, according to professional medical judgment, increasing disfiguration of the patient's personality and/or increasing deterioration of already unbearable suffering could be expected;</li> <li>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</li> <li>Whether, and if so to what extent, the doctor had explored other means of alleviating suffering.</li> </ol> <p>NB: First acceptance of conflict of duties defence.</p>	<p>The criteria laid down in <i>Postma</i>, <i>Wertheim</i> and <i>Schoonheim</i> but a patient need no longer be terminally ill so long as he or she is experiencing incurable mental suffering.</p> <p>In the case of psychiatric patients an additional requirement that there be an independent psychiatric consultation dealing with the degree of the patient's suffering, incurability and other avenues. Consultation does not necessarily mean examination in person. A failure to consult will not necessarily preclude raising the defence of conflict of duties.</p>	<p>In addition to the criteria laid down in <i>Postma</i>, <i>Schoonheim</i> and <i>Chabot</i> in the case of psychiatric patients:</p> <ol style="list-style-type: none"> <li>Two independent doctors should be consulted;</li> <li>One of the independent doctors must be a psychiatrist;</li> <li>All available treatment options must be considered and recommended.</li> </ol>	<ol style="list-style-type: none"> <li>A voluntary request for euthanasia;</li> <li>A well-considered request for euthanasia;</li> <li>The request is a durable wish;</li> <li>There is 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</li> <li>Consultation with a colleague with experience in the relevant field.</li> </ol>	<p>Euthanasia can be provided to newborns in the following circumstances:</p> <ol style="list-style-type: none"> <li>The baby is severely handicapped;</li> <li>The baby is undergoing intolerable, incurable suffering that cannot be alleviated in a medically meaningful way with no prospect of improvement;</li> <li>The doctor's actions comply with responsible medical opinion and prevailing medical ethics;</li> <li>There is an explicit, repeated and consistent request for euthanasia from the baby's parents;</li> <li>There must be no doubt as to diagnosis and prognosis;</li> <li>There must be consultation with colleagues as well as independent consultation;</li> <li>Death must be brought about in a careful and correct way; and</li> <li>The death must be reported to the Coroner as a case of euthanasia.</li> </ol>	<ol style="list-style-type: none"> <li>The doctor was convinced that the patient made a voluntary and well-considered request to die;</li> <li>the doctor was convinced that the patient was facing interminable and unendurable suffering;</li> <li>the doctor informed the patient about his/her condition and his/her prospects;</li> <li>together, with the patient, the doctor was convinced that there was no other reasonable solution;</li> <li>the doctor consulted at least one independent doctor who saw the patient and confirmed that the due care requirements had been complied with;</li> <li>the doctor helped the patient to die with due medical care; and</li> <li>reported the case to the Coroner as a case of euthanasia.</li> </ol> <p>Article 2(1)(a)-(f).</p>

<sup>1</sup> Table created from information contained in Chapter Five of this thesis.

# APPENDIX 11

## Reporting procedures in the Netherlands after euthanasia, 1998-2002

Figure 1<sup>1</sup>



<sup>1</sup> Figure taken from Figure 2, page 9 of Jacqueline M Cuperus-Bosma et al, 'Assessment of Physician-Assisted Death by Members of the Public Prosecution in the Netherlands' (1999) 25 *Journal of Medical Ethics* 8-15.

## APPENDIX 12

### Chronology of major events in relation to euthanasia in the Netherlands, 1953-2005<sup>1</sup>

Date	Event
1886	The Dutch Criminal Code is enacted.
1952	The first case of euthanasia comes before the District Court at Utrecht. The case receives scant attention. Euthanasia is held to be illegal.
1959	The RDMA publishes the third edition of its pamphlet on medical ethics, stating its opposition to euthanasia.
1973	The case of <i>Postma</i> comes before the District Court at Leeuwarden. The defence of conflict of duties is rejected and principles are laid down for the provision of palliative measures at the end of life. First set of principles of due care laid down. Accused convicted of manslaughter. Suspended sentence.
1973	Working paper issued by RDMA. The Association says that a doctor who shortens the life of a terminally ill patient at the patient's request should have a defence but the courts should deal with such cases on a case-by-case basis.
1978	Members of Lower House of Parliament ask Minister for Health to establish a committee to develop policies in relation to euthanasia and consider legislation.
1981	The first case of AS by a layperson comes before Rotterdam Criminal Court in <i>Wertheim</i> . Additional due care guidelines laid down which are relied upon by the Public Prosecutor in conjunction with the ones laid down in <i>Postma</i> .
1982	State Commission on Euthanasia established by Dutch Government to develop policies on euthanasia and comment on legalisation.
1984	The case of <i>Schoonheim</i> comes before the Dutch Supreme Court. Conflict of duties defence accepted for the first time. Further requirements set out for euthanasia.
1984	RDMA publishes a position statement on euthanasia – that a patient should not have to be terminally ill to qualify for euthanasia. The prime consideration should be intolerable and hopeless suffering.
1985	State Commission on Euthanasia releases its report. It recommends that the Criminal Code be amended to permit euthanasia in the circumstances developed by the courts. The government does not act on its recommendation.
1986	Government submits draft Bill to legalise euthanasia but with a letter stating the government's preference is that the courts continue to decide cases of euthanasia on a case-by-case basis.
1991	The R Emmelink Report is published. It shows 1,000 cases annually of LAWER, an unsatisfactory level of reporting of euthanasia and consultation prior to euthanasia.
1991	A reporting procedure is introduced for euthanasia by the Dutch Government.
1993	The RDMA endorses the view of the Dutch Association of Psychiatry that euthanasia should be available to psychiatric patients who are competent, undergoing incurable mental or physical suffering but not terminally ill.
1993	The Dutch Government stipulates what should be contained in the doctor's report to the Coroner after a case of euthanasia.

Date	Event
1994	The case of <i>Chabot</i> comes before the Dutch Supreme Court. The conflict of duties defence is accepted where euthanasia was provided to a person who was not terminally ill but who was undergoing incurable mental suffering.
1994	The Dutch Government states that in the case of a psychiatric patient, the patient should be examined by two independent doctors, one of whom is a psychiatrist, and examined by both before euthanasia is provided. Also, all treatment options should have been considered and recommended.
1995	The RDMA releases <i>Vision on Euthanasia</i> containing recommendations for doctors as to the due care guidelines. The recommendations are not entirely consistent with those developed by the courts but are not binding.
1996	The cases of <i>Prins</i> and <i>Kadijk</i> come before the Court of Appeal. The net effect of both judgments is that euthanasia is acceptable for newborn babies in the following circumstances: the baby is experiencing intolerable, incurable suffering that cannot be alleviated in a medically meaningful way; there is no prospect of improvement; the doctor's actions comply with responsible medical opinion and prevailing ethics; there is an explicit, repeated and consistent request for euthanasia from the parents; there must be no doubt as to diagnosis and 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.
1996	The Dutch Government arranges for the reporting process, introduced in 1991, to be reviewed.
1997	RDMA initiates Support and Consultation for Euthanasia in Amsterdam (SCEA).
2000	The case of <i>Sutorius</i> comes before the Supreme Court. The court holds that there must be a medical condition to justify euthanasia. Being tired of life is rejected as a valid reason. Dr Sutorius is found guilty of AS but no punishment is imposed.
2000	The case of <i>van Oijen</i> comes before the Supreme Court. Dr van Oijen is found guilty of murder for euthanasing a patient at the request of the patient's family – the patient was unconscious at the relevant time. No punishment is instituted. The RDMA supports Dr van Oijen's actions.
2001	RDMA initiates Support and Consultation for Euthanasia in the Netherlands (SCEN).
2002	TLRASA enacted.
2003	A trainee anaesthetist, Dr Vencken, is arrested and held in custody for giving pain relief and an anaesthetic drug to a dying patient. He is charged with murder but acquitted after it is determined that his actions were palliative care.
2003	Report commissioned by RDMA is released. It states that suffering from non-medical causes (existential) suffering is not beyond the experience of doctors (contrary to <i>Sutorius</i> ).
2003	RDMA calls for doctors who have engaged in a life terminating act without explicit request to be judged by a committee of three doctors and an ethicist instead of a court.
2004	First case of euthanasia by advance directive.
2005	Dutch doctors adopt the Gronigen Protocol which sets out criteria for euthanasing newborn babies.

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<sup>1</sup> Chronology created from the information contained in Chapter Five of this thesis.

## APPENDIX 13

### Reported non-leading cases of voluntary and involuntary euthanasia and DAS, 1986-2004<sup>1</sup>

1. ***District Court at Rotterdam, 20 March 1985, Tijdschrift voor Gezondheidsrecht 1985/44***

***High Court of the Hague, 2 April 1987: NJ 1987, 756, Tijdschrift voor Gezondheidsrecht 1987/34***

***Supreme Court, 15 December 1987: NJ 1988, 811; Tijdschrift voor Gezondheidsrecht 88/13***

#### *Charge*

Euthanasia, breach of Article 293

#### *Facts*

A 72-year-old patient with ovarian cancer refuses high doses of pain medication because she wants to stay fully alert. The doctor ends her life by injecting valium and then pavulon (a muscle relaxant). He claims that the patient died by natural causes. The pharmacist becomes suspicious and informs the authorities.

#### *Defence*

The doctor claims that his duty of confidentiality prevented him from reporting the death as not being due to natural causes.

#### *Outcome*

The District Court fines the doctor for making a false declaration and accepts the defence of conflict of duties. The doctor appeals to the High Court. The High Court accepts the defence of conflict of duties but lowers the fine to what would be about euro 110. The doctor appeals again to the Supreme Court in relation to the fine. The Supreme Court confirms that euthanasia is not a natural death and must not be recorded as such on the death certificate.

#### *Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denverter, Kluwer: 1988) Chapter 11

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<sup>1</sup> Information in this appendix adapted from Appendix I of Henk ten Have & Jos Welie, *Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice* (2005) at 187-210. Note that I have only included cases involving treating doctors, AVE or AS, and a breach of one or more of the due care guidelines.

**2. Medical Disciplinary Court of Amsterdam, 25 June 1985: Tijdschrift voor Gezondheidsrecht 1985/54: Medische Contact 1986 951-952**

**Central Medical Disciplinary Court of Appeals, 12 June 1986; Tijdschrift voor Gezondheidsrecht 1987/3**

**District Court at Haarlem, 4 April 1986: NJ 1987, 287**

*Charge*

Involuntary termination of life in breach of Article 298

*Facts*

A 93-year-old patient had been with the same family doctor for about 15 years. She had multiple diseases linked to old-age but was mentally alert. She said she did not see any purpose in living and rejected further treatment but believed that she had to bear her illnesses so she rejected euthanasia. She refused hospitalization after fracturing her hip. The doctor gave her morphine for pain and she became comatose. The next day, after consulting with the nursing staff and the family, the doctor ended the patient's life by injecting morphine, atropine and alloferine.

*Defence*

Conflict of duties

*Outcome*

The Medical Disciplinary Court imposes a reprimand. The District Court concludes that the wish that life will end does not amount to a request for euthanasia and rejects the defence of conflict of duties. The Court imposes a suspended sentence of one week.

*Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denver, Kluwer: 1988) at Chapter 13

**3. The District Court of The Hague, 21 June 1985: NJ 1985, 709**

*Charge*

Euthanasia, breach of Article 293

*Facts*

Dr Admiraal, a nationally and internationally renowned proponent of euthanasia, ends the life of a patient with multiple sclerosis and notifies the authorities in an attempt to have the matter determined by the courts.

*Defence*

Conflict of duties

*Outcome*

The Court accepts the defence of conflict of duties because the patient was fully-dependant on the doctor, experienced her suffering as unbearable and dreaded dying by suffocation or pneumonia.

*Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denventer, Kluwer: 1988) at Chapter 12

**4. District Court of The Hague, 6 August 1985: NJ 1985, 708**

**High Court of The Hague, 12 November 1986: NJ 1987, 609**

**Medical Disciplinary College of The Hague, 28 October 1987: Tijdschrift voor Gezondheidsrecht 1988/15.**

*Charge*

Involuntary termination of life, breach of Article 289

*Facts*

Police went to De Terp Nursing Home to investigate charges of theft. Whilst investigating they uncover 20 suspicious deaths. The doctor is charged with four counts of murder.

*Defence*

None stated

*Outcome*

Three counts of murder are proven. The Court imposes a one year sentence because it considers the doctor's motive was to relieve suffering. The RDMA puts forward its view that this outcome may drive euthanasia practice underground. The doctor appeals to the High Court. The High Court finds that evidence was obtained illegally. The doctor is acquitted. The Medical Disciplinary Court criticises the doctor for undermining the public's trust in the medical profession and imposes a warning for not following the due care requirements.

*Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denventer, Kluwer: 1988) at Chapter 14

**5. District Court at Almelo, 24 November 1987**

*Charge*

Euthanasia. Breach of Article 293

*Facts*

A 73-year-old patient with terminal cancer repeatedly requested euthanasia. On 16 August 1984 the doctor ended the patient's life with morphine and a curare-like drug and recorded the death as a natural death. The doctor failed to consult beforehand.

*Defence*

The doctor argues that since it is clear that a conflict of duties applied he should not be prosecuted in the first place.

*Outcome*

The District Court rejects the doctor's defence. The doctor appeals to the High Court. The High Court accepts the defence. The Prosecution appeals to the Supreme Court. The Supreme Court accepts the defence and remits the matter back to the District Court. The District Court fines the doctor for falsifying a death certificate.

*Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denverter, Kluwer: 1988) at Chapter 19.

**6. District Court of The Hague, 12 November 1987**

***High Court of The Hague, 23 March 1989: Tijdschrift voor Gezondheidsrecht 1990, 42-43***

*Charge*

Non-voluntary termination of life, breach of Article 289 (murder)

*Facts*

A 16-year-old girl who is pregnant tries to induce an abortion but fails. A gynaecologist agrees to do an abortion thinking she is about 19 or 20 weeks pregnant. On the day he is ill and asks his assistant to do the abortion. The assistant re-examines the girl and thinks she is 27 weeks pregnant. But since the drugs have been given and will probably harm the foetus the assistant continues but is unsuccessful. The gynaecologist orders that the baby be delivered and it is delivered live. The baby's mouth is covered when it cries so the mother will not hear. The child is left in a container on top of a heater. After about 30 minutes the assistant thinking the child has died puts it in a refrigerator away from view. A

passing nurse hears a sound coming from the refrigerator about an hour later. The child dies later that evening.

*Defence*

None stated

*Outcome*

The court finds the assistant guilty of murder and imposes a suspended sentence. The charges against the chief gynaecologist could not be proven and he was acquitted. The assistant appealed to the High Court. The High Court reached the same verdict but imposes no punishment.

*Alternate Source*

None stated.

**7. District Court at Almelo, 1 March 1988: Tijdschrift voor Gezondheidsrecht 1988/43**

*Charge*

Non-voluntary termination of life, breach of Article 289 (murder)

*Facts*

A patient's condition deteriorates further after surgery. The patient becomes short of breath which cannot be relieved. Neither the patient nor the family requested euthanasia. The doctor decides to end the patient's life without consultation and orders a nurse to inject the patient with 100mg of morphine when the patient has not previously been receiving morphine.

*Defence*

None stated

*Outcome*

The court does not question that the doctor had sincere motives but criticises him for not consulting and for ordering a nurse to give the injection. The court imposes a fine and a suspended sentence of six months.

*Alternative Source*

L Enthoven, *Het recht of Leven en Dood* (Denver, Kluwer: 1988) at Chapter 20

**8. High Court of the Hague, 25 May 1993: *Tidschrift voor Gezondheidsrecht* 1993/52; *Medisch Contact* 48 (1994) 1377-1381**

*Charge*

AS of a psychiatric patient. Breach of Article 294

*Facts*

A 50-year-old patient who is healthy but who has a history of depression and multiple suicide attempts asks her neurologist for AS. He writes a script on 2 October 1985 and mails it to the patient's family doctor who gives it to the patient on 3 October 1985. The patient obtains the drugs the next day and takes them with a large amount of alcohol. The matter is prosecuted.

*Defence*

The family doctor argues that it is already clear that the defence of conflict of duties applies and that he should not be prosecuted.

*Outcome*

The District Court accepts the defence of conflict of duties. The Prosecution appeals. The High Court agrees that the doctor followed the due care principles at the time that the death occurred but had it occurred at the time of the hearing there would have been a breach of the due care guidelines because there was no consultation with another psychiatrist.

*Alternate Source*

None stated

**9. Medical Disciplinary Court, city and date unknown**

***Central Medical Disciplinary Court of Appeals, 29 March 1990: *Tijdschrift voor Gezondheidsrecht* 1990/77***

*Charge*

Assisted suicide

*Facts*

A patient with emphysema is voluntarily admitted to a psychiatric hospital with depression. He is committed when he becomes suicidal. The patient continues to request AS. The clinic agrees. The psychiatrist asks that the committal be lifted and goes to the patient's house with the patient on 17 July 1984 where he gives him a lethal potion. The criminal investigation against the psychiatrist is dismissed in November 1984. The Inspector for Health files a complaint with the Medical

Disciplinary Court. The Court finds that the patient was competent and his suffering was unbearable and prospectless.

*Outcome*

The Court of Appeal finds that the psychiatrist acted too hastily in finding the patient's condition beyond prospect and criticised him not stating why he wanted the commitment lifted and for involving members of nursing staff who were against euthanasia and for not consulting with an independent *external* psychiatrist. No penalty is imposed because the doctor had consulted with other psychiatrists and adequately informed the family.

*Alternate Source*

Not stated

**10. District Court of Almelo, 20 December 1991: NJ 1992, 210; Tijdschrift voor Gezondheidsrecht 1992/19**

*Charge*

AS. Breach of Article 294

*Facts*

A 25-year-old patient with severe anorexia since she was eight years old asks for AS orally, in writing and on video. Her paediatrician grants the request.

*Defence*

The doctor argues that he should not be prosecuted because he was under a conflict of duties.

*Outcome*

The court rejects the protest against prosecution but accepts the defence of conflict of duties because the patient situation was unbearable and prospectless short of force feeding. No punishment is instituted.

*Alternate Source*

Not stated

**11. District Court at Rotterdam, 26 April 1994: Tijdschrift voor Gezondheidsrecht 1994/64**

*Charge*

Euthanasia. Breach of Article 293

### *Facts*

A 72-year-old patient who suffers from diabetes and severe chronic obstructive pulmonary disease repeatedly requests euthanasia and issues a testament. The family doctor refers the patient to another doctor who is a member of the Dutch Society for Voluntary Euthanasia who has several meetings with the patient. The consulted doctor ends the patient's life on 8 August 1992 using nesdonal and alloferine.

### *Defence*

Conflict of duties

### *Outcome*

The Court finds that the consulted doctor should in turn have consulted with another doctor as the family doctor was not willing to carry out euthanasia. The defence of conflict of duties is accepted.

### *Alternate Source*

None stated

## **12. District Court of Haarlem, 4 July 1994: Tijdschrift voor Gezondheidsrecht 1994/48; 49 (1994) Medisch Contact 1575-1577**

### *Charge*

AS. Breach of Article 294

### *Facts*

A patient is paralysed in one half of her body as a result of three strokes in 1988. She cannot bear her condition but refuses therapy to relieve suffering. The patient threatens to throw herself under a train. On 14 August 1991 her doctor provides her with lethal medication which she takes in his presence.

### *Defence*

Conflict of duties

### *Outcome*

The Court holds that the doctor should not have agreed so readily to the patient's refusal of treatment. The patient's suffering even it was unbearable was not without prospect. The patient's threat to throw himself in front of a train was not force majeure. The doctor is found guilty but no punishment is imposed because of the pressure from the patient and honourable motives on the part of the doctor.

*Alternate Source*

Not stated

**13. District Court of Rotterdam, 11 May 1995: Tijdschrift voor Gezondheidsrecht 1996/6**

*Charge*

Euthanasia. Breach of Article 293

*Facts*

A patient who is in the terminal stage of Kahler's disease explicitly requests euthanasia which her family doctor carries out. He does not seek a second opinion and he falsifies the death certificate and a prescription. There is expert evidence that the doctor may suffer from a developmental disorder resulting in a lack of judgement and self-control.

*Defence*

Force majeure/conflict of duties

*Outcome*

The Court criticises the doctor for not consulting and for falsifying the death certificate and the prescription. A fine and a six-month suspended sentence are imposed for breaching Article 293, falsifying the death certificate and the prescription.

*Alternate Source*

Not stated

**14. District Court of The Hague, 24 October 1995: Tijdschrift voor Gezondheidsrecht 1996/13**

*Charge*

Non-voluntary euthanasia, breach of Article 289 (murder)

*Facts*

On 18 June 1993 the children of a hospitalised patient ask that their father's life be ended. The doctor directs the nurses to increase the patient's morphine in an attempt to end the patient's life. The patient dies the next day.

### *Defence*

The doctor argues that the patient had previously said he did not want to vegetate in a nursing home. The patient's spouse denies that he ever expressed such a wish.

### *Outcome*

The Court finds that this is not a request for euthanasia, rejects the defence of conflict of duties, finds the doctor guilty of murder and imposes a three-month suspended sentence.

### *Alternate Source*

Not stated

## **15. District Court at Almelo, 28 January 1997: Tijdschrift voor Gezondheidsrecht 1997/44**

**High Court of Arnhem, 18 September 1997**

**Supreme Court, 30 November 1999: Tijdschrift voor Gezondheidsrecht 2000/20**

### *Charge*

Euthanasia, breach of Article 293

### *Facts*

A terminally ill patient with metastatic cancer of the prostate suffers severe pain that is difficult to relieve. On 26 January 1996 the patient is treated with increasing doses of morphine. When this does not work he is given dormicum. He stops breathing but suddenly starts to breathe again after a few minutes. The doctor ends the patient's life in accordance with a previous request by injecting potassium chloride. He certifies death due to natural causes.

### *Defence*

The doctor argues that he does not have to assist in his own conviction (defence of *nemo tenetur*) and therefore does not have to report euthanasia. He also argues conflict of duties.

### *Outcome*

Defence of conflict of duties accepted but not the defence of *nemo tenetur*. This is confirmed by High Court and Supreme Court. Fine imposed for falsifying documents.

*Alternate Source*

None stated

**16. District Court of Amsterdam, 1 April 1997**

*Charge*

Euthanasia. Breach of Article 293

*Facts*

In 1995 a family practitioner (Makdoembaks) ends the life of a 75-year-old patient with cancer at her explicit request even though he admits her suffering was not unbearable and without prospect. He does not get a second opinion or record his actions.

*Defence*

Conflict of duties

*Outcome*

The Court criticises the doctor for not getting a second opinion or maintaining records. Conflict of duties defence rejected. 10 month suspended sentence instituted.

*Alternate Source*

Not stated

**17. District Court at Leeuwarden, 8 April 1997: Tijdschrift voor Gezondheidsrecht 1997/45**

*Charge*

Euthanasia, breach of Article 293

*Facts*

Dr Schat, a family doctor, ends the life of an elderly patient at home at her explicit request by injecting morphine, Phenobarbital and insulin. He certifies her death as due to natural causes. He does not consult and keeps scant notes.

*Defence*

Conflict of duties, psychological *force majeure*, no requirement to incriminate self (*nemo tenetur*)

*Outcome*

The Court criticises the doctor for not consulting and for keeping inadequate records. Due to this it cannot accept the defence of conflict of duties or force majeure. The court rejects *nemo tenetur* and imposes a suspended sentence of six months.

*Alternate Source*

Not stated

**18. District Court at 's-Hertogenbosch, 31 July 1997: Tijdschrift voor Gezondheidsrecht 1997/57**

*Charge*

AS, breach of Article 294

*Facts*

A patient had a 15-year history of anorexia for which she had been hospitalized intermittently and had received extensive treatment. Her husband and her mother died in 1993 and she asked for AS. In March 1994 after another failed attempt at treatment the doctors agreed her condition was hopeless but none of the hospital psychiatrists would provide AS. She was discharged and another psychiatrist assisted her to suicide.

*Defence*

Conflict of duties

*Outcome*

Defence rejected because the psychiatrist had not done all necessary to help her first. Punishment not stated.

*Alternate Source*

Not stated

**19. Medical Disciplinary Court, place and date of verdict unknown. High Court of Leeuwarden, 13 January 1998**

*Charge*

AS, breach of Article 294

### *Facts*

A family doctor provides a patient's daughter with vesperax for the purpose of committing suicide. He does not know the daughter and is aware that a consulting psychiatrist at the nursing home had rejected euthanasia. The doctor has a previous conviction for euthanasia.

### *Defence*

The doctor tells the Disciplinary Court that the rules for AS are a hindrance and he does not intend to abide by them in the future. Given the previous conviction for euthanasia, the Disciplinary Court revokes the doctor's licence to practice. The doctor appeals to the High Court. The High Court reduces the penalty to six month's suspension.

### *Alternate Source*

Not stated

## APPENDIX 14

### Incidence of AVE, AS and LAWER, 1990-2005; and levels of reporting and consultation in the Netherlands, 1990-2003

**Table 1: End of Life practices in the Netherlands in 1990, 1995 and 2001**

	<b>1990 (128 824)</b>	<b>1995 (135 675)</b>	<b>2001 (140 377)</b>
<b>Interview studies (% [95% CI])</b>			
Number of requests for euthanasia or assisted suicide later in disease	25 100 (23 400 – 27 000)	34 500 (31 800-37 100)	34 700 (32 200-37 100)
Number of explicit requests for euthanasia or assisted suicide at a particular time	8 900 (8 200-9 700)	9 700 (8 800-10 600)	9 700 (8 800-10 500)
<b>End of Life practices (% [95% CI])</b>			
Euthanasia	1.9% (1.6-2.2)	2.3% (1.9-2.7)	2.2% (1.8 - 2.5)
Physician assisted suicide	0.3 % (0.2 – 0.4)	0.4% (0.2-0.5)	0.1 (0.0-0.2)
Ending of life without patient's explicit request	*	0.7% (0.5-0.8)	0.6% (0.4-0.9)
<b>Death certificate studies (% [95% CI])</b>			
Euthanasia	1.7% (1.4-2.1)	2.4% (2.1-2.6)	2.6% (2.3-2.8)
Physician-assisted suicide	0.2% (0.1-0.3)	0.2% (0.1-0.3)	0.2% (2.3-2.8)
Ending of life without patient's explicit request	0.8% (0.6-1.1)	0.7% (0.5-0.9)	0.7% (0.5-0.9)
Alleviation of symptoms with possible life shortening effect	18.8% (17.9-19.9)	19.1% (18.1-20.1)	20.1% (19.1-21.1)
Non-treatment decision	17.9% (17.0-18.9)	20.2% (19.1-21.3)	20.2% (19.1-21.3)
Total	39.4% (38.1-40.7)	42.6% (41.3-43.9)	43.8% (42.6-45.0)

\* Frequency not assessed in 1990.

**Table 2: Interview study findings on euthanasia, physician-assisted suicide, and ending of life without a patient's explicit request 1990, 1995 and 2001**

	1990 (n=405)	1995 (n=405)	2001 (n=410)	P*
<b>Euthanasia or assisted suicide</b>				
Performed it ever	54%	53%	57%	0.33
Performed it in previous 24 months	24%	29%	30%	0.08
Never performed it but would be willing to do so under certain circumstances	34%	35%	32%	0.51
Would never perform it but would refer patient to another physician	8%	9%	10%	0.22
Would never perform it not refer patient	4%	3%	1%	0.0002
<b>Ending of life without a patient's explicit request</b>				
Performed it ever	27%	23%	13%	<0.0001
Performed it in previous 24 months	10%	11%	5%	0.009
Never performed it but would be willing to do so under certain conditions	32%	32%	16%	<0.0001
Would never perform it	41%	45%	71%	<0.0001

\* Based on logistic regression analysis with study year as predictor

**Table 3: Death-certificate study findings on end-of-life practices according to patients' characteristics in 1990, 1995 and 2001**

1990 (n=5,197)					1995 (n=5,416)					2001 (n=5,617)					
	Number of death cases studied (%)	Proportion of deaths after and end-of-life decision (%)				Number of death cases studied (%)	Proportion of deaths after and end-of-life decision (%)				Number of death cases studied (%)	Proportion of deaths after and end-of-life decision (%)			
		Euthanasia and assisted suicide	Ending of life without explicit request	Alleviation of symptoms	Non- treatment decision		Euthanasia and assisted suicide	End Life without explicit request	Alleviation of symptoms	Non- treatment decision		Euthanasia and assisted suicide	Ending of life without explicit request	Alleviation of symptoms	Non- treatment decision
Characteristic															
Age (years)															
0-64	1170 (22%)	3.0	1.6	20	13	1313 (21%)	4.6	1.1	21	14	1435 (20%)	5.0	1.0	19	16
65-79	1999 (37%)	2.3	0.5	20	15	1792 (36%)	2.9	0.6	20	17	1773 (34%)	3.3	0.4	21	19
>80	2038 (41%)	1.0	0.7	17	23	2041 (43%)	1.2	0.6	18	26	2409 (45%)	1.4	0.7	20	23
Sex															
Male	2664 (52%)	2.1	1.1	17	16	2611 (50%)	2.2	0.7	19	17	2602 (49%)	3.1	0.7	19	18
Female	2533 (48%)	1.7	0.5	20	20	2535 (50%)	2.8	0.7	20	24	3015 (51%)	2.5	0.7	21	22
Cause of death															
Cancer	2174 (30%)	4.4	1.7	35	17	2119 (29%)	7.0	1.0	36	17	2306 (29%)	7.4	1.0	33	17
Circulatory disease	1103 (29%)	0.5	0.3	9	15	910 (29%)	0.3	0.1	8	11	958 (25%)	0.4	0.6	11	12
Other or unknown	1920 (40%)	1.1	0.5	13	21	2117 (43%)	1.0	0.9	15	29	2353 (46%)	1.2	0.5	17	27
Type of doctor															
Family doctor	1766 (42%)	3.1	0.6	19	13	2493 (45%)	4.3	0.5	18	11	2421 (42%)	5.8	0.6	21	13
Specialist	2356 (41%)	1.4	1.1	15	19	1560 (36%)	1.8	1.1	17	25	1493 (35%)	1.8	1.2	18	28
Nursing home	986 (17%)	0.1	0.6	28	31	929 (19%)	0.3	0.5	27	36	1213 (24%)	0.4	0.4	32	31

**Table 4: Interview study findings on physicians' attitudes towards end-of-life decision making in 1990, 1995, and 2001**

Physician's attitudes	1990 (n=405)	1995 (n=405)	2001 (n=410)	P*
People have the right to decide about their own life and death	64%	64%	56%	0.02
When patients are willing to perform euthanasia if needed, they will less frequently ask for it	46%	53%	47%	0.20
Adequate pain control and terminal care make euthanasia redundant	37%	31%	33%	0.04
Substantial economic measures in health care will increase the pressure on physicians to provide assistance in dying	9%	12%	15%	0.005
<b>During the preceding 5 years</b>				
Became more permissive	25%	18%	12%	<0.0001
Became more restrictive	14%	12%	20%	0.02
Remained unchanged	61%	70%	69%	0.01

\* Based on logistic regression analysis with study year as predictor

Tables 1, 2, 3 and 4 above taken from B Ontwukeaka-Philipsen et al, 'Euthanasia and Other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001' 362 (2003) *The Lancet*: 395-399.

**Table 5: Frequencies of euthanasia, assisted suicide and other end-of-life practices in the Netherlands from 1990-2005 (death certificate studies)**

Variable	1990	1995	2001	2005
No. of studied deaths†	5197	5146	5617	9965
No. of questionnaires	4900	4604	5189	5342
Most important practice that possibly hastened death (95% CI)*				
Euthanasia	1.7 (1.5-2.0)	2.4 (2.1-2.6)‡	2.6 (2.3-2.8)‡	1.7 (1.5-1.8)
Assisted suicide	0.2 (0.1-0.3)	0.2 (0.1-0.3)	0.2 (0.1-0.3)‡	0.1 (0.1-0.1)
LAWER	0.8 (0.6-1.0)‡	0.7 (0.5-0.9)‡	0.7 (0.5-0.9)	0.4 (0.2-0.6)
Intensify alleviations of symptoms	18.8 (17.9-19.9)‡	19.1 (18.1-20.1)‡	20.1 (19.1-21.3)‡	15.6 (15.0-16.2)
Withhold/withdraw treatment	17.9 (17.0-18.9)‡	20.2 (19.1-21.3)‡	20.2 (19.1-21.3)‡	15.6 (15.0-16.2)
Total	39.4 (38.1-40.7)‡	42.6 (41.3-43.9)	43.8 (42.6-45.0)	42.5 (41.1-43.9)
Continuous deep sedation§	NA	NA	NA	8.2 (7.8-8.6)

\* All percentages were weighted for sampling fractions, for non-response and for random-sampling deviations. CI denotes confidence interval, and NA not available.

† The number of deaths is largest in 2005 because all deaths in which the cause of death precluded physician assistance during dying were included, whereas only 1 in 12 of these cases was included in the other study years.

‡ P<0.05 for comparison with the frequency for 2005.

§ Continuous deep sedation may have been provided in conjunction with practices that possibly hastened death.

Table 5 above taken from Table 1, page 1961 of Agnes Van der Heide et al, 'End-of-Life Practices in the Netherlands under the Euthanasia Act' 356 (19) *New England Journal of Medicine* 1957-1965.

**Table 6: Numbers of cases of euthanasia and doctor-assisted suicide, number of reported cases, and notification rates, Netherlands 1990, 1995 and 2001**

	General Practitioners	Medical Specialists	Nursing Home Doctors	Total
1990				
All cases	NA*	NA	NA	2700
Reported cases	NA	NA	NA	486
Notification Rate (95% CI)	NA	NA	NA	18 (16-23)
1995				
All cases	2625	900	75	3600
Reported cases	1163	274	26	1463
Notification Rate (95% CI)	44	30	35	41 (35-49)
2001				
All cases	2925	775	100	3800
Reported cases	1761	252	41	2054
Notification rate	60	33	41	54 (50-67)

\* Not available.

Table 6 taken from Bregje D Ontwuteaka-Philipsen et al, 'Dutch Experience of Monitoring Euthanasia' 331 (2005) *British Medical Journal* 691-693 at 692.

**Table 7: Notification of cases of euthanasia and doctor-assisted suicide in the Netherlands from 1981-2003**

Year	Number of reported cases	Notification Rate (CI 95%)
1981-1985	71	
1986	84	
1987	126	
1988	184	
1989	338	
1990	486	18 (16-23)
1991	866	
1992	1201	
1993	1304	
1994	1487	
1995	1466	41 (35-49)
2000	2123	
2001	1761	54 (50-67)
2002	1882	
2003	1815	

Table 7 created from: Bregje D Onwuteaka-Philipsen et al, 'Dutch Experience of Monitoring Euthanasia' 331 (2005) *British Medical Journal* 691 at 692; G van der Wal, 'Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands' 335 (22) (1996) *The New England Journal of Medicine* 1706 at 1708 (Table 1); and Tony Sheldon, 'Dutch Reporting of Euthanasia Cases Falls - Despite Legal Reporting Requirements' (2004) 328 *British Medical Journal* 1336.

## APPENDIX 15

### Frequency of end-of-life decisions for non-sudden deaths in European countries\*

Table 1<sup>1</sup>

	UK	Belgium	Denmark	Italy	Holland	Sweden	Switzerland
Number of non-sudden deaths	629 (extrapolated to 20 235)	1942	1963	1852	3574	2248	2282
No ELD	29.8 (23.1-36.5)	<b>41.0 (38.8-43.2)</b>	<b>38.9 (36.7-41.4)</b>	<b>67.5 (65.4-69.6)</b>	34.6 (33.1-36.2)	49.1 (47.0-51.2)	25.0 (23.2-26.8)
Total ELDs	70.2 (63.6-76.8)	<i>59.0 (56.8-61.2)</i>	<i>61.1 (58.9-63.6)</i>	<i>32.5 (30.4-34.6)</i>	65.4 (63.8-67.0)	<i>50.9 (48.8-53.0)</i>	75.0 (73.2-76.8)
Doctor-assisted dying	0.54 (0-1.16)	<b>2.78 (2.05-3.51)</b>	1.17 (0.7-1.64)	0.16 (0-0.34)	<b>5.12 (4.4-5.84)</b>	0.31 (0.08-0.54)	1.53 (1.03-2.03)
Euthanasia (voluntary)	0.17 (0-0.51)	0.46 (0.17-0.75)	0.10 (0-0.24)	0.05 (0-0.15)	<b>3.89 (3.49-4.29)</b>	–	0.39 (0.13-0.65)
Physician-assisted suicide	0.00	0.05 (0-0.15)	0.10 (0-0.24)	0.00	<b>0.31 (0.13-0.49)</b>	–	0.52 (0.22-0.82)
Ending life without explicit request from patient	0.36 (0-0.87)	<b>2.26 (1.59-2.93)</b>	1.02 (0.57-1.47)	0.11 (0-0.26)	0.90 (0.59-1.21)	0.31 (0.08-0.54)	0.61 (0.29-0.93)
Alleviation of symptoms with possible life-shortening effect	36.3 (29.9-42.6)	33.4 (31.2-35.6)	38.9 (36.7-41.1)	<i>26.7 (24.7-28.7)</i>	30.1 (28.6-31.6)	30.3 (28.4-32.2)	32.3 (30.4-34.2)
Non-treatment decisions	33.4 (27.1-39.8)	<i>22.8 (20.9-24.7)</i>	<i>20.9 (19.4-22.4)</i>	<i>5.6 (4.6-6.6)</i>	30.1 (28.6-31.6)	<i>20.2 (18.5-21.9)</i>	41.1 (39.1-43.1)

\* 95% confidence interval, figures are in percentages.

<sup>1</sup> Table taken from Table 3, page 7 of Clive Seale, 'National Survey of End-of-Life Decisions Made by UK Medical Practitioners' (2006) 20 *Palliative Medicine* 3-10.

Figures where the UK is significantly lower are marked in bold type; figures where the UK is significantly higher than that country are italicised and underscored.

Figures for countries other than the UK are calculated from A van der Heide et al, 'End-of-Life Decision-Making in Six European Countries: Descriptive Study' (2003) 362 *Lancet* 345-350.

**Table 2<sup>2</sup>: Frequency of end-of-life decisions in the United Kingdom and Australia\*\***

	<b>UK (2004)</b>	<b>Australia (1996)</b>
Total ELDs	63.6 (57.2-76.4)	64.8 (61.9-67.9)
Euthanasia (voluntary)	0.16 (0-0.36)	1.8 (1.2-2.4)
Physician-assisted suicide	0.00	0.1 (0.02-0.18)
Ending of life without an explicit request from the patient	0.33 (0-0.76)	3.5 (2.7-4.3)
Alleviation of symptoms with possible life-shortening effect	32.8 (28.1-37.6)	30.9 (28.0-33.8)
Non-treatment decisions	30.3 (26.0-34.6)	28.6 (25.7-31.5)

\*\* 95% confidence interval. Figures are in percentages.

<sup>2</sup> Tables adapted from H Kuhse et al, 'End-of-Life Decisions in Australian Medical Practice' (1997) 166 *The Medical Journal of Australia* 191-196 (Australian figures) and Clive Seale, 'National Survey of End-of-Life Decisions Made by UK Medical Practitioners' (2006) 20 *Palliative Medicine* 3 at 7.