ALAN ROTHSCHILD ***LLM PhD.***

LAWYER

[redacted]

9 April 2008

Committee Secretary
Senate Legal and Constitutional Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia.

Dear Sir,

I am writing in regard to the Committee's *Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008.* and attach a submission regarding the bill together with a preliminary abstract.

By way of a quick CV, I am a practising lawyer with a Masters Degree in Law (University of Melbourne) and a Doctor of Philosophy (Monash University). My PhD was titled *Euthanasia and Physician-Assisted Suicide: The Law and the Case for Reform.* Since gaining my PhD (in 2006) I have maintained my interest on issues at end-of-life, having given a paper regarding physician-assisted death at an international medico/legal conference in Italy; written articles on the subject and published in refereed medical, legal and ethical journals and have had a chapter on Australian law regarding end-of-life issues published in a book *Giving Death a Helping Hand* (Springer 2008) in which commentators from various countries were each asked to write on their country's position regarding end-of-life matters.

Most importantly, I have kept up to date with current developments both in Australia and overseas. In particular I travelled to Europe last year and in England interviewed Lord Joel Joffe noted human rights lawyer and member of the House of Lords and Professor Rafi Cohen-Almagor. I also travelled to the Netherlands where I interviewed Professor Agnes van der Heide, Doctor Judith Rietjens, Professor Sjef Gevers, Associate Professor Bregje Onwuteaka-Philipsen, Doctor Mette Rurup, and Doctor Rob Jonquiere all of whom are prominent researchers or active in this area.

Apart from these face to face interviews, I am aware of all data coming from both the Netherlands and Oregon the two jurisdictions most pertinent to any review of Australian law. Later this year I will be travelling to Oregon to interview persons regarding their *Death With Dignity Act* and see the situation there first hand.

Apart from my legal practice I currently am doing casual legal research with a team headed by Professor Bernadette McSherry at the Faculty of Law Monash University regarding the reform of mental health law.

Should there be any queries regarding my submission, please feel free to be in contact.

Yours faithfully,
Alan Rothschild

Abstract to the Submission to the Senate Legal and Constitutional Committee regarding the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* by Dr. Alan Rothschild.
9 April 2008.

ABSTRACT

The sole intent of the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* is the repeal of the *Euthanasia Laws Act 1997* which in turn had overridden the Northern Territory's *Rights of the Terminally Ill Act 1995* (NT). Therefore it is physician-assisted death which must be examined, for that is what again becomes legal should the bill become law and the *Rights of the Terminally Ill Act 1995* once more is an option at end-of-life.

Whether for better or worse, Australia was at one time a world leader in reform of the law at end-of-life when in 1995 the Northern Territory enacted the *Rights of the Terminally Ill Act 1995* (NT), giving a patient, subject to legally enforceable safeguards the right to request physician-assisted death. But because of a peculiarity in Australian law, the Federal Government was able to introduce legislation allowing it to overrule the *Rights of the Terminally Ill Act 1995* (something it could not have done if the Northern Territory were a state) and the test bed for reform that was the Northern Territory was over after only nine months of being in force.

The four persons who made use of the *Rights of the Terminally Ill Act 1995* all died in a similar manner, by a mechanism developed by pro-reform campaigner Dr. Philip Nitschke called the "Deliverance Machine". This was a laptop computer attached to a syringe driver which was inserted into the patient's arm. After the patient answered a series of questions on the computer, a lethal drug was released and the patient died. As it was the patient who in effect self-administered the drug, it was physician-assisted suicide rather than euthanasia. For the nine months it was in operation, there was not to the author's knowledge, any evidence to show that there was any abuse or exploitation of the weak or vulnerable under the provisions of the *Rights of the Terminally Ill Act 1995*.

The *Rights of the Terminally Ill Act 1995* caused a furore nationally, and internationally with extensive debate for and against. With assertions by English commentator John Keown that it is a long and complex Act,[1] and as "both vague and lax."[2] Keown gave examples such as the definition of

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[1] Keown J., *Euthanasia, Ethics, and Public Policy, An Argument Against Legalisation,* (Cambridge University Press, 2002) at 153.

[2] Ibid at 158. It is of interest that Keown in attempting to prove his argument as to the inherent dangers of physician-assisted death states that Oregon's *Death With Dignity Act* is even more lax and vague than either the ROTI or the Dutch

"terminal illness" as being too broad and a lack of clarity as to what treatment "reasonably available" meant.[3] As a general observation, any Act, on any subject, can be criticised on its detail. It can never be assumed that an Act will cover all scenarios to which that Act relates. If such legislation could be written, would there ever be a need for judicial interpretation?

Further, the *Oregon Dying With Dignity Act* described in detail later in this submission actually has fewer safeguards than the *Rights of the Terminally Ill Act 1995* but its annual reports show that it has not been abused. The vulnerable such as the poor, uneducated and elderly have not been targeted. Research shows that it is largely the educated, employed, and medically insured who make use of the Oregon Act.

Other commentators have suggested the *Rights of the Terminally Ill Act 1995* was a commendable piece of legislation.[4] Professor Arthur LaFrance said this: "... [the *Rights of the Terminally Ill Act 1995*] is thoughtful, conservative, disciplined, and balanced in its approach to the personal and societal interests in physician assisted death."[5]

It is inescapable that the law is lagging behind the progression of both medical science and patient autonomy, when it should be ahead or at least abreast of so it can set standards to follow rather than improvise. The more the science of medicine advances, the more it encroaches on all aspects of life including end-of-life. Studies show that doctors have helped patients die in legitimate settings by manipulation of medication or the withholding or withdrawal of treatment for years and these practices once again need to be reviewed with the increased options modern medicine has given to doctors and patients. Should these options now include legislation such as the *Rights of the Terminally Ill Act 1995* and physician-assisted death?

Suffering is a subjective experience, it will vary from person to person. For example, patients with amyotrophic lateral sclerosis (Lou Gehrig's Disease) may accept their increasingly cruel impairments and inevitable fate, because of their beliefs or the adequacy of the care received. But, with only themselves

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guidelines: ibid at 171. This is in spite of the detailed annual reports put out by the Oregon Department of Human Services indicating that the Act is working but only for whom it is intended.

[3] Ibid at 159.

[4] When discussing the Oregon *Death With Dignity Act* and where it could be improved, Cohen-Almagor R. & Hartman M., in their article, "The Oregon Death With Dignity Act: Review and Proposals for Improvement", *Journal of Legislation* Vol. 27, (2001), 269-298, frequently cited with approval the provisions of the RTIA.

[5] Professor of Law Lewis & Clark Law School Portland Oregon. Visiting Professor Murdoch University Law School. "Physician Assisted Death: A Comparison of the Oregon and Northern Territory Statutes" 1*Newcastle Law Review* 33 1995-1996 at 35.

knowing the extent of their suffering, and fearful for the loss of their integrity, dignity and an awful death, they may wish for an earlier end.

But will the advent of physician-assisted death by endorsing the *Rights of the Terminally Ill Act 1995* be the start of the feared "slippery slope"? By sanctioning the physician-assisted death for terminally ill competent persons suffering unbearably, will the practice expand to an unwanted outcome of say non-voluntary or even involuntary euthanasia? When the studies emanating from Oregon are examined, it appears not.

A basic principle of the law and societal values is the "sanctity of life" which is a fundamental argument against physician-assisted death. A person cannot intentionally be put to death because of the inherent value of human life.[6] The sanctity of life is of a higher, or more fundamental value than that of person's right of autonomy such as dying at a time and in a manner of his or her choosing. But the sanctity of life is already compromised, it has exceptions, such as the right of a patient to ask for the withholding or withdrawal of life supporting medical treatment, knowing the result will be that he or she will die.

It should be remembered that the *Rights of the Terminally Ill Act 1995* does not give the medical profession carte blanche to do away with their patients although it relieves doctors and health care providers of criminal, civil, and professional liability if they correctly follow its provisions. If not, not only are there are penalties under the *Rights of the Terminally Ill Act 1995*, there is always the criminal law which can be invoked if need be including homicide.

This submission will not be a subjective discourse giving personal accounts and anecdotes of why the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* should or should not be passed. It will attempt instead to concentrate on the law and medical practice at end-of-life as they now are, whether they can remain as they are, and the validity of reasons given for change by the reimposition of the *Rights of the Terminally Ill Act 1995*.

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[6] There are accepted exceptions including a just war and self-defence.

SUBMISSION

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Introduction

Senator Brown's bill is very simple. It seeks to repeal the *Euthanasia Laws Act 1997* (Cth) which in turn had rendered the Northern Territory's *Rights of the Terminally Ill Act 1995* ("ROTI") ineffective. So what was the ROTI and what were its implications? Is Australia better off without it? This submission will look at Australian law, Australian medical practice and international law particularly in the Netherlands and Oregon, both of which have allowed forms of physician-assisted death in their jurisdictions.

Rights of the Terminally Ill Act 1995

The Northern Territory, with an area of 1.35 million km2, is about the size of France, Spain and Italy combined. It is sparsely populated, with its population of approximately 200,000 representing only about 1% of Australia's 20 million residents. But the twenty five members of its single house Legislative Assembly passed a law never before approved by any government in any country, when on 25 May 1995 the *Rights of the Terminally Ill Act* was passed. The Northern Territory became the first jurisdiction in the world to have legislated for physician-assisted death.

The ROTI was introduced into the Northern Territory's Legislative Assembly by then Chief Minister Marshall Perron on 22 February 1995 as a private member's bill. A Select Committee on Euthanasia was established to enquire about the bill and after making extensive enquiries their report was tabled with the Legislative Assembly. Over 50 amendments were made to the original bill before it was passed by 15 votes to 10 on 25 May 1995, becoming operative on 1 July 1996. On 22 September, cancer sufferer Bob Dent was the first person to die pursuant to its provisions.

Under section 6 of the *Northern Territory (Self Government) Act 1978* (Cth) the Legislative Assembly of the Northern Territory has the power to make laws for the peace, order and good government of the Territory. Chief Minister Marshall Perron in introducing the bill, stated:

> Through the laws in place today, society has made an assessment for all of us that our quality of life, no matter how wretched, miserable or painful, is never so bad that any of us will be allowed to put an end to it. I am not prepared to allow society to make that decision for me and those I love.[1]

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[1] First Reading Speech to the Rights of the Terminally Ill Bill, *Northern Territory Legislative Assembly*, 22 February 1995.

The ROTI was a significant piece of legislation. It was the first legislation in the world to specifically address the issue of physician-assisted death.[2] It was legislation designed for an explicit class of person, that of the autonomous, terminally ill, informed, and competent person. It argued the concerns of the opponents of physician-assisted death, by implementing safeguards to protect the mentally ill and the vulnerable who may make decisions through impulse, coercion or depression, provided penalties for those who wished to take advantage of the ROTI for their own purpose, ensured there would be no liability on doctors either ethically or legally who followed the ROTI's provisions, and gave transparency by providing for reporting.

Opponents of physician-assisted death called for the repeal of the ROTI and while various attempts in the Legislative Assembly to amend or repeal the ROTI were made, they were not successful. There was also an application before the Northern Territory Supreme Court. In *Wake and Gondarra v Northern Territory and Asche*,[3] it was claimed that no valid assent had been given to the legislation and that the Northern Territory did not have the legislative competence to introduce the ROTI. The allegations failed and an appeal was lodged with the High Court of Australia. The appeal was not heard as the Commonwealth stepped in and used its power under section 122 of the Australian Constitution to pass the *Euthanasia Laws Act 1997* (Cth) and override the ROTI, an action that could not have been taken if the Northern Territory was a State. It is this Act that the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* seeks to repeal.

In the nine months of its operation, only four persons, all patients of Dr. Philip Nitschke who would later become nationally and internationally known for his reformist zeal, died under the provisions of the ROTI.

Euthanasia Laws Act 1997

It cannot be disputed that under section 122 of the Australian Constitution, the Commonwealth may make laws for the government of any territory. Chief Justice Barwick found that the power conferred under this section: "... is as large and universal a power of legislation as can be granted ... (it) ... is not only plenary but is unlimited by reference to the subject matter."[4] As such, the Commonwealth may obviously override Territory legislation.

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[2] The Oregon *Death With Dignity Act*, the Netherlands *Termination of Life on Request (and Assisted Suicide) Review Procedures Act* (2002) and Belgium's *Act Concerning Euthanasia*, all came into being after the Australian Act.

[3] (1996) 5 NTLR 170.

[4] *Spratt v Hermes* (1965) 114 CLR 226 at 242.

It may be argued that the members of Federal Parliament who voted for the *Euthanasia Laws Act 1997* (Cth), failed to address the fact that while it is applicable to the Territories it cannot be applicable to the States,[5] and the democratic rights of Territorians are seemingly limited when compared with fellow Australians with State rights. This is so even though the Territories are self-governing and participate in a system of representative government. As a result, Territorians may be seen to be somehow democratically and politically inferior to their counterparts in the States and consequently there is a perception they cannot be trusted to govern themselves. With the limiting of their democratic rights, this Act has limited the right of Territorians to enact laws in relation to euthanasia, a right held by the States. Conversely, with the ROTI still being on the statute books, if the Northern Territory becomes a State, or if the *Euthanasia Laws Act* is repealed, the ROTI is again operative.

Euthanasia

The *Euthanasia Laws Act* cannot be described as a particularly well drafted Act. It does not properly define "euthanasia" nor "physician-assisted suicide" the primary reasons for its existence. The closest it gets to definitions is in Schedules 1, 2 and 3, "... the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life".

While there is no textbook definition, euthanasia may be more properly defined as *the intentional conduct for compassionate or altruistic reasons at the deceased's informed and voluntary request of a person other than the deceased, which causes the death of the deceased so as to relieve the deceased's suffering*. This definition, which encompasses active voluntary euthanasia, does not include non-voluntary and involuntary euthanasia. Non-voluntary euthanasia is where the perpetrator kills the deceased without the deceased being able to express his or her wishes; involuntary euthanasia is where the perpetrator kills the deceased against his or her wishes.

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[5] Although Williams G. & Darke M., "Euthanasia Laws and The Australian Constitution," 20(3) *UNSW Law Journal*, (1997), 647 – 665, have put forward the proposition that if a State did enact legislation similar to the RTIA, the Commonwealth could still override such legislation by passing its own legislation that is inconsistent with the State legislation. They point out that State law that is inconsistent with Commonwealth law is rendered "invalid" by s. 109 of the Constitution; at 655. Also, under s. 81 the Commonwealth could withhold Medicare benefits or even revoke the Medicare provider number of doctors participating in euthanasia or physician-assisted suicide; at 662-663. Or under s. 51 the Commonwealth may be able to utilise its tax, corporations or races powers, to tax participating doctors, pass legislation consistent with international treaties to which it is a signatory such as the International Covenant on Civil and Political Rights, or legislate that it is an offence to practice euthanasia or physician assisted suicide on a certain race such as indigenous Australians; at 662-664.

Without doubt, euthanasia under current criminal law is murder, all necessary elements being present.[6] There is the intent to kill, the act of killing, the death, and under existing law, no justification or excuse. The motive being compassion and that the deceased was a consenting competent adult, although potentially relevant in sentencing, are not relevant to legal responsibility. Nor is it relevant that the person is suffering greatly from a terminal disease and will die soon anyway.[7] The legal systems of virtually all nations including Australia do not recognize the right to choose the time and manner of one's dying with the act, aid or assistance of another based on a desired quality of life rather than simply biologically existing.

Physician-Assisted Suicide

Suicide is generally no longer a crime, but it is commonly acknowledged that assisting a suicide is unlawful. It was held by the House of Lords in *Pretty v DPP and Secretary of State for the Home Department,*[8] and reaffirmed on appeal by the European Court of Human Rights,[9] that even if a "mentally competent adult who knows her own mind, is free from any pressure and has made a fully-informed and voluntary decision" has requested assistance to die, any person so assisting will be criminally liable.[10]

Physician-assisted suicide, where a doctor provides the means for the patient to commit suicide, is therefore a criminal offence with mitigating factors such as compassion only becoming relevant when sentencing.

Is the Illegality of Physician-Assisted Suicide Logical?

Should the refusal of life sustaining medical treatment by a patient be considered a suicide? If a doctor follows his or her patient's instructions, ought an omission to treat put the doctor at risk of: "... aiding or abetting any other person in the commission of suicide or in an attempt to commit suicide."[11] Is there really a distinction between making a patient die and letting a patient die?

From the University of Tasmania, Professor Margaret Otlowski suggests that the courts have interpreted the refusal of treatment by patients as: "being aimed at avoiding unwanted treatment, pain or the violation of religious principles, rather than causing one's own death"[12] and so the specific intent of a self initiated action

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[6] Lord Bingham at para. 9 in *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 noted that voluntary euthanasia is murder.

[7] Skene L., *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis, Butterworths, Australia, 2nd. ed., 2004) at 296. Otlowski M., *Active Voluntary Euthanasia A Timely Reappraisal*, (The University of Tasmania Law School, 1992) at 5-6.

[8] [2001] UKHL, 61.

[9] *Case of Pretty v The United Kingdom* ECHR Fourth Section (Application no. 2346/02), Judgment 29 April 2002. The United Kingdom by virtue of the *Human Rights Act* 1998, being subject to the European Convention on Human Rights.

[10] *Pretty v DPP and Secretary of State for the Home Department*, [2001] UKHL, 61 per Lord Bingham at para. 29.

[11] S. 6B(2)(b) *Crimes Act 1958* (Vic).

[12] Otlowski M., *Voluntary Euthanasia and the Common Law*, (Clarendon Press Oxford,1997) at 66.

causing death is therefore absent.[13] Canadian Professor Margaret Somerville similarly suggests that the withdrawal of treatment at a patient's request is to respect his or her right to inviolability, including his or her right not to have treatment without consent.[14]

What is the situation if with continued treatment the patient will continue to live for an indeterminate time, but the withdrawal or withholding of treatment by the doctor at the patient's request will knowingly hasten death? Can this be regarded as assisting a suicide? The following two examples are from the United States and English jurisdictions.

In the Californian Court of Appeal case of *Bouvia v Superior Court*,[15] Elizabeth Bouvia was a quadriplegic, unable to care for herself but mentally competent. She was bedridden, not even able to sit in a wheelchair and in continual pain. On several occasions she had expressed a wish to die. The court confirmed a long line of United States cases[16] that "a competent adult patient has the legal right to refuse medical treatment ... the patient himself should be the ultimate decision maker ... there is no practical or logical reason to limit the exercise of this right to terminal patients."[17] The Court of Appeal noted that with continued medical care Bouvia could live another 15-20 years but without such care, she had "merely resigned herself to an earlier death (and) her decision to allow nature to take its course is not equivalent to an election to commit suicide."[18]

While acknowledging that it is a crime to aid a suicide,[19] the Court of Appeal concluded that "[n]o criminal or civil liability attaches to honouring a competent, informed patient's refusal of medical service" and "if the right to refuse treatment exists, it matters not what "motivates" its exercise."[20] As Otlowski notes, this "proposition appears to acknowledge, implicitly at least, that a refusal of treatment by a patient may amount to suicide but suggests that the right to refuse treatment is virtually absolute and will be upheld regardless of whether the exercise of that right is tantamount to suicide."[21] United States commentator Wesley J. Smith agrees that the

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[13] Ibid at 69.

[14] Somerville M., "Euthanasia by Confusion", 20(3) *UNSW Law Journal*, (1997), 550-575 at 560.

[15] (1986) 225 Cal. Rptr. 297.

[16] Ibid at 302, *Matter of Spring* (1980) 380 Mass. 629, 405 N.E.2d 115; *Lane v Candura*(1978) 6 Mass.App. 377, 376 N.E.2d 1232; *Matter of Quackenbush* (Morris County Ct. 1978) 156 N.J.Super. 282, 383 A.2d 785; *Matter of Conroy* (1985) 98 N.J. 321, 486 A.2d. 1209; *Satz v Perlmutter* (Fla.1980) 379 So.2d 359; *In re Osborne* (D.C.1972) 294 A.2d 372 and *Superintendent of Belchertown School v Saikewicz* (1977) 373 Mass. 728, 370 N.E.2d 417 "are but a few examples of the decisions that have upheld a patient's right to refuse medical treatment even at the risk to his health or his very life."

[17] Ibid at 301-302.

[18] Ibid at 306.

[19] Id.

[20] Id.

[21] Otlowski M., *Voluntary Euthanasia and the Common Law*, (Clarendon Press Oxford,1997), at 67.

exercise of the right is tantamount to suicide, but reverses the argument by concluding the right to refuse treatment should not have been allowed, it being effectively assisted suicide.[22]

In the English High Court case of *Re B (Adult: Refusal of Medical Treatment)*,[23] a tetraplegic patient[24] (Ms. B) was dependent on a ventilator to breathe. She made repeated requests for the ventilator to be withdrawn, which her doctors were reluctant to do, partially because they did not want to be seen to be assisting in her death. Butler-Sloss P. confirmed that a legally competent patient has the autonomous legal right to refuse or request discontinuation of life sustaining treatment, however unreasonable it may appear to others.[25] This approach includes the subordination of both the sanctity of life principle and the principle of beneficence to that of the patient's autonomy,[26] irrespective of the outcome of the patient's decision. Further, that the patient is not terminally ill and would not have died with the continuance of treatment should not be of relevance in determining the legality of his or her request.[27] Manning noted that Ms. B's purpose in wanting the ventilator removed was to bring about her own death, so it is difficult to resist the conclusion that it was her intention to commit suicide.[28] Six weeks after the decision was given, Ms. B utilised her right to have the ventilator turned off.[29] This case would appear to have moved the legality of assisted suicide in English law a step closer.

It is suggested that the lines of reasoning in the above cases are further examples of the convoluted reasoning by those who have shaped current law so that acts which equate to physician-assisted death are not seen to be condoned. In both Elizabeth Bouvia's and Ms. B's situations, the manner and timing of their deaths could be determined by them and the underlying illness was the means of achieving their end. Instead of the apparent legal gymnastics, the ROTI with its transparency would appear to be more straightforward.

In Canada, Chief Justice Lamer, dissenting in *Rodriguez,*[30] believed that to deny assistance to suicide where a person is physically unable to do so is discriminatory:

> The effect of this is to deny some people the choice of ending their lives solely because they are physically unable to do so.

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[22] Smith W., *Forced Exit* (Spence Publishing Coy., Dallas, 2003) at 226-227.

[23] [2002] All ER 449.

[24] Tetraplegia is paralysis of all four extremities and the torso.

[25] At paras.16 – 21.

[26] At paras 22 – 27.

[27] "... the right of the competent patient to request cessation of treatment must prevail over the natural desire of the medical and nursing profession to try to keep her alive." : at para. 27.

[28] Manning J., "Autonomy and the Competent Patient's Right to Refuse Life-Prolonging Medical Treatment – Again", 10 *Journal of Law and Medicine*, 239-247 at 243.

[29] Ibid at 247.

[30] *Rodriguez v Attorney General of Canada* [1993] 3 S.C.R. 519.

> This deprives Sue Rodriguez of her security of the person (the right to make decisions concerning her own body, which affect only her own body) in a way that offends the principles of fundamental justice ... It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body. [31]

Simply put, if a person is physically able, the law allows that person to commit suicide. If a person is physically disabled, so that he or she requires assistance to commit suicide, that person is not allowed to gain that assistance unless he or she is able to suicide by having medical treatment withheld or withdrawn. Switching off life support at the patient's request according to legal principle, may be assisting the patient to die but is not assisting him or her to suicide. Rather than such semantics, would it be reasonable to conclude that the doctor switching off life support has assisted in the patient's suicide, even if by omission rather than by an act and, that this is a valid recognition of the patient's right of self-determination.

In relation to assisted suicide, the European Court of Human Rights in *Pretty's* case gave this rationale:

> The law in issue in this case [assisting a suicide] ... was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life. ... The Court does not consider therefore the blanket nature of the ban on assisted suicide is disproportionate.[32]

However, the facts would indicate otherwise. Oregon, which has legalized physician-assisted suicide keeps detailed statistics of deaths under its *Death With Dignity Act*. These statistics show that there is no evidence of the fears held for the weak or vulnerable.[33]

Patient Rights

As the law now stands the determining criteria as to the legality of medical treatment when patients die earlier than they would otherwise are based on the criminal law eg causation, intent, and acts or omissions. Should the criterion be one of patient rights? If, as under the ROTI a competent and informed adult patient,

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[31] Ibid at 617-618.

[32] *Pretty v United Kingdom* ECHR Fourth Section, (Application no. 2346/02) at para. 74 and 76

[33] Oregon Department of Human Services, *Sixth Annual Report on Oregon's Death With Dignity Act*, March 10, 2004.

suffering intolerably from a terminal illness wishes to utilise his or her right of self-determination, including that of physician-assisted death, should he or she be allowed to do so? It appears reasonable that the patient would be in the best position to determine what his or her interests are. This argument focuses on the patient's rights rather than actions, omissions or intent of another. It also recognizes what is already undoubtedly widespread practice among the medical profession and would allow proper regulation of what is currently a criminal and covert activity (as will be detailed later in this submission).

Withholding and Withdrawal of Medical Treatment

As medical science improves, and this has been especially true in the last fifty to sixty years, infectious diseases have waned in import as causes of death, while degenerative diseases have become the dominant cause of death.[34] Decisions that can be made by or on behalf of the patient have necessarily become more complex, and being able to participate in a decision to withhold or withdraw medical treatment allows a patient to have some control over the timing and manner of his or her death.[35]

A Reasonable Distinction?

Is the distinction reasonable between the withholding or withdrawing of treatment where the patient as a direct consequence dies sooner than he or she would otherwise have if treatment had continued, which is sometimes called passive euthanasia, and active euthanasia wherein there is an overt act with the same result? There is no doubt that legally, there is the distinction, and it has been suggested that this is because the disparity is more acceptable to legislatures, the medical profession, and to the courts themselves.[36] Morally, in the House of Lords Lord Browne-Wilkinson in *Airedale NHS Trust v Bland* found this hard to accept:

> How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral

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[34] See generally Seale C., "Changing Patterns of Death and Dying", 51*Social Science & Medicine*, (2000), 917-930.

[35] New York State Task Force on Life and the Law, *When death is sought: euthanasia and physician assisted suicide in the medical context*, (1994) at 109.

[36] Meisel A., "Shifting the Focus from Means to Ends", chapter in Quill T.E., & Battin M.P., eds. *Physician-Assisted Dying, The Case for Palliative Care & Patient Choice,* (The John Hopkins University Press, 2004) at 284-285; *Airedale NHS Trust v Bland* [1993] AC 789.

> answer to that question. But it is undoubtedly the law and nothing I have said casts doubt on the proposition that the doing of a positive act with the intention of ending life is and remains murder.[37]

While there is the undoubtedly risk of error or abuse for physician-assisted death, is the distinction reasonable when the same problems would appear to exist for the legal withholding or withdrawal of treatment? There does not appear to be any reason why a patient and particularly the vulnerable, cannot be coerced or pressured into having treatment withheld or withdrawn which may save or at least extend his or her life. The doctor's actions are just as calculated in the withholding and withdrawal of medical treatment as in physician-assisted death. Plus, there are few safeguards for currently accepted practices, unlike the ROTI where stringent safeguards are mandatory.

In two Dutch studies,[38] euthanasia[39] was quoted as 1.8% and 2.4% of annual deaths and assisted suicide 0.3% and 0.4% respectively. However, further examination showed that of the legal withholding and withdrawal of treatment which accounted for 17.5% and 20.2 % respectively of all deaths annually, not prolonging the patient's life was an explicit goal in more than half of those cases.[40] These figures demonstrate that the emphasis on barring physician-assisted death at end-of-life may be misplaced, for it is the accepted withholding and withdrawal of treatment and its potential for manipulation which should be by far the greater source of concern.

Palliative Care

Palliative care involves a holistic approach to the care of patients. It includes not only the giving of medication for the relief of pain but also attendance to patients well being and that of their families. It is however, the giving of palliative medication for the relief of pain in potentially lethal quantities which becomes a factor in medical end-of-life legal decision making. If, bearing in mind the criminal law, the primary intent is not the death of the patient but to ease his or her suffering, and there is an unintended but foreseen secondary consequence, being the patient's death, it will be condoned.[41] But it can be argued that the principle may be

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[37] [1993] AC 789 at 885.

[38] Van Der Maas P.J., et. al., "Euthanasia and Other Medical Decisions Concerning the end of Life", 338 *The Lancet*, (1991), 669-674; Van Der Maas P.J., et al, "Euthanasia, Physician Assisted Suicide and other Medical Practices Involving the End of Life in the Netherlands, 1990-1995", 335(22) *New England Journal of Medicine*, 1699-1705.

[39] Defined as "the intentional termination of life by somebody other than the person concerned at his or her request." Van Der Maas P.J., et. al., "Euthanasia and Other Medical Decisions Concerning the end of Life", 338 *The Lancet*, (1991), 669-674 at 669.

[40] Van Der Maas P.J., et. al., "Euthanasia and Other Medical Decisions Concerning the end of Life", 338 *The Lancet*, (1991), 669-674 at 672; Van Der Maas P.J., et al, "Euthanasia, Physician Assisted Suicide and other Medical Practices Involving the End of Life in the Netherlands, 1990-1995", 335(22) *New England Journal of Medicine*, 1699-1705 at 1702.

[41] *R v Bodkin Adams* [1957] Crim. LR 365.

manipulated to covertly and intentionally ensure the patient's death in a legitimate setting where patients are suffering to the degree that their quality of life is such that for them death is preferable to life.

It is noteworthy that in Oregon, the only state in the United States to permit physician-assisted suicide, and with probably the best palliative care system, the Oregon Board of Medical Examiners was the first state medical licensing board to discipline a doctor for inadequate pain relief treatment to gravely ill or terminally ill patients.[42] Oregon and palliative care will be described in greater detail later.

Doctrine of Double Effect

Providing palliative care with the intent of alleviating or palliating the suffering of the patient which may as a secondary effect hasten the patient's death is commonly known as the doctrine of double effect.[43] That is, there are two effects of such care, the primary effect being the intended effect of alleviating suffering and the secondary effect, being the unintended although foreseen effect of causing death.[44] In the House of Lords, Lord Goff:

> [There is] the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows an incidental effect of the application will be to abbreviate that person's life.[45]

In Australia, the High Court has stated:

> not every fatal act done with the knowledge that death or grievous bodily harm will probably result is murder. The act may be lawful,

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[42] Rich B.A., "A Prescription for the Pain: The Emerging Standard of Care for Pain Management" 26 *Wm Mitchell Law Review,* (2000), 1-91 at 59

[43] Although opponents of end of life reform suggest that the term "doctrine of double effect could be construed as 'double think' and it would be better if it were given a bland term such as 'unintended bad side-effects": Keown J., *Euthanasia, Ethics and Public Policy, An Argument Against Legalisation,* (Cambridge University Press, 2002) at 20. It is suggested that this is just an exercise in semantics.

[44] Although the doctrine is accepted by most commentators without question, it is disputed by some who argue that "Today, guidelines for the appropriate administration of opioids based on scientific principles have been formulated and if properly adhered to, should increase the person's well being without hastening death": Dr. Danuta Mendelson, *Health Care, Crime and Regulatory Control,* Smith R. ed., (Hawkins Press 1998), 149–166 at 150. Dr Mendelson then suggests: "The focus should be ... on the appropriateness of treatment for the individual patient.": at 153. If this is done:, "Properly administered medical therapy will effectively control the patient's physical discomfort and minimize his or her dependence without hastening death.": at 151; See also Ashby M.,"The fallacies of death causation in palliative care", 166 *Medical Journal of Australia,* (1997) 176; Ashby M., "Hard Cases, Causation and Care of the Dying", 3 *Journal of Law and Medicine* (1995), 152; and Foley K., "Controversies in Cancer Pain: Medical Perspectives", *Cancer,* 63 (1989), 2257-2265; The Royal College of Physicians in the UK state that: "correctly used, morphine and other opioid analgesics are very safe, and so allow doctors to relieve pain and ensure a comfortable death without shortening life.": Royal College of Physicians, *Principles of Pain control in palliative care for adults* (London, RCP, 2000).

[45] *Airedale NHS Trust v Bland* [1993] AC 789 at 867.

> that is justified or excused by law. A surgeon who competently performs a hazardous but necessary operation is not criminally liable if the patient dies, even if the surgeon foresaw that his death was probable. Academic writers have pointed out that in deciding whether an act is justifiable its social purpose or social utility is important.[46]

On this reasoning, the social purpose or utility of palliative care, particularly in the area of pain relief, suggests that the doctrine of double effect would constitute a valid defence and be lawful, constituting a justified "social purpose or social utility." The use of palliative care, notwithstanding that it carries the risk of death, may be justified if it is the most appropriate means of alleviating intolerable suffering and the patient has been properly informed as to risks and consequences.[47]

Is the Doctrine of Double Effect Distorted?

Professor John Finnis of Oxford University believes that the rule of double effect and its reliance on intent is "problematic, difficult to validate externally, and inconsistent with other analysis of human intention."[48] An explicit intent to commit a criminal act or a reckless disregard for the well being of the patient going beyond the doctor's duty of care must be proved for a prosecution to succeed. If there is no direct evidence of criminal intent, it would be extremely hard for the prosecution to prove there has been a specific intent to kill as long as there is competent medical evidence to support the accused's course of action, even if death was the foreseeable result.

If a doctor argues that it was necessary to administer palliative care knowing that it would in addition also shorten the patient's life, then can it also be acknowledged that he or she may "knowingly, for sufficient reason put an end to his patient's life immediately"?[49] Conventional legal thinking would say that this is not the doctrine of double effect but physician-assisted death. However, it removes the subjectivity of the doctor's actions and the mental gymnastics to determine the primary intent.

Terminal Sedation

Terminal sedation is the practice of rendering terminally ill individuals unconscious until their death through the administration of drugs. It is the logical extension of the doctrine of double effect where usual palliative

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[46] *R v Crabbe* (1985) 58 ALR at 421.
[47] *Rogers v Whitaker* (1992) 175 CLR 479.
[48] Finnis J., *A Philosophical Case Against Euthanasia* at 28, in *Euthanasia Examined, Ethical, Clinical and Legal Perspectives.* Keown J. ed. (Cambridge University Press, 1995).
[49] Williams Glanville, *Sanctity of Life and the Criminal Law,* (Alfred A. Knopf: New York, 1957) at 324

care has failed to control the patient's suffering.[50] It requires patients to linger for an indeterminate time until their death, and may profoundly compromise their dignity particularly when combined with the usual practice of withholding nutrition and hydration.[51]

While terminal sedation may be a legal alternative to physician-assisted death, is it morally unacceptable?[52] Billings and Block write:

> when the patient was clearly comatose from medication administered with the purpose of producing central nervous system depression and when death was sure to come soon unless these medications were withdrawn or fluids were administered, what value is there in prolonging the dying process? Is there value in keeping the patient in limbo, profoundly sedated, and hence pain free, but not quite dead yet – while waiting for "nature to take its course", heavily assisted by medicine?[53]

Doctors working within the principles of the doctrine of double effect as with withholding or withdrawal are not subject to safeguards anywhere near as strict as those that would exist if the ROTI was again in use. Interestingly, the risks normally espoused by those against physician-assisted death can again be seen in the doctrine of double effect. The doctor is foreseeing the hastening of death by his or her act; trust between doctor and patient could be undermined with the knowledge that the giving of palliative drugs may cause death; the vulnerable whose lives may be seen as not of the same worth as the rest of society may be in danger of being terminally sedated; if the doctrine holds for the terminally ill who are suffering, perhaps it will be expanded to the non-terminally ill who are not suffering (the "slippery slope").

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[50] It has been asserted that terminal sedation is a practice that although still performed in appropriate situations, is now quite rare with increasing sophistication of palliative medication: O'Conner M., Kissane D., & Spruyt O., "Sedation in the Terminally Ill – a Clinical Perspective", 18 (3) *Monash Bioethics Review*, (1999), 17-27.

[51] "Abatement of artificial nutrition or hydration is one of the commonest decisions at the end of life in health care facilities.": Mashford M.L. et.al., *Therapeutic Guidelines: Palliative Care* (Therapeutic Guidelines Limited, 2001) at 19.

[52] A distinction which the author disputes. Terminal sedation is 'slow' euthanasia.

[53] Billings A. & Block S., "Slow Euthanasia", 12(4) *Journal of Palliative Care*, (1996), 21-30 at 27.

The Medical Profession

Undoubtedly the medical profession will be intimately involved with the ROTI should the *Euthanasia Laws Act* be repealed, just as it is now in end-of-life decision making. The practical effect of legalising physician-assisted death will be that the medical profession subject to the ROTI guidelines, will face new decisions relating to end-of-life. This will be confronting to traditional medical ethics, summed up in the Hippocratic Oath, "I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion to this effect..."[54].

This ancient oath still has as advocates probably the majority of the medical profession, with Kass arguing that "killing patients – even those who ask for death – violates the inner art of healing",[55] although as will be shown later in this submission there is a sizable minority of the profession in Australia who disagree.

Ethics For and Against

Conventional medical ethics as guided by the Hippocratic Oath would suggest the danger in legalising physician-assisted death is that it twists the traditional role of the medical profession as healers and carers to a profession of purging those it could not heal or care for by intentional killing. Acceding to a patient's request to die is a harm under any circumstance which violates one of the most significant principles of medical ethics.[56]

This prohibition has its foundation in the principle of the sanctity of life. The medical profession is a prime mover in upholding the principle of the sanctity of life, partially because it has the knowledge, means and opportunity to kill not readily available to those outside the profession. As such, the medical profession traditionally draws the line between refraining from preventing death and causing death.[57]

Intentional killing could also be considered a twist on the slippery slope fear. If medical ethics is diluted by allowing intentional killing of competent informed patients, will such ethics be further diluted to allow the killing of patients without capacity to consent? Will the unscrupulous take advantage of the greater freedom to practice and stretch the rationale of the ethics of killing?

Australian commentator Professor Margaret Somerville of McGill University of Montreal Canada, suggests that physician-assisted dying would raise concern not only for the institution of medicine, but for the harm to

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[54] As cited by Kerridge I. et al, *Ethics and Law for the Health Professions* (Social Science Press, Australia, 1998) at 4.
[55] Kass L., *Life, Liberty, and the Defence of Dignity: The Challenge for Bioethics*, (Encounter Books, 2002) at 250.
[56] Mangini L., "To Help or Not to Help: Assisted Suicide and its Moral, Ethical and Legal Ramifications", 18 *Seton Hall Legislative Journal* 1994, 728-778 at 749.
[57] Kerridge I., et al. *Ethics and Law for the Health Professions*, (Social Science Press, Australia, 1998) at 194.

society that damage to the profession would cause.[58] The potential to influence patients end-of-life decisions could lead to an erosion of trust and respect for the welfare of the patient that has always been inherent in a patient-doctor relationship.[59] This is particularly so if the doctor under certain circumstances may intentionally kill the patient and "the profession ... will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty."[60]

A reasonable answer to this proposition would be that this argument does not seem to take into account that any properly constructed reform such as the ROTI revolves around the wishes of the patient with safeguards to strictly limit the power of the doctor. Further, from an ethical perspective, it is significant that no doctor must be involved with the ROTI against his or her will. Participation is entirely discretionary. If a doctor has a patient who wishes to make use of the ROTI, there is no obligation on the doctor to be involved.

Also, it is suggested that the doctor's involvement in assisted suicide as it is in Oregon can be viewed as an indirect act as it is the patient who takes the final step. The doctrine of double effect, which is ethically accepted, and exemplified by terminal sedation, has the doctor actively involved up to the time of the patient's death, particularly if there is withdrawal of nutrition and hydration and the patient dies not from the underlying disease but from dehydration.

Studies undertaken of end-of-life practices in the Netherlands (euthanasia and physician-assisted suicide) and Oregon (physician-assisted suicide) do not indicate any lessening of society's respect for the medical profession in those two jurisdictions. And it is in these jurisdictions where physician-assisted death is a reality that society would be most likely to distrust or even fear the medical profession.

A Twisted Ethic?

Dr. Rodney Syme of Dying With Dignity Victoria has termed terminal sedation as "pharmacological oblivion".[61] Associate Professor Roger Magnusson of the University of Sydney writes of "an uneasy hypocrisy at work."[62] While he suggests pharmacological oblivion may be preferable to euthanasia, "a drug-induced stupor in a patient who has requested release ... (may be regarded) ... as a cruel denial of patient autonomy at a time when the patient is most vulnerable to abuse."[63]

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[58] Somerville M., *Death Talk, The Case Against Euthanasia and Physician-Assisted Suicide,* (McGill-Queen's University Press, 2001) at 116.

[59] Ibid at 408-409. This danger of unsatisfactory doctor involvement

[60] Gaylin W. et al. "Doctors must not kill", chapter in *Euthanasia: The Moral Issues*, Baird R. and Rosenbaum S. eds. (Prometheus Books, 1989) at 27.

[61] It has also been described as "slow euthanasia".

[62] Magnusson R., *Angels of Death Exploring the Euthanasia Underground,* (Melbourne University Press, 2002) at 87.

[63] Id.

Magnusson concludes from interviews conducted that "physician induced coma" rather than being an alternative to euthanasia, was "one method of choice for precipitating the patient's death."[64] It is not necessarily for the patient's benefit (although any suffering will obviously be alleviated) that he or she is sedated to unconsciousness. It may be performed so that death is pursuant to ethical and legal principle without blame being attributed to the medical profession. It can be explained as simply the end treatment of aggressive palliative care.

Terminal sedation, particularly when combined with the withdrawal of nutrition and hydration, both of which are induced and controlled by the treating doctor, is arguably a form of slow euthanasia.[65] Once the patient is sedated and food and water withdrawn, it is inevitable that the patient's death will follow. The death is not necessarily from the underlying illness but from the doctor's actions. The medical profession is able to legitimately utilise such a practice both legally and ethically, but it arguably carries a greater risk of abuse than physician-assisted death, as there are no safeguards that are incorporated into any reform such as the ROTI.

A study of terminal sedation in the Netherlands,[66] with 2001 as the base year, indicated that it was frequently used in end-of-life care, the use preceding 10% of all Dutch deaths.[67] The authors speculated that a reason for the high incidence of terminal sedation was as a result of doctors not being able to fulfil the requirements of the legal and ethical practices regarding euthanasia, but to which terminal sedation, with a similar end result, was not subject.[68]

The Australian Medical Profession Surveyed

It has been argued by opponents of reform such as the English commentator John Keown that physician-assisted dying is not common and that: "there appears to be little hard evidence that they are at all frequent."[69] In Australia, the various studies of the medical profession conducted over a period of some 20 years seem to rebut this argument. Not being identical in nature, the studies cannot be compared in great detail but do show the medical profession's involvement despite the illegality

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[64] Magnusson R., *Angels of Death Exploring the Euthanasia Underground,* (Melbourne University Press, 2002) at 88.

[65] See generally, Billings A. and Block S., "Slow Euthanasia", 12(4) *Journal of Palliative Care.* (1996) 21-30.

[66] Rietjens J., et al, "Physician Reports of Terminal Sedation without Hydration or Nutrition for Patients Nearing Death in the Netherlands", 141 *Annals of Internal Medicine,* August 3, 2004, 178-185.

[67] Ibid at 180.

[68] Ibid at 183-184.

[69] Keown J. *Euthanasia, Ethics and Public Policy, An Argument Against Legalisation*, (Cambridge University Press, 2002) at 61.

Several studies will be mentioned but one study in particular will be examined, it being a nationwide study with a disturbing comparison between its results and those of similar studies from the Netherlands.

This study was titled *End-of-Life Decisions in Australian Medical Practice*[70]and conducted between May and July 1996 when the ROTI was operative. At this time, apart from the Northern Territory, the only jurisdiction where euthanasia was tolerated if not legal, was the Netherlands, which in 1990,[71] and again in 1995,[72] conducted surveys in relation to euthanasia and other end-of-life medical practices. Doctors' practices in this study were separated into four categories: euthanasia (including physician-assisted suicide); ending of life without the patient's explicit request (non-voluntary euthanasia); alleviation of pain and symptoms with opioids in large enough doses so that there was a probable life shortening effect (double effect); and decision not to treat (withholding or withdrawal of treatment). The authors of this study used a similar questionnaire to the Dutch studies with some essential differences,[73] to ascertain the number of deaths in Australia which involve medical end-of-life decisions and to compare these figures with the Dutch figures.

The questionnaire was arranged so as to reveal: what medical action if any, preceded death, the doctor's intention, whether there had been an explicit request from the patient or only a wish, whether there was discussion with the patient or others, whether the patient was competent either making the request or when participating in discussions, and the estimated length of life shortened.[74]

The survey commenced with 3,000 randomly selected doctors Australia wide,[75] particularly from disciplines where there would be the possibility of making an end-of-life decision. The response rate was 1918 (64%) which was lessened to the 1361 doctors who had attended a death in the previous year. Of these, 1112 had the opportunity to make a medical end-of-life decision with the intention to shorten life or foreseen as probably or certainly shortening life, and 800 actually did.

The following paragraph is in bold to highlight the importance of the figures obtained.

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[70] Kuhse H. et. al., "End-of-life decisions in Australian medical practice", 166 *Medical Journal of Australia,* Feb. 1997, 191-196.

[71] van der Mass P.J., van Deldren J.J.M., Piijnenborg L., "Euthanasia and other medical decisions concerning the end of life", 338 *Lancet,* (1991), 669-674.

[72] van der Maas P.J., et. al., "Euthanasia, physician assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995", 335 *New England Journal of Medicine,* (1996), 1699-1705.

[73] Mainly because the Australian study needed anonymous responses, as some questions regarding end of life issues were based on illegal practices. While the questionnaire was similar, there were no face to face interviews as in the Dutch studies.

[74] Kuhse H. et. al., "End-of-life decisions in Australian medical practice", 166 *Medical Journal of Australia,* Feb. 1997, 191-196, at 192.

[75] From a list of 27000 that had been extracted from the Australian Medical Masterfile Database (Australasian Medical Publishing Company, Sydney).

Of the 800, 3.2% reported acts of euthanasia; 6.4% reported ending the patient's life without an explicit request; 36.1% made a decision not to treat, which could be broken down to 19% having no intention to hasten death and 81% having such an intention; 54.2% alleviated the patient's pain with large doses of medication, of which 77.2% had no intention to hasten death, while 22.8% had such an intention. When this data is extrapolated, a medical decision either intended to hasten death or not prolong life occurred in 36.5% of all deaths in Australia, with 17.8% or almost half being classified as non-voluntary euthanasia.[76] The authors estimated 1.8% of all Australian deaths were the result of euthanasia (1.7%) or physician-assisted suicide (0.1%).[77] The treating doctor in 0.7% of all deaths could not discuss with the patient "the possible hastening of death by prescribing, supplying or administering drugs" because the patient was incompetent to do so.[78] In 6.5% of all deaths, palliative care with the intent of both relieving pain and hastening death was given. Of those 6.5%, 0.9% palliative care had been given because of an explicit request; and in 3.2% there had been some discussion with the patient or the doctor had formed the opinion that the patient wanted death to be hastened. In the remaining 2.4%, the treating doctor had hastened death in this manner without any acquiescence whatsoever from the patient.

It may be reiterated that the authors noted that of Australian deaths in the subject period, 36.5% involved a medical decision either partly or explicitly intended to hasten death or not prolong life. This is compared to 19.5% of deaths in the Netherlands,[79] remarkable figures considering that such acts are specifically criminal acts in Australia, whereas at the time, they were tolerated if not legal in the Netherlands. The authors made the observation that if euthanasia could be classified as all cases in which death is "intentionally accelerated by a doctor", 30% of all Australian deaths would be in this manner compared to 16.6% for the 1995 Netherlands survey.[80]

The authors concluded that the practice of euthanasia in Australia has not been stopped by the prohibition of the intentional termination of life, whether by act or omission.[81] A table was compiled comparing medical end-of-life decisions between the Netherlands and Australia. This is copied below:

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[76] Kuhse H. et. al., "End-of-life decisions in Australian medical practice", 166 *Medical Journal of Australia*, Feb. 1997, 191-196, at 193.
[77] Id.
[78] Id.
[79] Ibid at 195.
[80] Id.
[81] Ibid at 196.

	Australia	**Netherlands**	
End-of-life decision	1995-1996	1990	1995
Euthanasia	1.8%	1.7%	2.4%
Physician-assisted suicide	0.1%	0.2%	0.2%
Ending of life without patient's explicit request	3.5%	0.8%	0.7%
Administration of opioids in large doses with or without an intent to hasten death	30.9%	18.8%	9.1%
Non-treatment with or without an intent to hasten death	28.6%	17.9%	20.2%
Total	64.8%	39.4%	42.6%

As the Netherlands figures of 0.8% for non-voluntary euthanasia (ending of life without patient's explicit request) in 1990 and then 0.7% in 1995 were at the time a major argument against euthanasia in the Netherlands, the figures being an indication that euthanasia could not be controlled, surely the argument could now work in the reverse. The findings indicate that in Australia where euthanasia is definitely a criminal act, the practice is under less control and far less evident than open and direct killing.

The withholding or withdrawing of treatment (non-treatment in the table), or the administration of palliative care by way of large doses of opioids with the known effect of shortening a patient's life (double effect) may be applied to a far wider range of applications than physician-assisted death and because they are so less controversial and more accepted, have an air of invisibility. Not to institute dialysis, or switching off a respirator may be less obvious than euthanasia but such conduct can still bring about the patient's death just as easily.

In another Australian study, Baume and O'Malley concluded that the illegality of euthanasia has not prevented substantial numbers of medical practitioners from practising physician-assisted death.[82] This led the authors to believe that the practice of physician-assisted death was widespread amongst the profession, notwithstanding its illegality and not being approved by many colleagues or by any official body.[83]

In a further study by Stevens and Hassan,[84] the authors acknowledged that with the advancement of medical knowledge and technology, the medical profession has greater control over life and death processes, and with this advancement comes medical conditions which may be chronic, painful or debilitating and treatments which may be invasive, involve an element of risk, and cause pain.[85] The authors from this study concluded that there is legal ambiguity in relation to the hastening of the death of a patient and that the patient is often dependent on the moral and ethical codes of his or her treating doctor when decisions are made.[86] Some medical practitioners were prepared to flout the law and take active steps to hasten their patients' death. The authors noted that should there be reform of the law, there needs to be adequate safeguards to protect against "abuses due to lack of adequate protection of life."[87] Would the ROTI be the required safeguard?

A study with some similar results to the Australia, Netherlands comparison detailed above was conducted by Douglas et al but aimed specifically at surgeons.[88] The authors noted the ambiguity of giving potentially lethal drugs to a patient "to treat symptoms, *foreseeing* but not necessarily *intending* a medically hastened death."[89] The authors concluded that over a third of surgeons surveyed specifically gave drugs intending to hasten death, with more than half giving the medication without an explicit request. Because the giving of medication apart from direct physician-assisted death could be construed as palliative care, the true purpose of the doctor's act can be on the basis of their self-reported intention. From a legal perspective, "[l]egal and moral distinctions based solely on a doctor's intentions are problematic."[90] This study strongly indicates that the respondents configure their means of practice around the constraints of the law to fit the practicalities they have to face. As one doctor in the study was quoted:

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[82] Id.
[83] Id.
[84] Stevens C. & Hassan R., "Management of death dying and euthanasia: attitudes and practices of medical practitioners in South Australia." 20 *Journal of Medical Ethics,* March 1994, 41-46.
[85] Ibid at 41
[86] Stevens C. & Hassan R., "Management of death, dying and euthanasia: attitudes and practices of medical practitioners in South Australia." 20 *Journal of Medical Ethics,* March 1994, 41-46 at 45.
[87] Id.
[88] Douglas C., et al, "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia", 175 *Medical Journal of Australia*, Nov. 2001, 511-515.
[89] Ibid at 511.
[90] Douglas C., et al, "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia", 175 *Medical Journal of Australia*, Nov. 2001, 511-515, at 511.

> Talk of bolus (large or lethal) injections in fully competent patients is not the real life situation. We help very ill patients to die by a combination of sustenance withdrawal, increasing analgesia and 'masterly inactivity.'[91]

The Netherlands

Most argument on the ROTI is theoretical, but there are two overseas jurisdictions which are very relevant as to how physician-assisted death may work in practice, the Netherlands and the United States state of Oregon.

The Netherlands is the most widely known jurisdiction to allow physician-assisted death, it being accepted, if not strictly legal for nearly thirty years until legislation making it a legitimate practice was passed in 2002. The Dutch system had developed incrementally by court rulings until the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* ("the Netherlands Act") took effect on 1 April 2002. Euthanasia and physician-assisted suicide remain culpable under the Netherlands Act unless certain guidelines are met. These guidelines are applicable to doctors only and the main tenets include: the patient must be informed of his or her condition and prospects; the patient's request must be voluntary and persistent; the patient's condition must be unbearable and lasting but not necessarily terminal; the patient and doctor must agree that there is no medical alternative; and the patient's condition must be medically based whether physically or mentally, that is, a patient cannot request euthanasia simply because he or she is tired of life.

Slippery Slope

With the incremental approach, there has been a vagueness in the evolution of Dutch law which has caused concern and been likened to the proverbial "slippery slope" (something good in itself inevitably widening to include unwanted consequences) by opponents of reform such as Wesley J. Smith and John Keown.[92]

In leading Canadian and United States court judgements, there was expressed the very real fear of legalising physician-assisted death as it would lead to unwanted variants such as non-voluntary and involuntary euthanasia.[93]But as is often the case, even in the higher courts of Canada and the United States, there was the rhetoric but few facts to back the argument.

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[91] Ibid at 514.

[92] Smith W., *Forced Exit* (Spence Publishing Coy. Dallas, 2003) at 107-139; Keown J., *Euthanasia, Ethics, and Public Policy, An Argument Against Legalisation,* (Cambridge University Press, 2002) at 115-124.

[93] *Rodriguez v British Columbia (Attorney-General)* [1993] 3 S.C.R. 519, 603 (S.C.C.); *Washington v Glucksberg* 521 U.S. 702 (1997).

Nevertheless, while there may be evidence of abuse in the Netherlands as is shown by the 1990 and 1995 studies which are in the table detailed earlier, is it the regulation of physician-assisted death that has caused the abuse, or that abuse occurs more frequently because of regulation? Indeed, the regular national studies of which there have been two more since 1995 indicate that there is no slippery slope in the sense that there is no evidence that abuse of the system is growing, that abuse is the result of the system, or that the abuse was actually greater before the system was put in place.

The author in a July 2007 interview with Sjef Gevers, Professor of Health Law at the University of Amsterdam, debated the effectiveness of the Dutch guidelines. Professor Gevers used the word "flexibility" stating that the guidelines pursuant to the Netherlands Act were necessarily general so that there was room for interpretation of individual cases and that this may have caused the notion that the effectiveness of their guidelines was less than optimal.

If the patient is incompetent to give an informed request, under the Dutch system it is arguably left to medical judgement and the notion of beneficence.[94] This was the reason given by many of Professor Raphael Cohen-Almagor's interviewees in his study of Dutch practice for the undeniable practice of sometimes hastening death without the patient's explicit request. This would fit with the Dutch concept of euthanasia as a last option of medical treatment. Cohen-Almagor's interviewees also noted that such practices occur not only in the Netherlands but around the world.[95] Perhaps it is only because the Dutch regularly conduct national studies such as those in 1990 and 1995 referred to plus others published in 2001 and 2007 that these practices are brought to light while elsewhere they remain veiled.

Further, also speaking In July 2007 to Professor Agnes van der Heide and Dr. Judith Rietjens, senior researchers at Erasmus University in Rotterdam, they seemed to encapsulate the generally held belief that as a result of studies conducted, the most recent being published in May 2007, that there are not any significant problems with the system in the Netherlands.[96] A point echoed by Professor Martin Buijsen's (also of Erasmus University in Rotterdam) comment that Dutch law is quite clear.[97]

The Dutch themselves disagree with the proposition that their system has led them down the slippery slope. Dr. Mette Rurup notes that the Dutch Supreme Court considers the diagnosis of a particular severe disease

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[94] Cohen-Almagor R., *Euthanasia in the Netherlands*, (Kluwer Academic Publishers, Dordrecht Netherlands 2004) at 28-29.

[95] Ibid at 75.

[96] van der Heide A., et al., "End-of-Life Practices in the Netherlands under the Euthanasia Act" 356(19) *New England Journal of Medicine* May 10 2007, 1957-1965

[97] Professor of Health Law Erasmus University Rotterdam in a conversation with the author July 2007.

whether or not somatic and a physician's knowledge of the accompanying clinical picture as very important in assessing the extent of the patient's suffering which is a necessary prerequisite before taking advantage of their system.[98] In another study, Dr. Rurup concluded that most doctors in the Netherlands refused requests for physician-assisted death in the absence of severe disease.[99]

So, it should be emphasised that Professor Gevers as other Dutch researchers and academics I interviewed were comfortable with their system with the view that physician-assisted death was the final option of good health care when other available medical treatments have been tried and found wanting. Several made the further observation that what was suitable for Dutch society may not be for others.

It may be mentioned once more that studies have found that rates of ending life without the patient's explicit request is higher in Australia than in the Netherlands.[100]

Oregon

Oregon, a state of approximately 3.3 million people, has reformed end-of-life decision making within its jurisdiction by allowing physician-assisted suicide with the passing of the Oregon *Death With Dignity Act* (the Oregon Act). It is the only state in the United States which has done so.[101] Its fully legislative guidelines with detailed due care criteria and reporting may be compared with the more ad hoc Dutch system. There is a legal framework which can be worked within, rather than a gradual liberalism as in the Netherlands which has led to the continued accusations of abuse, whether it be hypothetical or real. The Oregon Act as a wholly encompassing legislative system is thus more closely aligned with the ROTI.

The Oregon Act allows the attending doctor to prescribe lethal medication for an adult patient[102] who is a resident of Oregon, mentally competent, and diagnosed with a terminal illness, but does not allow for active euthanasia.[103] The prognosis of death within six months must be confirmed by a second doctor,[104] and the

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[98] Rurup M., et al, "When being tired of living plays an important role in a request for euthanasia or physician-assisted suicide: patient characteristics and the physician's decision.", 74 *Health Policy* (2005), 156-166 at 158.

[99] Rurup M., et al, "Requests for euthanasia or physician-assisted suicide from older persons who do not have a severe disease: an interview study." 35 *Psychological Medicine*, 2005, 665-671.

[100] Kuhse H. et al., "End-Of-Life Decisions In Australian Medical Practice", 166 *Medical Journal of Australia*, (1997) 191-196.

[101] There have been attempts in quite a few other states to introduce bills to allow euthanasia and/or physician-assisted suicide but without success. These include Alaska; Arizona; California; Colorado; Conneticut; Hawaii; Illinois; Maine; Massachusetts; Michigan; Mississippi; Nebraska; Vermont; Washington; and Wisconsin.

[102] Over the age of 18.

[103] S. 3 (14).

[104] Who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease; who has examined the patient and their medical record; and has confirmed in writing of the terminal disease, the patient is capable, acting voluntarily and has made an informed decision: s. 3.02.

patient must have been given sufficient applicable information to make an informed decision.[105] The patient must make three requests, two verbal and one in writing[106] (in a form substantially as that provided in the Act)[107] over a period of not less than 15 days. The attending doctor must report in writing to the Oregon Department of Human Services that he or she has prescribed the lethal medication and complied with the Act's guidelines. As an additional safeguard, the pharmacist supplying the medication is required to provide a report separate from the attending physician,[108] thus providing a cross check and further ensuring proper reporting.

As the Oregon Act allows for physician-assisted suicide,[109] not assisted suicide, the assistance of a person other than the attending and consulting doctors[110] would give rise to a criminal offence. There is no requirement however, for the attending doctor to be present when the patient takes the prescribed medication, a potential flaw in the legislation where a debilitated and untrained patient, possibly alone, is left to fend for him or herself.[111] There can be no civil or criminal liability or professional disciplinary action for participating in and complying with the Act, and conversely there is no obligation to participate.[112] The doctor can only prescribe or dispense the lethal medication.[113] It is up to the patient him or herself to self-administer it.

Annual Reports described further below are published by the Department of Human Services give a detailed insight into the workings of the Oregon Act and those who make use of it. These reports are able to answer many questions including if the Oregon Act is working, and the fears held by those who are against physician-assisted death.

Slippery Slope

The New York State Task Force on Life and the Law (at 120)[114] stated that legalising physician-assisted suicide would pose profound risks to many individuals such as the poor, the elderly and the sick, that is, the

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[105] Including being informed of their diagnosis and prognosis; potential risks of taking the medication to be prescribed; the probable result of taking the medication; feasible alternatives including but not limited to comfort care, hospice care and pain control; recommend that the patient notify their next of kin; counsel the patient about having others present when taking the medication; advise the patient that they may rescind their request at any time: s. 3.01.

[106] The form is to be signed before two witnesses, one of whom is not a relative of the patient; entitled to part of the patient's estate; associated with a health care facility in which the patient resides or is undergoing treatment; or the patient's attending doctor.

[107] S. 6.01.

[108] S. 3.11 (1)(b).

[109] Prescribing lethal medication in accordance with the Act does not constitute physician-assisted suicide (s. 3.14), but as "physician-assisted suicide" is the term commonly used in literature when the Act is referred to and is the term used in the Act's annual reports, this thesis will also use that term.

[110] S. 2.01.

[111] Described by Magnusson R. as "medical abandonment": *Angels of Death Exploring the Euthanasia Underground,* (Melbourne University Press, 2002) at 269.

[112] S. 4.01.

[113] S. 2.01; s. 3.01(L).

[114] http://www.health.state.ny.us/nysdoh/consumer/patient/preface.htm viewed 30 January 2001.

vulnerable. It concluded that if physician-assisted suicide was permissible, such persons may utilise it so that their families would not be burdened with expensive end-of-life health care costs. Similarly, the majority of the Canadian Supreme Court in *Rodriguez v British Columbia (Attorney General)* (1993) 3 SCR 519 found that the state has an overriding duty to protect the vulnerable in society.

In Australia, Manne[115] has argued:

> [O]nce we agree to the principle of doctors performing voluntary euthanasia by what effort of societal will, on what rock of ethical principle, can we resist its extension to ever new categories of sufferers? There is no such will: no such fixed and reliable principle.

Is there reason to fear the slippery slope?

Annual Reports

Under the Oregon Act, Health Services (now the Oregon Department of Human Services): "...shall generate and make available to the public an annual statistical report of information...".[116] The figures provided by the Annual Reports are not assumptions, nor are they conjecture or rhetoric as arguments fearing the slippery slope can be.[117] The Annual Reports provide evidence that the safeguards and regulations provided by the Oregon Act appear to be working and that only those for whom the Oregon Act was intended are making use of it.[118] That a previously illegal activity such as physician-assisted suicide could be legislated for without it spiralling out of control and down the slippery slope seems to have been demonstrated in the eleven years of the Oregon Act's operation.

The tables and figures below are components of the 2007 Annual Report taken from the Oregon Department of Human Services.

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[115] Manne R, "The Slippery Slope is a Life and Death Argument", *The Age*, 14 June 1995, p 18.

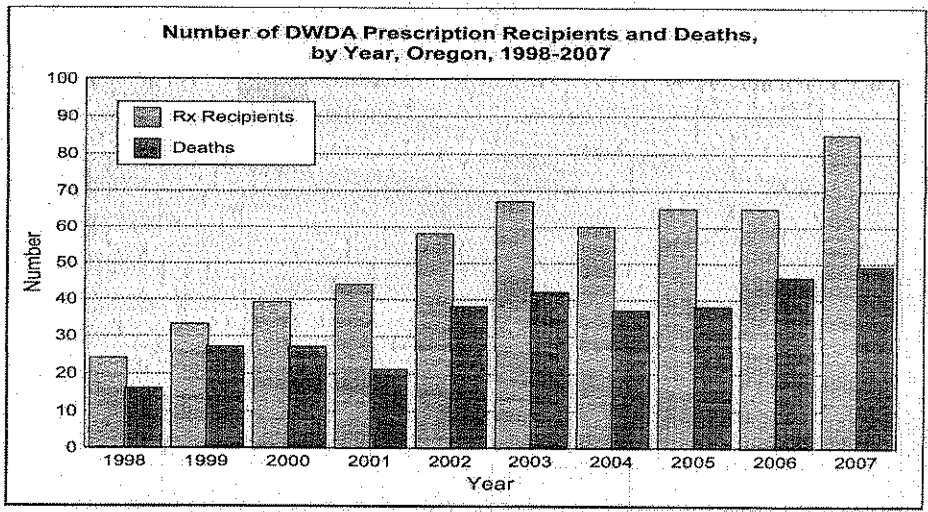
[116] S. 3.11(3).

[117] See also a discussion on the slippery slope in section "The Vulnerable and the Slippery Slope" in chapter "Quality of Life".

[118] A view supported by commentators: Boyle B., "The Oregon Death With Dignity Act: A Successful Model or a Legal Anomaly Vulnerable to Attack?", *Houston Law Review*, Spring 2004, 1387-1421 at 1392.

Summary of Oregon's Death with Dignity Act - 2007

Oregon's Death with Dignity Act (DWDA) allows terminally ill adult residents to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Department of Human Services is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2007 are listed below. For more detail, please view the tables on our web site: *http://oregon.gov/DHS/ph/pas/index.shtml*.


Number of DWDA Prescription Recipients and Deaths, by Year, Oregon, 1998-2007

- During 2007, 85 prescriptions for lethal medications were written under the provisions of the DWDA compared to 65 during 2006 (Figure). Of these, 46 patients took the medications, 26 died of their underlying disease, and 13 were alive at the end of 2007. In addition, three patients with earlier prescriptions died from taking the medications, resulting in a total of 49 DWDA deaths during 2007. This corresponds to an estimated 15.6 DWDA deaths per 10,000 total deaths.

- Forty-five physicians wrote the 85 prescriptions (range 1-10).
- Since the DWDA was passed in 1997, 341 patients have died under the terms of the law.
- As in prior years, most participants were between 55 and 84 years of age (80%) white (98%), well educated (69% had some college), and had terminal cancer (86%). Patients who died in 2007 were younger (median age 65 years) than in previous years (median age 70 years).
- During 2007, more patients resided in the Portland Metropolitan area (Clackamas, Multnomah, and Washington counties) (55%) compared to prior years (39%).
- All patients had some form of health insurance: 65% had private insurance, and 35% had Medicare or Medicaid.
- As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (100%), decreasing ability to participate in activities that made life enjoyable (86%), and loss of dignity (86%). During 2007, more participants were concerned about inadequate pain control (33%) than in previous years (26%).
- Most patients died at home (90%) and were enrolled in hospice care (88%).
- Complications were reported in three patients during 2007; they all regurgitated some of the medication. One person lived 3½ days.
- During 2007, no physician referrals were made to the Oregon Medical Board.

Table 1. Characteristics and end-of-life care of 341 DWDA patients who died after ingesting a lethal dose of medication, Oregon, 1998-2007

Characteristics	**2007 (N = 49)**	**1998-2006 (N= 292)**	**Total (N = 341)**
Sex	**N (%)***	**N (%)***	**N (%)***
Male (%)	26 (53.1)	157 (53.8)	183 (53.7)
Female (%)	23 (46.9)	135 (46.2)	158 (46.3)
Age			
18-34 (%)	1 (2.0)	3 (1.0)	4 (1.2)
35-44 (%)	2 (4.1)	8 (2.7)	10 (2.9)
45-54 (%)	3 (6.1)	28 (9.6)	31 (9.1)
55-64 (%)	18 (36.7)	55 (18.8)	73 (21.4)
65-74 (%)	10 (20.4)	83 (28.4)	93 (27.3)
75-84 (%)	11 (22.4)	87 (29.8)	98 (28.7)
85+ (%)	4 (8.2)	28 (9.6)	32 (9.4)
Median years (range)	65 (29-93)	70 (25-96)	69 (25-96)
Race			
White (%)	48 (98.0)	284 (97.3)	332 (97.4)
Asian (%)	0 (0.0)	6 (2.1)	6 (1.8)
American Indian (%)	0 (0.0)	1 (0.3)	1 (0.3)
Hispanic (%)	1 (2.0)	1 (0.3)	2 (0.6)
African American	0 (0.0)	0 (0.0)	0 (0.0)
Other	0 (0.0)	0 (0.0)	0 (0.0)
Marital status			
Married (%)	21 (42.9)	133 (45.5)	154 (45.2)
Widowed (%)	10 (20.4)	63 (21.6)	73 (21.4)
Divorced (%)	12 (24.5)	74 (25.3)	86 (25.2)
Never married (%)	6 (12.2)	22 (7.5)	28 (8.2)
Education			
Less than high school (%)	2 (4.1)	25 (8.6)	27 (7.9)
High school graduate (%)	13 (26.5)	82 (28.1)	95 (27.9)
Some college (%)	15 (30.6)	64 (21.9)	79 (23.2)
Baccalaureate (%)	11 (22.4)	60 (20.5)	71 (20.8)
Postbaccalaureate (%)	8 (16.3)	61 (20.9)	69 (20.2)
Residence			
Metro counties (%)[Δ]	27 (55.1)	113 (38.7)	140 (41.1)
Coastal counties (%)[+]	4 (8.2)	21 (7.2)	25 (7.3)
Other western counties (%)	15 (30.6)	136 (46.6)	151 (44.3)
East of the Cascades (%)	3 (6.1)	22 (7.5)	25 (7.3)
Underlying illness			
Neoplasms, all forms (%)	42 (85.7)	238 (81.5)	280 (82.1)
Lung and bronchus (%)	11 (22.4)	54 (18.5)	65 (19.1)
Pancreas (%)	3 (6.1)	27 (9.2)	30 (8.8)
Breast (%)	5 (10.2)	25 (8.6)	30 (8.8)
Colon (%)	4 (8.2)	19 (6.5)	23 (6.7)
Prostate	5 (10.2)	15 (5.1)	20 (5.9)
Other (%)	14 (28.6)	98 (33.6)	112 (32.8)
Amyotrophic lateral sclerosis (%)	3 (6.1)	23 (7.9)	26 (7.6)
Chronic lower respiratory disease (%)	3 (6.1)	12 (4.1)	15 (4.4)
HIV/AIDS (%)	1 (2.0)	6 (2.1)	7 (2.1)
Heart disease (%)	0 (0.0)	5 (1.7)	5 (1.5)
Other illnesses listed below (%)[ψ]	0 (0.0)	8 (2.7)	8 (2.3)

End-of-Life Care			
Hospice			
Enrolled (%)	43 (87.8)	248 (85.5)	291 (85.8)
Not enrolled (%)	6 (12.2)	42 (14.5)	48 (14.2)
Unknown	-	*2*	*2*
Insurance			
Private (%)	32 (65.3)	180 (62.5)	212 (62.9)
Medicare or Medicaid (%)	17 (34.7)	105 (36.5)	122 (36.2)
None (%)	0 (0.0)	3 (1.0)	3 (0.9)
Unknown	*0*	*4*	*4*
End-of-life Concerns[*]			
Losing autonomy (%)	49 (100)	251 (87.2)	300 (89.0)
Less able to engage in activities making life enjoyable (%)	42 (85.7)	250 (86.8)	292 (86.6)
Loss of dignity (%)[e]	42 (85.7)	131 (80.4)	173 (81.6)
Losing control of bodily functions (%)	31 (63.3)	165 (57.3)	196 (58.2)
Burden on family, friends/caregivers (%)	22 (44.9)	110 (38.2)	132 (39.2)
Inadequate pain control or concern about it (%)	16 (32.7)	76 (26.4)	92 (27.3)
Financial implications of treatment (%)	2 (4.1)	7 (2.4)	9 (2.7)
PAS Process			
Referred for psychiatric evaluation (%)	0 (0.0)	36 (12.6)	36 (10.7)
Patient informed family of decision (%)**	46 (93.9)	207 (94.5)	253 (94.4)
Patient died at			
Home (patient, family or friend) (%)	44 (89.8)	275 (94.2)	319 (93.5)
Long term care, assisted living or foster care facility (%)	4 (8.2)	13 (4.5)	17 (5.0)
Hospital (%)	0 (0.0)	1 (0.3)	1 (0.3)
Other (%)	1 (2.0)	3 (1.0)	4 (1.2)
Lethal Medication			
Secobarbital (%)	40 (81.6)	135 (46.2)	175 (51.3)
Pentobarbital (%)	9 (18.4)	152 (52.1)	161 (47.2)
Other (%)[ΔΔ]	0 (0.0)	5 (1.7)	5 (1.5)
Health-care Provider Present When Medication Ingested[**]			
Prescribing physician (%)	11 (22.4)	63 (29.2)	74 (27.9)
Other provider, prescribing physician not present (%)	25 (51.0)	115 (53.2)	140 (52.8)
No provider (%)	13 (26.5)	38 (17.6)	51 (19.2)
Unknown	*0*	*6*	*6*
Complications			
Regurgitated (%)	3 (6.3)	16 (5.6)	19 (5.7)
Seizures (%)	0 -	0 -	0 -
Awakened after taking prescribed medication (%) ψψ	0	1	1
None (%)	46 (93.8)	269 (94.4)	314 (94.3)
Unknown	*0*	*8*	*8*
Emergency Medical Services			
Called for intervention after lethal medication ingested (%)	0 (0)	0 (0)	0 (0)
Calls for other reasons (%)[##]	0 (0)	4 (1.4)	4 (1.2)
Not called after lethal medication ingested (%)	49 (100)	284 (98.6)	333 (98.8)
Unknown	-	*4*	*4*
Timing of PAS Event			
Duration (weeks) of patient-physician relationship			
Median	8	12	11
Range	0-1440	0-1065	0-1440
Unknown	*2*	*16*	*18*

Duration (days) between prescription written and death			
Median	14	6	7
Range	0-463	0-698	0-698
Minutes between ingestion and unconsciousness			
Median	5	5	5
Range	1-20	1-38	1-38
Unknown	*3*	*28*	*31*
Minutes between ingestion and death			
Median	25	25	25
Range (minutes - hours)	6 min-83 hrs	1 min-48 hrs	1 min-83 hrs
Unknown	*5*	*20*	*25*

[*] Unknowns are excluded when calculating percentages.

[Δ] Clackamas, Multnomah, and Washington counties.

[+] Excluding Douglas and Lane counties.

[Ψ] Includes alcoholic hepatic failure, corticobasal degeneration, diabetes mellitus with renal complications, hepatitis C, organ-limited amyloidosis, scleroderma, and Shy-Drager syndrome.

[#] Affirmative answers only ("Don't know" included in negative answers). Available for 17 patients in 2001.

[θ] First asked beginning in 2003.

[**] First recorded beginning in 2001. Since then, 10 patients (3.7%) have chosen not to inform their families and five patients (1.9%) have had no families to inform.

[ΔΔ] Other includes combinations of secobarbital, pentobarbital, and/or morphine.

[++] The data shown are for 2001-2007 since information about the presence of a health care provider/ volunteer, in the absence of the prescribing physician, was first collected in 2001.

[ΨΨ] In 2005, one patient regained consciousness 65 hours after ingesting the medications, subsequently dying from his/her illness 2 weeks after awakening. The complication is recorded here but the patient is not otherwise included in the total number of DWDA deaths.

[##] Calls included three to pronounce death and one to help a patient who had fallen off a sofa.

Prescription History – Oregon Death with Dignity Act

Year	Deaths	Prescriptions	# Physicians
1998	16	24	--
1999	27	33	--
2000	27	39	22
2001	21	44	33
2002	38	58	33
2003	42	68	42
2004	37	60	40
2005	38	65	39
2006	46	65	40
2007	49	85	45

Usual arguments put forward against physician-assisted death including that it will discriminate against the poor, uneducated, and vulnerable, can be seen to be misleading. It simply does not happen in Oregon. Nor have there been major increases in the number of persons dying pursuant to the Oregon Act from year to year. Far less persons die than are prescribed lethal medication.

It is very relevant that pain, often cited as the key reason for physician-assisted death was not the major influencing factor of those who utilised the Oregon Act's provisions. Major factors did include, loss of autonomy, decreasing activities that make life enjoyable, and loss of dignity.

A possible weakness in the reporting procedure is that patients and their families were not interviewed. While these annual reports can only give its findings based on doctors who report pursuant to the Oregon Act,[119] it is also reasonable to assume that doctors are not likely to treat patients illegally when they have a legal means of doing so. It is a logical premise that doctors will afford themselves the protection of the Oregon Act if it is available. This argument is validated by the fact that almost no doctors have been prosecuted under the provisions of the Oregon Act.

Further, it is a requirement that pharmacists provide to the Department of Human Services a separate "Pharmacy Dispensing Record" giving patient, doctor, pharmacist and type of medication information. This provides a valuable cross check against the attending doctors reports.

In summary, concerns by persons wherein a previously illegal activity in physician-assisted suicide would expand uncontrollably in Oregon if legalised, that is, the slippery slope, appear to be unfounded. Extremely small numbers of Oregonians request physician-assisted suicide and fewer actually utilise it. It is only utilised for those for whom it is intended.

Nurses Study

Studies undertaken of the operation of the Oregon Act have unsurprisingly focused on participating doctors. A questionnaire was mailed in 2001 to all nurses and social workers who care for patients enrolled in hospice programs in Oregon.[120]

From this study which had a response rate of 73%, it was determined that the main reasons given by patients to whom lethal medication had been administered were: a desire to control the circumstances of their death, a readiness for death, the desire to die at home, a loss of or a fear of losing independence, a poor or a fear of a

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[119] "Eighth Annual Report on Oregon's Death with Dignity Act", *Oregon Dept. of Human Services,* March 9, 2006 at 15.

[120] Ganzini L. et al, "Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance With Suicide." 347(8) *The New England Journal of Medicine,* 582-588.

poor quality of life, and pain or a fear of worsening pain.[121] Psychiatric disorders including depression, lack of social support and financial concerns were seen to be relatively unimportant.[122]

Comparing other hospice patients with patients who had received lethal medication, 77% of the latter had a greater fear of loss of control in circumstances of death and 62% had a greater fear of loss of independence.[123] These fears fit the argument for an enhanced right of autonomy, so that the patient is able to determine for him or herself, according to his or her beliefs, decisions at end-of-life.

The authors of this study noted that outside of Oregon: "one of the most consistent findings in studies of seriously or terminally ill patients is that depression increases the likelihood of a preference for hastening death."[124] But in this study, depression or other psychiatric disorders were rated amongst the least important reasons for requesting a prescription for lethal medication.[125] Perhaps the Oregon Act provides comfort not available to the terminally ill in other jurisdictions.

Palliative Care

An important finding is that the Oregon Act has focused the attention of Oregonians on end-of-life issues.[126] More than any other United States state, Oregonians suffering from terminal illness are dying in the comfort and security of their own home with the aid of hospice care.[127] In 1997, approximately 30% of decedents in Oregon died while under hospice care,[128] compared with a national average of about 25%,[129] which made Oregon one of the four top states in hospice use in the United States.[130] Of patients who have utilised the Oregon Act, an average of over 85% were enrolled in hospice care.

With strong community resources available to support patients and their families in Oregon, dying at home or in a nursing home is a realistic alternative to hospital.[131] This would seem to denounce the theory that in removing the legal ban on physician-assisted suicide, allocation of resources at end-of-life would diminish, it

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[121] Id.

[122] Id.

[123] Id.

[124] Id.

[125] Ibid at 584.

[126] Batavia A., "The Implementation of Oregon's Law: So far So Good: Observations on the First Year of Oregon's Death With Dignity Act", 6 *Psychology Public Policy and Law*, 291 – 304.

[127] Tolle S. et al, "Oregon's Low in Hospital Death rates: What Determines where People Die and Satisfaction with Decisions on Place of Death?" 130(8) *Annals of Internal Medicine*, (1999), 681– 685.

[128] Ibid.

[129] Hedberg K., Hopkins D., Southwick K., "Legalised Physician-Assisted Suicide in Oregon." 346 *New England Journal of Medicine*, (2002), 450-452.

[130] Tolle S. et al, "Oregon's Low in Hospital Death rates: What Determines where People Die and Satisfaction with Decisions on Place of Death?" 130(8) *Annals of Internal Medicine*, (1999), 681– 685.

[131] Id.

being the quicker and cheaper alternative to palliative care. Palliative measures have arguably been given greater prominence as part of the care for the chronically and terminally ill as a consequence of the Oregon Act.

A study specifically aimed at doctors' attitudes about and experiences with end-of-life care since the enactment of the Oregon Act, concluded that rather than the availability of physician-assisted suicide diverting attention from efforts to improve care for dying patients, most Oregon doctors who treated the dying had endeavoured to improve their ability to treat those patients.[132] A statutory authority, the "Pain Management Commission"[133] was established to administer pain management education programs for licensed health care professionals who treat patients for chronic or terminal pain.

Comparison Between the ROTI and the Oregon Death With Dignity Act

With the demonstrable success of the Oregon Act it is useful to compare it with the ROTI to ascertain the major similarities and differences between the two.

- Both are wholly legislative schemes.
- Both apply to capable or competent persons only.
- The Oregon Act allows for physician-assisted suicide only. The ROTI allows for both euthanasia and physician-assisted suicide.
- In both, the initial diagnosis and prognosis may be made by an "attending" doctor. Thereafter the diagnosis and prognosis must be confirmed by a "consulting" doctor specialising or with experience in the patient's particular illness.
- In both the patient must have been diagnosed with a terminal illness and less than 6 months to live.
- Only in the ROTI must the patient not only have a terminal illness but also be in severe pain or suffering.
- The attending doctor under the Oregon Act does not need to be present when the lethal medication is taken. The attending doctor must be present under the ROTI. In view of potential complications and variances in the time from ingesting the lethal medication to unconsciousness and then to death, it is suggested that a health professional should be on hand to either help with the final act if such help is required, or to assist if there are complications.
- The Oregon Act allows for a "cooling off" period of 15 days, the ROTI 9 days.

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[132] Ganzini L., et al, "Oregon Physicians' Attitudes About and Experiences With End of Life Care Since Passage of the Oregon Death With Dignity Act", 285(18) *Journal of the American Medical Association*, (May 9, 2001), 2363 – 2369.

[133] Oregon Revised Statutes 409.560 (2003).

- The Oregon Act only mandates that a patient be seen by a psychiatrist or psychologist if either of the attending or consulting doctors believe that the patient is suffering from impaired judgement. The ROTI ensures a psychiatrist examines the patient to ensure the patient is not suffering from treatable clinical depression in relation to his or her illness.
- Only the ROTI allows for an interpreter recognising the multi-cultural Australian society.

Summary on the Oregon Death With Dignity Act

Oregon has controversially recognized that current practices at end-of-life as accepted by other jurisdictions such as Australia, are not always adequate for the individual patient.[134] The withholding or withdrawal of medical treatment or the administration of palliative care with the "unintentional" consequence that patients die before they otherwise would have, may not be suitable for the patient who is looking to retain some degree of autonomy and dignity at the end-of-life. The Oregon Act as a comparison with the incremental evolution of the law in the Netherlands and allegations of a slippery slope in that jurisdiction,[135] reinforces the view that legislative change is preferable to change on a case by case basis through the courts.

It may also be argued that Oregon has acknowledged the reality of end-of-life medical practice. The *New York State Task Force on Life and the Law* conceded that practices such as physician-assisted suicide occur but remarkably preferred to quietly tolerate them as illegal acts committed privately between doctor and patient.[136] In Australia, Magnusson has detailed many face to face interviews with anonymous doctors who acknowledge practising physician-assisted dying, but often to the detriment of the patient due to lack of regulation and training.[137] That physician-assisted death is relatively widespread in Australia is more than just anecdotes. As already shown, several studies both nationally and in individual states confirm with little doubt that these practices, despite their illegality, occur on a relatively widespread scale.[138]

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[134] Controversial as government sponsored studies in Victoria, Australia and around the world have declined to recommend a change to the law at end of life: Victorian Parliament Social Development Committee, *Inquiry in Options for Dying With Dignity, Second and Final Report* (April 1987); the parliamentary House of Lords *Report of the Select Committee on Medical Ethics* (1994); *Of Life and Death,* Report of the Special Senate Committee on Euthanasia and Assisted Suicide, (Canada), June 1995; Senate Legal and Constitutional Legislation Committee, *Euthanasia Laws Bill 1996* (Australia), March 1997; Parliament of Tasmania, House of Assembly, Community Development Committee, *Report on the Need for Legalisation of Voluntary Euthanasia, Report No. 6,* 1998; and Parliament of South Australia, Social Development Committee, *Inquiry into the Voluntary Euthanasia Bill 1996,* 20 October 1999.

[135] Hendin H., "The Dutch Experience", 17 *Issues in Law and Medicine,* Spring 2002, 223-246; Cohen-Almagor R., "Euthanasia in the Netherlands: The Legal Framework", 10 *Michigan State University-DCL Journal of International Law,* Summer 2001, 319-342; Jochemsen H., & Keown J., "Voluntary euthanasia under control? Further empirical evidence from the Netherlands", 25 *Journal of Medical Ethics,* (1999) 16-21.

[136136] As cited in Rothschild A., "BWV: Resolved and Unresolved Issues at end of Life", 11 *Journal of Law and Medicine,* Feb. 2004, 292-311 at 310.

[137] Magnusson R., *Angels of Death Exploring the Euthanasia Underground,* (Melbourne University Press, 2002).

[138] See section "Australian surveys" in chapter "Medical Ethics and Practice".

The Oregon Act is a legal and social experiment on end-of-life medical practices within a common law jurisdiction, and which, based on its eleven years of operation, apparently works.

Conclusion

In recent years there has been a greater recognition of a patient's right of medical self-determination. As has been argued in this submission, a patient whether terminally ill or not, is able to determine if he or she will or will not receive medical treatment, notwithstanding that the decision will knowingly result in death. But a terminally ill patient, even if competent and informed, who has decided that because of his or her intolerable suffering that he or she no longer wants to continue to live, cannot ask for physician-assisted death.

Sophisticated treatment at the end-of-life can prolong the progression of the illness but may not deny the end. Treatment may make a terminal illness a continuing or chronic illness. Such treatment may actually exacerbate the suffering while keeping the patient alive. With the explosion of medical technology, rather than a disease taking its natural course, patients: "... have slowly wound their way through layers of staff, rooms, and machines towards a death declining in quality and dignity to a level which oftentimes would be considered inhumane ... ".[139]

If the patient is slowly deteriorating, he or she must wait until the disease has reached a stage where treatment which would otherwise keep him or her alive can be withheld or withdrawn. Patients may not want to burden themselves or their family with a protracted and degenerative decline which is inherent in the treatment of many illnesses today. They may not want to die in a stupor of drugs or in the clinical surroundings of a hospital, but in their own home with family and friends and a semblance of control.

The changing demographic of the Australian population must be considered in any argument for a reform of current law. It is the elderly more than any other age group who realistically must consider medical end-of life decisions. The Australian Bureau of Statistics notes that by 2051 there will be a much greater proportion of people aged 65 years and over than in 2004 ... In 2004 people aged 65 years and over made up 13% of Australia's population. This proportion is projected to increase to between 26% and 38% in 2051 and to between 27% and 31% in 2101.[140]

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[139] LaFrance A., "Physician Assisted Death: A Comparison of the Oregon and Northern Territory Statutes", 1(3) *Newcastle Law Review*, (1996), 33-55 at 54.

[140] "3222.0 - Population Projections, Australia, 2004 to 2101" *Australian Bureau of Statistics*, Released 29 November 2005.

A *Herald Sun* "Issues Survey" (Victorians only) found that of the overwhelming preponderance of respondents favouring euthanasia, of those in the group aged 65 and over, 61% were in favour, 38% were against, and 1% did not answer the question.[141] The proportion of the aged in society is increasing rapidly, arguably more rapidly than the official government statistics show, according to Professor Rob Hyndman, head of Monash University's Business and Economics Forecasting Unit.[142] A compassionate and humane society should not turn a blind eye to such figures.

Complying with a request that deliberately or intentionally results in the death of a patient attracts criminal liability. The question is, why? It is a dubious legality that individuals can deny themselves treatment condemning themselves to a slow and potentially painful death, or are able to receive palliative care in the knowledge that as a foreseen effect the treatment will also kill them, but are not able to request physician-assisted death so that they may die quickly and painlessly at a time of their choosing. These do not seem to be reasonable distinctions that the law has made.

The potential for abuse that a reform of the law such as the ROTI would allow is at best argumentative. It cannot be said for sure that there would be a lessening in the value of life or that the poor, disabled, elderly, and vulnerable will be at risk. Indeed, it is suggested that such arguments can be turned around because of the risk of abuse under current practices where there is no regulation for considered, persistent and informed decisions to be made for withdrawal of treatment, or palliative care including terminal sedation.

Further, the Oregon Act has shown factually that the risk of abuse from a well constructed legislative scheme such as the ROTI is minimal. While evidence in the Netherlands is more debateable, the bottom line there is that the Dutch themselves are comfortable with their system.

If there is to be a reform of the law there needs to be a balance between patients who have the capacity to involve themselves in end-of-life decision making and at the same time limiting the undesirable consequences to which the recognition of such a right may potentially give rise.[143] The ROTI has been internationally recognised as giving such a balance.[144] It is probably a better Act that even the Oregon Act in this regard.

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[141] 20 January 2005, at 4.

[142] McAlister S & Anns R, "Uncertainty over population forecasting and the elderly", *Media Communications, Monash University,* http://www.monash.edu.au/news/releases/2004/may04-population.html accessed 16 December 2005.

[143] Including the possibility of abuse either individually or on a larger scale. At the same time for those wishing to avail themselves of any reform in the law, it should not be too limited or too burdensome: Chesterman C., "Last Right: Euthanasia, The Sanctity of Life, and The Law in the Netherlands, and the Northern Territory of Australia", 47 *International and Comparative Law Quarterly,* April 1998, 362-393 at 374.

[144] Cohen-Almagor R. & Hartman G. "The Oregon Death With Dignity Act: Review and Proposals for Improvement" 27 *Journal of Legislation* 2001, 269-298.

As a final note, Percy Bridgman, a Nobel Prize winning physicist, suffered from terminal cancer. In a memo he wrote before he fatally shot himself, he said: "It isn't decent for society to make a man do this thing himself."[145]

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[145] Cited in Boyle B., "The Oregon Death With Dignity Act: A Successful Model or a Legal Anomaly Vulnerable to Attack?" *Houston Law Review*, Spring 2004, 1387-1421 at 1421.