Submission

on the

Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

to the

Senate Legal and Constitutional Affairs Committee

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1. Introduction

On 12 March 2008, the Senate referred the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 to the Senate Standing Committee on Legal and Constitutional Affairs for inquiry and report.

The reporting date for this inquiry is 23 June 2008. The Committee has invited written submissions to be received by Wednesday 9 April 2008.

The Bill, a private senator's bill introduced by Senator Bob Brown, seeks to repeal the Euthanasia Laws Act 1997 in order to allow the Northern Territory, the Australian Capital Territory and Norfolk Island to make legislation for people who are terminally ill.

In doing so the Bill seeks to bring the Northern Territory's *Rights of the Terminally Ill Act 1995* back into full force and effect.

2. *Rights of the Terminally Ill Act 1995*

The *Rights of the Terminally Ill Act 1995* (ROTI) was in operation in the Northern Territory from 1 July 1996 until the commencement of the Euthanasia Laws Act 1997 on 27 March 1997.

The Act provides (Section 4) that "A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life."

The Act (Section 3) defines that "'terminal illness', in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient."

The Act further provides that a "medical practitioner who receives a request" may, if certain conditions are met, "assist the patient to terminate the patient's life".

The conditions to be met include that:

- "the medical practitioner is satisfied, on reasonable grounds, that – (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient; (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death;" (Section 7 (1) (b));

- a second "medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering" has examined the patient and has confirmed "(A) the first medical practitioner's opinion as to the existence and seriousness of the illness; (B) that the patient is likely to die as a result of the illness; and (C) the first medical practitioner's prognosis" (Section 7 (c) (i) and (iii));

- "a qualified psychiatrist" has "confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness" (Section 7 (c) (ii) and (iv)); and

- the illness is causing the patient severe pain or suffering (Section 7 (d))

During the nine month period in which the Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke. No other medical practitioner made use of the provisions of the Act to assist any other person to terminate his life.

Case studies on the four deaths under the Act, along with three other case studies of persons who sought to make use of the provisions of the Act before or after the Act was in operation, have been published.[1] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Dr Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Nitschke.

2.1 Terminal illness and further treatment options

In one of the four cases, case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides. "One oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with."[2]

In case 3[3] the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory. This raises a question about the meaning of a treatment being "reasonably available".

Should patients in remote and regional areas be offered lethal injections rather than the treatments that are readily accessible in the major population areas of Australia?

In case 5[4], the patient had an obstruction and was clinically jaundiced. The Act required Dr Nitschke as a "medical practitioner who receives a request" to have "informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient"[5]. However, Kissane reports[6] that "when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction" Dr Nitschke "acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act".

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke[7] to exihibit "indecisiveness" over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.

2.2 "Severe Pain or Suffering"

The *Rights of the Terminally Ill Act 1995* makes reference in various sections to pain, suffering or distress.

Section 4 of the Act provides that "A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life."

Section 7 (1) (d) provides that "a medical practitioner may assist a patient to end his or her life" only if, among other conditions, "the illness is causing the patient severe pain or suffering".

Section 8 of the Act provides that a "medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner" who has the "prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering" (cf Section 7 (1) (c) (i)), "there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient."

Kissane reports[8] that pain "was not a prominent clinical issue in our study". In case 3, "the patient took morphine for generalised bone pain".[9] For case 4, "pain was well controlled".[10] In case 5 the patient "complained of mild background pain incompletely relieved by medication".[11] In case 6 "regular analgesia was needed for abdominal pain".[12]

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3[13], these included "intermittent nausea, constipation, and diarrhoea" and "catheterisation". In case 4[14] the dominant problem was "pruritus". In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. (See discussion above at 2.1). In case 6[15] a key factor seemed to be patient's distress at "having witnessed" the death of her sister who also had breast cancer "particularly the indignity of double incontinence". She "feared she would die in a similar manner". She "was also concerned about being a burden to her children, although her daughters were trained nurses".

Kissane notes[16] in summary that "pain was not a prominent clinical issue in our study. Fatigue, frailty, depression and other symptoms contributed more to the suffering of patients." He observed that "palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care... There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care."

2.3 No clinical depression

From the case histories it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3[17], the patient had had "counselling and anti-depressant medication for several years"; he spoke of feeling sometimes so suicidal that if he had a gun he would have used it"; he had outbursts in which he would "yell and scream, as intolerant as hell" and he "wept frequently".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him at home were told he was being assessed for euthanasia. "A psychiatrist from another state certified that no treatable clinical depression was present."

In case 4[18] "the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose."

Kissane comments[19] that "case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management." While Dr Nitschke "judged this patient as unlikely to respond to further treatment" his co-author Professor David Kissane, comments that "nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia".

The US state of Oregon is one of the few jurisdictions in the world to have legalised physician assisted suicide. The Oregon Death With Dignity Act includes the following provision for counselling referral[20]:

"If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."

In the first 10 years of the operation of the Death With Dignity Act just 10.7% (36 out of 341) of those who made use of its provisions to end their lives were referred for counselling. However, from 2003-2006 only 2 people each year were referred for counselling (4.9%) and in 2007 not one of the 49 people who ingested the lethal prescriptions prescribed under the Act had been referred for counselling.

A 1996 survey of Oregon psychiatrists[21] found that "two-thirds of Oregon psychiatrists believe that physician-assisted suicide for competent terminally-ill persons should, under certain circumstances, be permitted. A slim majority favored implementation of Oregon's Death With Dignity Act, which would legalize physician-assisted suicide." However, the survey also found that "Ninety-four percent were not very confident, however, that within the context of a single evaluation they could determine whether or not a psychiatric disorder was impairing the judgment of a patient who was requesting assisted suicide."

This raises serious doubts about the adequacy of the provision in the *Rights of the Terminally Ill Act 1995* for confirming the absence of a treatable clinical depression.

These doubts are strengthened by the report on case 5[22]. Dr Nitschke reported that "on this occasion the psychiatrist phoned within 20min, saying that this case was straightforward". This assessment took place on the day on which euthanasia was planned. The Act allows this. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "his sadness over the man's loneliness and isolation as he administered euthanasia".

2.4 Should the *Rights of the Terminally Ill Act 1995* be revived?

The careful examination by Professor Kissane of all four cases in which people were given lethal injections under the *Rights of the Terminally Ill Act 1995* raises serious doubts about the adequacy of its provisions.

The Chief Minister of the Northern Territory, Paul Henderson, has observed[23] that the make up of the Territory Parliament is different and palliative care has improved since the voluntary euthanasia legislation was enacted. "Back in 1995 I was a supporter of euthanasia, but I have to say I haven't been in to the detail of how we provide palliative care, and all of the legal and ethical issues that are inherent in our society in 2008 as opposed to 1995," he said.

In the light of the serious problems with the operation of the Act from July 1996- March 1997, and the very pertinent observation by the Chief Minister about the possible medical, legal and ethical developments since 1995 it is not appropriate for the Commonwealth to take an action that would have the effect of immediately reviving, with full force and effect, the *Rights of the Terminally Ill Act 1995.*

> ***Conclusion 1:***
>
> ***As the immediate effect of the Bill is intended to be the revival with full force and effect of the* Rights of the Terminally Ill Act 1995, *and as that Act when it was in operation had demonstrable defects, and as the Northern Territory Legislative Assembly would not be given the opportunity to consider the issues raised by this 13 year old piece of legislation before it came back into full force and effect, the Bill should not be supported.***

3. Laws permitting euthanasia

Despite a decades old movement for legalised euthanasia in many countries in the developed world only a handful of jurisdictions have legalised euthanasia. These are the Netherlands, Belgium and Albania. The US State of Oregon has legalised physician assisted suicide. In Switzerland assisting suicide, other than for selfish motives, is not a crime.

Several high level inquiries into euthanasia have concluded that laws permitting euthanasia cannot be safely enacted.

3.1 United Kingdom

On 12 May 2006 the House of Lords voted 148-100 against the Assisted Dying for the Terminally Ill Bill.

This defeat indicates that the House of Lords still considered as valid the conclusions of the House of Lords Select Committee of Medical Ethics 1994 report[24] that society's prohibition of intentional killing should not be weakened. The select committee stated[25] "That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia."

The House of Lords select committee also concluded that it is not possible to set secure limits on voluntary euthanasia and that if a law permitting euthanasia were passed then vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death.[26]

3.2 Canada

In 1995 a Special Senate Committee on Euthanasia and Assisted Suicide reported[27] with a majority recommending that assisted suicide and voluntary euthanasia remain criminal offences.

"In their view, legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the health care system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.

"They think that some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect the health care infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary."

Bill C-407, An Act to Amend the Criminal Code (Right to Die with Dignity) was introduced by Francine Lalonde, MP in June 2005 but lapsed with the dissolution of Parliament in November 2005. The bill has not been re-introduced to date.

3.3 United States

3.3.1 New York Task Force on Life and the Law

The New York Task Force on Life and the Law in a 1997 supplement[28] to its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*,[29] affirmed and helpfully summarised its views on the primary risks associated with the legalization of assisted suicide or euthanasia as follows:

- *Undiagnosed or untreated mental illness.*

Many individuals who contemplate suicide — including those who are terminally ill — suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalized, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

- *Improperly managed physical symptoms.*

Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly undertreated in current clinical practice. If assisted suicide is legalized, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient's pain have thoroughly been explored.

- *Insufficient attention to the suffering and fears of dying patients.*

For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports — particularly, comprehensive hospice services — can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalized, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.

- · *Vulnerability of socially marginalized groups.*

No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

- *Devaluation of the lives of the disabled.*

A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.

- *Sense of obligation.*

The legalization of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.

- *Patient deference to physician recommendations.*

Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be "medically appropriate," some patients will feel that they have few, if any, alternatives but to accept the recommendation.

- *Increasing financial incentives to limit care.*

Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. As medical care shifts to a system of capitation, financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.

- *Arbitrariness of proposed limits.*

Once society authorizes physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

- *Impossibility of developing effective regulation.*

The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realized in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behavior to prevent mistake and abuse. We continue to believe that these profound dangers associated with legalizing physician-assisted suicide outweigh any benefits such a change in law might achieve in isolated cases.

3.3.2 Oregon

From 1994 through 2007, no fewer than 89 legislative proposals in 22 states of the United States that would have legalized assisted suicide have failed.[30]

The only proposal to succeed to date has been in Oregon where the *Death With Dignity Act* has been in operation since 1997.

An analysis of the ten years operation of this law has been carried out by the International Task Force on Euthanasia and Assisted Suicide[31].

Issues identified in this analysis include:

- Complications arising from self-administration of medication, including vomiting, and one case of a person being unconscious for 65 hours and then waking up.
- Possible coercion or undue influence by a family member on a woman with dementia to request physician assisted suicide.
- Patients with a history of depression being prescribed lethal drugs without a psychiatric referral, which is optional under Oregon's law.

- Oregon's Medicaid program funds an ever decreasing list of medical treatments while assisted suicide remains Medicaid funded.

- Although Oregon's law limits physicians to prescribing lethal drugs to those whose life expectancy is six months or less official reports indicate that several of those who have taken lethal drugs prescribed under the law have done so more than six months after the drugs were prescribed.

- Although Oregon's law requires at least 15 days between a patient's first request for a lethal prescription and the supply of the prescription official reports indicate that this condition is often breached.

3.4 The Netherlands

Since legalised euthanasia was introduced in the Netherlands, initially by court decision (1973) and subsequently by statute (2002), there is no doubt that there has been a rapid expansion of the categories of people considered eligible for physician administered death.

Children aged 16 and over can request euthanasia without parental agreement.

Children aged 12 to 16 can be killed by euthanasia if they request it and a parent agrees.

Children up to the age of 12, including newborns, may be killed by lethal injection with parental consent.

Psychiatric conditions such as depression or anorexia have been accepted as sufficient justification for requesting euthanasia.

Despite the official requirement for consent, ***involuntary*** euthanasia occurred in approximately 900 cases each year from 1995 through 2001.[32]

> ***Conclusion 2:***
>
> ***In the light of international experience with laws permitting euthanasia it can be concluded that it is not possible to enact a law permitting euthanasia that has adequate safeguards to prevent its abuse. This conclusion is sufficient reason for the Commonwealth to do all in its power to prevent the making of any law which would permit euthanasia, including retaining a restriction on the law making powers of the territories in regard to laws permitting euthanasia. Consequently, the Bill, which seeks to facilitate the making of laws permitting euthanasia, should not be supported.***

4. Territory self-government and euthanasia laws

Section 122 of the Constitution of Australia provides, in part, that: "The Parliament may make laws for the government of any territory surrendered by any State to and accepted by the Commonwealth, or of any territory placed by the Queen under the authority of and accepted by the Commonwealth, or otherwise acquired by the Commonwealth".

The Northern Territory was surrendered to the Commonwealth by South Australia on 1 January 1911. Norfolk Island was placed under Commonwealth responsibility in 1914 by Order in Council of King George V.

The Australian Capital Territory was created in … by land ceded by New South Wales to the Commonwealth in accordance with the provisions of Section 125 of the Constitution of Australia regarding a Commonwealth seat of government: "The seat of Government of the Commonwealth shall be determined by the Parliament, and shall be within territory which shall have been granted to or acquired by the Commonwealth, and shall be vested in and belong to the Commonwealth, and shall be in the State of New South Wales, and be distant not less than one hundred miles from Sydney."

Constitutionally, it is entirely a matter for the Commonwealth Parliament whether, and under what terms, these territories may be given self-government.

The *Australian Capital Territory (Self-Government) Act 1988* provides at Section 23 (1) that: "the Assembly has no power to make laws with respect to: (a) the acquisition of property otherwise than on just terms; (c) the provision by the Australian Federal Police of police services in relation to the Territory; (d) the raising or maintaining of any naval, military or air force; (e) the coining of money; (g) the classification of materials for the purposes of censorship.

The Commonwealth Parliament has a particular responsibility to oversee the seat of government. It would be inappropriate for the national capital to become a "death capital" as it may if the Australian Capital Territory's Legislative Assembly was given the power to make a law permitting euthanasia.

In regard to the Northern Territory, as well as limitations on the legislative power in the *Northern Territory (Self-Government) Act 1978* itself (cf. Section 50) the recent national emergency legislation has suspended or overridden the laws of the Northern Territory in order to adequately protect at-risk indigenous children.

In the light of the defects in operation of the *Rights of the Terminally Ill Act 1995* as discussed above it is entirely appropriate for the Commonwealth Parliament to maintain a restriction on the power of the Northern Territory's Legislative Assembly to make a law permitting euthanasia.

The Norfolk Island Act 1979 provides at Section 19 (2) that: "The power of the Legislative Assembly in relation to the making of laws does not extend to the making of laws: (a) authorizing the acquisition of property otherwise than on just terms; or (b) authorizing the raising or maintaining of any naval, military or air force; or (c) authorizing the coining of money."

In the case of each of these territories it is worth noting that their present arrangements for self-government each include a unicameral legislature. This means they lack one of the important checks and balances of a well-functioning democracy – a house of review. (Besides the Commonwealth Parliament every State except Queensland has a bicameral legislature.) This is an additional reason for the Commonwealth Parliament – and the Senate in particular – to continue to maintain an appropriate oversight of territory legislation.

> ***Conclusion 3:***
>
> ***A law permitting euthanasia undermines the inherent, inalienable right to life which is an indispensable foundation of the rule of law. It is entirely appropriate that, given the ultimate responsibility for the territories which the Commonwealth inescapably bears under the Constitution, it continue to uphold limits on the legislative powers of the territories' legislative assemblies preventing each of them from making a law permitting euthanasia. Accordingly, the Bill should not be supported.***

5. Conclusions

As the immediate effect of the Bill is intended to be the revival with full force and effect of the *Rights of the Terminally Ill Act 1995*, and as that Act when it was in operation had demonstrable defects, and as the Northern Territory Legislative Assembly would not be given the opportunity to consider the issues raised by this 13 year old piece of legislation before it came back into full force and effect, the Bill should not be supported.

In the light of international experience with laws permitting euthanasia, it can be concluded that it is not possible to enact a law permitting euthanasia that has adequate safeguards to prevent its abuse. This conclusion is sufficient reason for the Commonwealth to do all in its power to prevent the making of any law which would permit euthanasia, including retaining a restriction on the law making powers of the territories in regard to laws permitting euthanasia. Consequently, the Bill, which seeks to facilitate the making of laws permitting euthanasia, should not be supported.

A law permitting euthanasia undermines the inherent, inalienable right to life which is an indispensable foundation of the rule of law. It is entirely appropriate that, given the ultimate responsibility for the territories which the Commonwealth inescapably bears under the Constitution, it continue to uphold limits on the legislative powers of the territories' legislative assemblies preventing each of them from making a law permitting euthanasia. Accordingly, the Bill should not be supported.

Recommendation:

The Bill should not be supported because

(i) ***it seeks to revive the rights of the* Terminally Ill Act 1995 *which has demonstrable defects;***

(ii) ***international experience indicates that it is not possible to enact a law permitting euthanasia that has adequate safeguards to prevent its abuse and the Bill seeks to facilitate the making of such laws; and***

(iii) ***the Commonwealth Parliament's ultimate constitutional responsibility for the territories require it to protect the inherent and inalienable right to life of persons in the territories by rejecting a Bill whose only purpose is to allow laws that would deprive some persons of that inalienable right to life.***

6. Endnotes

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2. *Ibid.*, p 1101.

3. *Ibid.*, p 1099.

4. *Ibid.*, p 1100.

5. *Rights of the Terminally Ill Act 1995*, Section 7 (1) (e).

6. Kissane, D.W., Street, A, Nitchske, P., *op. cit.*, p 1101.

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7. *Ibid.*, p 1100.

8. *Ibid.*, p 1102.

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10. *Ibid.*, p 1099.

11. *Ibid.*, p 1100.

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15. *Ibid.*, p 1100.

16. *Ibid.*, p 1102.

17. *Ibid.*, p 1099.

18. *Ibid.*, p 1099-1100.

19. *Ibid.*, p 1101.

20. *The Oregon Death With Dignity Act: Oregon Revised Statutes,* 127.825 §3.03; www.oregon.gov/DHS/ph/pas/docs/statute.pdf.

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32. Allen, Mason L. "Crossing The Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia", *Brook Journal of International Law,* 2006, 31:2, pp 535-575; www.brooklaw.edu/students/journals/bjil/bjil31ii_allen.pdf.