

Washington International Law Journal

Volume 6 | Number 1

1-1-1997

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Recommended Citation

Roger S. Magnusson, *The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States*, 6 Pac. Rim L & Pol'y J. 1 (1997).

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THE SANCTITY OF LIFE AND THE RIGHT TO DIE: SOCIAL AND JURISPRUDENTIAL ASPECTS OF THE EUTHANASIA DEBATE IN AUSTRALIA AND THE UNITED STATES

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Abstract: This paper reviews social and legal issues in the current euthanasia debate. Focusing on Australia and the United States, the author argues that the legalization of physician-assisted suicide ("PAS") and/or active voluntary euthanasia ("AVE") is inevitable within the short to medium term, given recent developments which have undermined the sanctity of life ethic. Legal factors supporting this assessment include the changing definition of death, the growth of a legally-recognized right to self-determination extending to the withdrawal of life-support, and the recognition by some courts that life support may be withdrawn without consent because life is considered to be futile. The law, in turn, reflects broader changes in prevailing social philosophies that have been greatly influenced by rising individualism, the technological revolution in medicine and the promotion of debate through television and other media. Public opinion polls, the fragmentation of medical opinion over PAS/AVE and the declining influence of churches are also creating the conditions under which legalization would be a viable social policy. This paper reviews the emerging jurisprudence establishing a right to die in Australia, the United States and the Netherlands. In view of the likelihood of PAS/AVE reform, the author argues that it is vital to articulate a stable philosophical basis for PAS/AVE which will provide a principled basis for any further incremental derogation from the sanctity of life ethic.

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- I. INTRODUCTION

On March 25 1995, seven Australian doctors went public on the front page of a major Melbourne daily. In an open letter to the Victorian State Premier,¹ they admitted to having performed euthanasia, and called for the introduction of the assisted suicide Bill advocated by the Voluntary Euthanasia Society of Victoria.² The protest by the "Melbourne Seven" led to renewed media coverage of a controversy which is rapidly

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² Australia, like the United States, is a federal constitutional democracy consisting of six states (New South Wales, Victoria, Queensland, South Australia, Western Australia and Tasmania) and two mainland territories (the Northern Territory and the Australian Capital Territory). At both state and federal level, it follows a Westminster style of government. The leader of the government of a state is called the Premier; the leader of the government of a territory is called the Chief Minister, while the leader of the federal government is the Prime Minister. See, e.g., Michelle Grattan, *Premiers Propose "Hands-Off" Approach*, THE AGE (Melb.), Dec. 7, 1992 at 1.

² "Right to die" societies are known as "voluntary euthanasia societies" in Australia.

intensifying in Australia, the United States and other industrial democracies. Referring to the legal prohibition upon euthanasia, the doctors wrote,

[i]t cannot be right to tolerate this totally unsatisfactory situation, where it is a matter of chance whether patients will receive the treatment which they so desperately seek and where it must be only a matter of time before some doctor is prosecuted by the state for following the dictates of his conscience.³

Almost immediately, the seven were attacked by a spokesperson for the Premier (who had not been forewarned about the letter), by the Victorian branch of the Australian Medical Association (AMA), by "right-to-life" advocates, and other groups.⁴ An Opposition call for a Parliamentary inquiry into euthanasia was rejected,⁵ although the Premier expressed personal support for legalized voluntary euthanasia, and, following the enactment of the Northern Territory's recent euthanasia legislation,⁶ foreshadowed that Parliament would consider the issue during 1996.⁷ Subsequently, however, in response to an appeal by seventy Victorian doctors, the Premier indicated that his government would not be considering euthanasia in the "foreseeable future."⁸

In mid-1995, the Medical Practitioners' Board of Victoria and the Victoria Police held inquiries into the admissions made by the seven doctors, although in the absence of corroborative evidence and of further self-incriminating details from the doctors themselves, no further action has been taken.⁹ There seems little doubt that the Melbourne Seven will continue, discreetly, to practice euthanasia.

The admissions made by these seven Australian doctors, while premature in so far as they were intended to force either a "show-trial," or

³ Rodney Syme et al., *An Open Letter to the State Premier of Victoria*, (Mar. 24, 1995) (On file with the PAC. RIM L. & POL'Y J.).

⁴ Rachel Buchanan, *Charge Euthanasia Doctors, Says Right to Life*, THE AGE (Melb.), Mar. 27, 1995, at 1; Mark Forbes, *Fury Over Assisted Deaths*, THE SUNDAY AGE (Melb.), Mar. 26, 1995, at 3.

⁵ Shane Green, *Kennett Rejects Euthanasia Inquiry*, THE AGE (Melb.), April 4, 1995, at 5.

⁶ Rights of the Terminally Ill Act (1995) (Australia).

⁷ Gay Alcorn, *Kennett Flags Right-to-Die Bill*, THE AGE (Melb.), May 26, 1995, at 1; Shane Green & Steve Dow, *Premier Signals State Euthanasia Debate*, THE AGE (Melb.), May 27, 1995, at 3.

⁸ Steve Dow, *No Euthanasia Change, Says Kennett*, THE AGE (Melb.), Nov. 3, 1995, at 9; Terry Brown, *Euthanasia Appeal Rejected*, THE HERALD-SUN (Melb.), Nov. 3, 1995, at 39.

⁹ Rachel Gibson, *"Suicide" Doctors Face Probe*, THE AGE (Melb.), Apr. 1, 1995, at 1; Rachel Buchanan, *Board Abandons Probe into Euthanasia Doctors*, THE AGE (Melb.), June 21, 1995, at 3; Rachel Buchanan, *Police Probe on Euthanasia*, THE AGE (Melb.), June 22, 1995, at 3; Rachel Buchanan, *Police Drop Euthanasia Inquiry*, THE AGE (Melb.), Aug. 10, 1995, at 3.

legislative reform, are typical of an increasing unwillingness amongst sections of the medical profession to “play dumb” about their involvement in euthanasia.¹⁰ Doctors such as Jack Kevorkian and Timothy Quill in the United States, and Nigel Cox in England, have come to represent a growing protest against the laws which prohibit assisted suicide and euthanasia of the terminally ill. In the United States, much of the focus has been on *physician-assisted suicide* (“PAS”). As understood in this paper, PAS occurs when a doctor knowingly and intentionally gives a patient the means, or otherwise assists a patient who takes his or her own life. In Australia, the focus has largely been on *active voluntary euthanasia* (“AVE”), intentionally and directly causing the death of a terminally ill patient, in accordance with that patient’s wishes, in order to relieve the burden of disease or injury.

A. *The Inevitability of PAS/AVE Reform*

The current euthanasia debate did not arrive in a freak windstorm. Instead, challenging society’s traditional prohibition on the killing of terminally ill, consenting patients is the logical next step in a legal and ethical retreat from the sanctity of life ethic of the Judeo-Christian tradition. This retreat is one of the large-scale changes evident within western societies over the past few decades. When one looks to the law, the intellectual history of that retreat is reflected in the changing definition of death,¹¹ in the growth of a legally-supported right to self-determination extending to the withdrawal of life-support,¹² and in the recognition by some courts that—in limited circumstances—life-support may be withdrawn *without consent* because life is considered to be *futile*.¹³ The law, in turn, reflects broader changes in prevailing social philosophies that have been greatly influenced by the technological revolution which has occurred in medicine and by the promotion of debate through television and the media. It is as a result of these developments that head-on confrontation with the sanctity of life ethic is now possible in the late twentieth century.

¹⁰ One of the seven doctors, respected urologist Rodney Syme, confirmed to newspaper reporters a quiet history of euthanasia spanning over 20 years. Nick Davies, *A Matter of Life & Death*, THE AGE (Melb.), Mar. 25, 1995, at 1.

¹¹ See discussion *Infra* part III(A)(1).

¹² See discussion *Infra* Part III(A)(2); see, e.g., Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990).

¹³ See discussion *Infra* Part III(A)(3); see, e.g., Airedale N.H.S. Trust v. Bland, [1993] App. Cas. 789.

In view of the changing legal and moral foundations of society, it is inevitable—whether in the short or medium term—that courts and legislatures in western democracies will progressively legalize PAS/AVE. Within a generation, the suggestion that a terminally ill patient should be denied the right to die with medical assistance will appear primitive, if not absurd. Former Chief Minister of the Northern Territory, Marshall Perron, has compared the Northern Territory's euthanasia Act to legislation passed in 1894 by the (former) British colony of South Australia, which became the second jurisdiction in the world (after New Zealand) to give women the right to vote, and the first to allow women to stand for Parliament.

In the United States, in March 1996, the Ninth Circuit Court of Appeal held that the prohibition on PAS infringed the "liberty" interest enjoyed under the Due Process Clause of the Fourteenth Amendment.¹⁴ In April 1996, the Second Circuit invalidated New York State's prohibition on PAS on the basis that it violated the Equal Protection Clause of the Fourteenth Amendment.¹⁵ Although an adverse Supreme Court opinion could potentially retard the process of pro-euthanasia law reform, this would be a temporary delay only which could not survive generational change. In the United States and beyond, the development of a legal right to die with medical assistance, appears inevitable.

To some, the foregoing claims may appear audacious and even dangerous. The aim of this paper is therefore to substantiate these claims with reference to British Commonwealth and United States law, and to place the legal issues within a wider social context. Part II of the paper will consider the social context of the euthanasia debate, as it is evident from media reports and the recent literature. It will identify the major "players" in the euthanasia debate, some of the crucial issues in dispute, and will review some recent euthanasia research in order to show just how extensive is the fragmentation of opinion within the medical profession, and how divisions over the euthanasia issue in turn reflect more fundamental moral and philosophical viewpoints.

Part III of the paper will then turn to the law, arguing that the current euthanasia debate is the culmination of a steady retreat from the sanctity of life ethic evident in United States and British Commonwealth caselaw and legislation. Increasingly, the social factors which have given birth to right to die movements around the world, combined with the need to fashion a logically sustainable jurisprudence, will lead to a legally recognized right to die. Several models of legalized PAS/AVE have emerged already, and these are reviewed.

¹⁴ *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996).

¹⁵ *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

Regardless of whether legalized PAS/AVE is considered good social policy, an explicitly recognized right to PAS/AVE resolves, on a doctrinal level, many of the legal dilemmas currently faced by doctors—it allows them to kill. By contrast, in jurisdictions where such a right does not exist, doctors remain squeezed between the competing demands of a system which both respects and undermines the sanctity of life ethic; a legal system that is, in the words of one of Britain's most senior judges, "morally and intellectually misshapen."¹⁶

II. THE SOCIAL CONTEXT OF THE EUTHANASIA DEBATE

A. *Why Now?*

In books and newspapers, on television and the internet,¹⁷ euthanasia has become a familiar and constantly recurring subject of community debate. But why now, after so many centuries of prohibition? Prior to the enactment of the Northern Territory's euthanasia legislation, Melbourne's *Age* newspaper carried an essay which suggested several reasons:

The debate is about the limits of individual freedoms and the political power of the Baby Boomers, now at the age when they are beginning to contemplate their mortality. It's about an aging population and a limited health dollar. It's about an increasingly educated population losing its awe of the medical profession. And it provides an intriguing look at religion in a secular society.¹⁸

All of these factors, and more, are involved. The concepts of PAS/AVE are not new. Within the past two or three decades, however, these ideas have had a significant persuasive effect on the public. Politically active, right to die movements dedicated to PAS/AVE reform have sprung up in many western countries. A necessary condition to public support for PAS/AVE reform, and one which continues to fuel the

¹⁶ *Bland*, [1993] App. Cas. at 887.

¹⁷ For example, on-line sites such as *Deathnet*: <<http://www.islandnet.com/~deathnet/>>, provide on-line news reports, access to government reports, space for both advocates and opponents of euthanasia to post materials, as well as links to other on-line resources, including the Canada-based Last Rights Information Centre, and Derek Humphry's Euthanasia Research & Guidance Organization (ERGO).

¹⁸ Gay Alcom, *Marshall Law*, THE AGE (Melb.), May 24, 1995, at 13.

euthanasia debate, is the emerging ethic of what might be called "liberal individualism."¹⁹ According to Somerville,

We are now societies based on intense individualism—possibly individualism to the exclusion of any real sense of community, including in situations facing death and bereavement Matters such as euthanasia, that would have been largely the subject of moral or religious discourse are now explored in our courts and legislatures, particularly through the concepts of individual human rights, civil rights and constitutional rights.²⁰

Christian churches, particularly those with a more fundamentalist theology, and those with a tradition of hierarchical religious authority, such as the Roman Catholic church, are the mainstay of opposition to euthanasia law reform. This is not surprising, since euthanasia, like suicide, "represents a rejection of God's absolute sovereignty over life and death."²¹ Furthermore, since churches preside over the rites of passage, including death—to which special religious significance is attributed—euthanasia also undermines church influence by undermining the church's traditional moral domain. The decline of church influence in Australia has weakened what might otherwise have been a far more impressive impediment to PAS/AVE reform. Regardless of religious belief, however, many opponents of euthanasia remain more communitarian in outlook, believing that individual freedoms and interests should be tempered by communal values, social goals and traditional constraints.²² Euthanasia, in contrast, is atomistic in its philosophy, an affirmation of individual moral freedom in a world lacking moral absolutes.

The euthanasia debate takes place against a background of rapid medical advancement. The drugs and machines of modern medicine can keep the heart pumping and blood circulating far longer than nature could unassisted. But such life, frequently lived without privacy within the goldfish bowl of a hospital ward, comes at a cost. There are real concerns within the community that human dignity will become a casualty of the

¹⁹ Margaret Somerville, *Sentencing Society to Ethical Death*, THE AGE (Melb.), Nov. 13, 1995, at 13.

²⁰ *Id.*

²¹ Pope John Paul II, *EVANGELIUM VITAE: ON THE VALUE AND INVIOABILITY OF HUMAN LIFE* (1995), para 66. According to the Church, the height of arbitrariness and injustice is reached when certain people, such as physicians or legislators, arrogate to themselves the power to decide who ought to live and who ought to die. *Id.*, para 67.

²² See Tom L. Beauchamp et al., *Public & Private: Redrawing Boundaries*, 24 HASTINGS CENTER REPORT, May-June 1994, 18.

goal of prolonging longevity. The euthanasia movement is also a protest against medical bureaucracy and technological determinism. In the Netherlands, the Rummelink Committee—appointed in 1990 to consider options for euthanasia law reform and regulation—pointed to the increasing importance of end of life decisions in an era when there are an increasing number of cancer deaths, combined with a growth in the number of life-prolonging technologies.²³ Many of the factors mentioned above are also evident with Acquired Immune Deficiency Syndrome, (“AIDS”). AIDS patients are burdened by drug therapy and a lingering chronic phase.

Increasingly this century, and for the first time in human history, the majority of people in western societies are dying from diseases which are characterized by an extended deteriorative decline.²⁴ The predictability of this downhill road is having an important cultural effect, focusing attention onto the *manner* of dying, and challenging assumptions about the norms of dying.²⁵ This is particularly true of AIDS, which shares the “deteriorative decline,” yet is unique amongst twentieth century illnesses in its capacity to decimate young and healthy populations (mostly men) in a way not seen since medicine arrested the typical killers of past centuries such as typhoid, tuberculosis and smallpox. In this regard, AIDS challenges the assumption of “medical control” over disease, and so undermines traditional norms of medical management.

Not everyone accepts that euthanasia finds legitimacy as a reaction against the impersonal, biology-driven achievements of modern medicine nor the epidemiology of death in the twentieth century. Instead, some see the push for euthanasia as a symptom of the failure of doctors to communicate with their patients, their failure to respect patient choice, and to discontinue treatment when it is futile, and their failure to practice good palliative care.²⁶ Others point to the aging population, and economic pressures to free up hospital beds as reasons for the push for legalization.²⁷

²³ Paul van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 673 (1991).

²⁴ See Margaret P. Battin, ETHICAL ISSUES IN SUICIDE, 201, 225 (1995).

²⁵ See *Id.*

²⁶ E.g., Brian Pollard & Ronald Winton, *Why Doctors and Nurses Must Not Kill Patients*, 158 MED. J. AUSTL. 426 (1993).

²⁷ See B. A. Santamaria, *Tacit Consent to Euthanasia*, WEEKEND AUSTRALIAN, Apr. 1-2, 1995, at 28.

B. *Players In The Euthanasia Debate*

The euthanasia debate is not merely an academic squabble or media-driven talkfest. Instead, it is a process of political struggle between players with competing ideologies, and with far-reaching consequences. It is a debate which is extremely relevant to us all, as death comes to us all. The debate is reflected in media and community discussion. Not all participants, however, have equal ability to make themselves heard, nor to influence the processes required for social change. To appreciate the complexity of the process of ideological struggle we are witnessing, it is useful to consider each of the participants, as well as the major issues they tend to focus upon.

1. *The Wider Public*

We have reached the point in Australia and the United States where there is now broad community support for assisted suicide and/or voluntary euthanasia legislation. A review of United States polls reveals majority support for legalizing medically assisted death since 1973 (53%), rising to 60% in 1977 and 63% in 1991.²⁸ A 1996 Gallup poll reported 75% in favour of lawful, medically assisted death.²⁹ In Australia, letters to *The Age* newspaper, following the front page story of the Melbourne Seven who admitted to performing euthanasia, were two to one in favour of legalization.³⁰ In July 1994, a Newspoll reported that four out of five Australians supported pro-euthanasia law reform.³¹ A similar result was obtained in a June 1995 AGB McNair AgePoll conducted in the wake of the Northern Territory legislation.³² Morgan polls have shown steady majority support for permitting doctors to give lethal drug doses to terminally ill patients (78% support in June 1995).³³

²⁸ Harvard Program on Public Opinion and Health Care, *Should Physicians Aid their Patients in Dying?* 267 JAMA 2658, 2659 (1992).

²⁹ *Public Support Rising for Assisted Suicide*, ERGO! U.S. NEWS BULLETINS, Apr. 15, 1996, ERGO's NEWS ARCHIVES: <<http://www.islandnet.com/~deathnet/ergo.html>>.

³⁰ *Whose Life Is It?*, THE AGE (Melb.), Mar. 31, 1995, at 15 (Editorial).

³¹ Steve Dow, *Overwhelming Support for Pro-Euthanasia Law Reform*, WEEKEND AUSTRALIAN, July 30-31, 1994, at 1.

³² Steve Dow & Elissa Blake, *Most Back Euthanasia: Poll*, THE AGE (Melb.), June 7, 1995, at 1 (reporting 74% (male) and 76% (female) support for a law protecting doctors who perform euthanasia. 80% support was evident among twenty-five to thirty-nine year-olds, with 70% support amongst people over fifty-five).

³³ Cf. 77% support in July 1990, 76% support in March 1992: *Australia 1995, Support for Voluntary Euthanasia Stands at 78%*, Last Rights Online Library, <http://www.rights.org/~deathnet/lr_library.html>; Australian polls found at: <http://www.islandnet.com/~deathnet/Aus_poll.html> (citing THE BULLETIN (Austl.) June 28, 1995).

In Canada, a 1994 poll in the wake of the Supreme Court's ruling in the *Rodriguez* case,³⁴ found that 74% were in favour of PAS, although support diminished marginally in the higher age categories (64% in those 51 and older).³⁵ Significantly, Dutch public opinion, which rose sharply in favour of voluntary euthanasia between 1966 and 1970, had only reached 57% support by 1991, with the highest levels of opposition in the sixty-five to seventy age group.³⁶ Pro-euthanasia poll results have, inevitably, been met with criticism that the wrong questions were asked.³⁷ Sampling errors are another unexplored issue.

There is a sizeable body of research looking at the factors which mould individual attitudes toward active voluntary euthanasia (AVE). Caddell and Newton's 1995 US study found conservative Protestants and Catholics least supportive of active euthanasia, with higher levels of support amongst liberal Protestants, Jews and those with no religious affiliation (63% support overall).³⁸ Ho and Penney's 1992 Australian study confirmed that highly religious people were less approving of euthanasia than non-religious people. They argued, however, that this correlation reflected underlying differences in level of conservatism and that it was level of conservatism (rather than religiosity) which best predicted pro-euthanasia attitudes.³⁹

These polls may, of course, give a flawed impression of the level of support for PAS/AVE amongst patients themselves. Seale and Addington-Hall's 1994 English study of the relatives of 3696 decedents reported that "about a quarter of respondents who answered the question felt that it would have been better if [the patient] had died earlier, and that a similar proportion of the dying people were said to have felt this."⁴⁰ 3.6% were said to have asked for euthanasia. Pain was found to be a significant factor

³⁴ *Rodriguez v. British Columbia*, [1993] 107 D.L.R. 4th 342 (holding that the prohibition on assisted suicide in British Columbia did not violate the Canadian Charter of Rights and Freedoms).

³⁵ *Public Opinion on the Right to Die and Doctor Assisted Suicides*, Last Rights Online Library, *supra* note 29; Canadian polls found at: <http://www.islandnet.com/~deathnet/Angus_Reid2.html> (poll dating from Feb. 22-24, 1994).

³⁶ Paul van der Maas et al., *Changes in Dutch Opinions on Active Euthanasia, 1966 Through 1991*, 273 JAMA 1411, 1412 (1995).

³⁷ E.g., Warren K. Bartlett, *Poll Push Shapes Assisted Death of an Ethical Debate*, THE AGE (Melb.), June 9, 1995 (letter); Jim Dominguez, *Great Moral Issues Cannot be Resolved by Opinion Polls*, THE AGE (Melb.), June 16, 1995, at 13 (criticizing the AGM McNair poll, *supra* note 32). In England, the Voluntary Euthanasia Society apparently claimed 79% support for voluntary euthanasia on the basis of the question: "Would you like medical help to a peaceful death?" *Their Lordships on Euthanasia*, 343 LANCET 430, 431 (1994).

³⁸ David P. Caddell & Rae R. Newton, *Euthanasia: American Attitudes Toward the Physician's Role*, 40 SOC. SCI. MED. 1671 (1995).

³⁹ Robert Ho & Ronald K. Penney, *Euthanasia and Abortion: Personality Correlates for the Decision to Terminate Life*, 132 THE J. SOC. PSYCHOL. 77 (1992).

⁴⁰ Clive Seale & Julia Addington-Hall, *Euthanasia: Why People Want to Die Earlier*, 39 SOC. SCI. MED. 647, 648 (1994).

in causing respondents to feel that an earlier death would have been preferable in cancer deaths, but it was less important in non-cancer deaths. In non-cancer deaths, dependency was a far more important factor than pain in causing respondents to feel it would have been better for the deceased to have died earlier. The factors reported as most important in motivating a wish to die earlier amongst the decedents themselves related to mental problems and dependency, and control issues were found to be very significant in cases where there was a direct request for euthanasia.⁴¹ These results challenge the myth that unrelieved pain is the dominant factor driving the euthanasia debate. While they direct attention to a broader notion of palliative care, they also point to the underlying existential and philosophical issues of personal autonomy and control.

2. *The Medical Profession*

a. *The doctor as killer, martyr or celebrity*

An important feature of the euthanasia debate is the massive media attention given to those doctors who have achieved notoriety or celebrity status either by openly admitting to PAS/AVE, or by being “found out” and prosecuted for homicide. Such public prosecutions are not only a recent phenomenon. In 1956, for example, Dr John Adams, an English family practitioner, was tried at the Old Bailey for the murder of an eighty-one year-old patient whom he had injected with 2.6 grams of heroin and 2.6 grams of morphine during the last days of her life.⁴² Although the defendant was eventually acquitted,⁴³ the *Adams* case is notable for Justice Devlin’s expression of the now well-established⁴⁴ principle of “double

⁴¹ *Id.* at 649-51.

⁴² The patient, Mrs. Morrell, was an eighty-one year-old widow suffering the results of a stroke, and from cerebral arterio-sclerosis (hardening of the arteries of the brain). Adams’ case was not helped by massive publicity which revealed that, at his encouragement, elderly patients had frequently left him gifts, instead of paying his fees (which attracted heavy rates of tax). In fact, Mrs. Morrell had signed a will leaving Dr. Adams a chest containing silver, and, if her son pre-deceased her, a Rolls-Royce. Henry Palmer, *Dr. Adams’ Trial for Murder*, CRIM. L. REV. 365, 367, 374 (1957). The silver and the Rolls-Royce were, as it turned out, given to Dr. Adams after Mrs. Morrell’s death, as an act of favour by her son. In an earlier death the Coroner had investigated, Adams had received a £1000 cheque from the deceased. Clifford Hawkins, MISHAP OR MALPRACTICE? 62 (1985).

⁴³ Dr. Adams was fined heavily, however, for a variety of offenses which included making false statements (by claiming he was not a beneficiary under his patient’s will), attempting to conceal phials of morphine, and obstructing police. The General Medical Council later barred him from practicing for 3 years. C. Hawkins, *supra* note 43, at 64-65. Devlin J., the presiding judge (later Lord Devlin), wrote a book about the case after Adam’s death. P. DEVLIN, *EASING THE PASSING: THE TRIAL OF DR. JOHN BODKIN ADAMS* (Bodley Head, London, 1985).

⁴⁴ This principle has been accepted as part of the common law of the United Kingdom (*Blond*, [1993] App. Cas. at 867); the United States (*Compassion in Dying v. Washington*, 79 F.3d 790 (9th

effect," which provides that if the doctor's purpose in administering potentially lethal drugs to a terminally ill patient is to relieve pain and suffering, such treatment will be lawful, even if the incidental effect of the drug dosages is to shorten life.⁴⁵

More recent trials, however, have taken place against the backdrop of already significant levels of public support for PAS/AVE legalization. The doctor in his or her role as killer, martyr and celebrity has fanned the flames of the debate and probably crystallised public support like no one before. The media have brought the issue of euthanasia into the homes and onto television screens, and people have made up their own minds.

On September 19, 1992, an eminent British consultant rheumatologist, Dr. Nigel Cox, was found guilty of attempted murder.⁴⁶ Cox injected potassium chloride into Mrs. Lillian Boyes, a seventy year-old woman who had suffered acute rheumatoid arthritis for twenty years, with serious complications.⁴⁷ Boyes, who had been Cox's patient for thirteen years, had "developed ulcers and abscesses on her arms and legs, a rectal sore penetrating to the bone, fractured vertebrae, deformed hands and feet, swollen joints, and gangrene from steroid treatment."⁴⁸ Five days before her death, Mrs. Boyes pleaded for an injection to end her life. She was no longer absorbing diamorphine in doses of fifty milligrams an hour and she "howled and screamed like a dog"⁴⁹ when anyone touched her.⁵⁰ Two days before Mrs. Boyes' death, Dr. Cox wrote in his notes, "[s]he still wants out and I don't think we can reasonably disagree."⁵¹ After attempting unsuccessfully to ease her pain with one hundred milligrams diamorphine, he injected two ampoules of potassium chloride, and recorded this in the notes.⁵² Mrs. Boyes died peacefully within a minute or two of the injection. The cause of her death was recorded as bronchopneumonia, and her body was cremated.⁵³

Cox was discovered when a Catholic nurse who was relieving on the ward read the notes and reported the matter to hospital authorities, who then informed police. In the absence of a body, and the risk in asking a jury to convict for murder (which carries a mandatory life sentence in

Cir. 1996)); and New Zealand (Auckland Area Health Board v. Attorney-General, [1993] 1 N.Z.L.R. 235, 252 & 253).

⁴⁵ Henry Palmer, *Dr. Adams' Trial for Murder*, CRIM. L. REV. 365, 375 (1957).

⁴⁶ Clare Dyer, *Rheumatologist Convicted of Attempted Murder*, 305 BRIT. MED. J. 731 (1992).

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ Diana Brahams, *Euthanasia: Doctor Convicted of Attempted Murder*, 340 LANCET 782, 782 (1992).

⁵² Dyer, *supra* note 46, at 731.

⁵³ Brahams, *supra* note 51, at 782.

Britain), Cox was charged with attempted murder.⁵⁴ As Sir Harry Ognall, the presiding judge, later remarked, the principal strength of an English jury is that it will frequently say "[t]o hell with the law—to convict this person would not be fair."⁵⁵ Nevertheless, Justice Ognall rejected the argument that Cox's intention in injecting lethal quantities of a drug which did not possess analgesic properties was to relieve pain, rather than to kill.⁵⁶ A distressed and crying jury found Cox guilty, and Justice Ognall, declaring that Cox had "betrayed his unequivocal duty as a physician,"⁵⁷ imposed a 12 month suspended prison sentence.⁵⁸ The General Medical Council, "tempering justice with mercy," imposed no further penalty.⁵⁹

Unlike Dr. Adams in the 1950s, and the more recent case of Dr. Arthur in 1981,⁶⁰ Dr. Cox was found guilty of a serious crime. In the United States, the best-known advocates of PAS/AVE reform have (so far) been more fortunate. In 1991, Timothy Quill, a forty-one year old intern from Rochester, New York, published an account of PAS involvement in the *New England Journal of Medicine*. Earlier, in 1989, Quill had been one of twelve physicians who had written an article about the care of hopelessly ill patients for the *Journal*, which stated that "all but two of us . . . believe that it is not immoral for a physician to assist in the rational suicide of a terminally ill person."⁶¹

⁵⁴ Brahams, *supra* note 51, at 782.

⁵⁵ The Honourable Mr. Justice Ognall, *A Right to Die? Some Medico-Legal Reflections*, 62 MEDICO-LEGAL J. 165, 168-69 (1994).

⁵⁶ *Id.* at 170.

⁵⁷ *The Final Autonomy*, 340 LANCET 757, 758 (1992) (editorial).

⁵⁸ *Id.*

⁵⁹ R. T. Shepherd, *Untitled*, 60 MEDICO-LEGAL J. 227, 229 (1992).

⁶⁰ Dr. Leonard Arthur, an experienced consultant pediatrician, was charged with the murder of a Down Syndrome child rejected by its parents. This charge was later reduced to attempted murder. Dr. Arthur had written, "Parents do not wish it [the baby] to survive. Nursing care only." The doctor prescribed the drug dihydrocodeine (DF 118), a morphine-type drug, which alleviates stress. Diana Brahams, *Acquittal of Paediatrician Charged After Death of Infant with Down Syndrome*, 2 LANCET 1101, 1101 (1981). The defense argued that Dr. Arthur's intention was to put the baby on a "holding operation until a decision was made about his future or until something overtook the child which caused death." *Judge Tells Jury to Examine Baby Doctor's Intention*, THE TIMES (London), Nov. 5, 1981, at 2. The prosecution, on the other hand, argued that the child was doomed from the start, and that Arthur took the view that a handicapped child rejected by its parents was better off dead. The evidence showed, however, that the baby's health was such that it could have died at any moment; the judge observing that "hope of infection was realized rather more swiftly than anyone may have thought." The case arose because an unidentified informer reported Dr. Arthur to an organization called "LIFE," which alleged to police that the child had been starved to death. Dr. Arthur died from a brain tumor six months following his acquittal. Diana Brahams, *Doctors in the Dock: the Last Sixty Years*, 60 MEDICO-LEGAL J. 227, 228 (1992). See also *Women Cry 'Thank God' as Dr. Arthur is Cleared*, THE TIMES (London), Nov. 6, 1981, at 2; *Baby Had 80% Chance of Survival, Doctor Trial Told*, THE TIMES (London), Nov. 4, 1981, at 4.

⁶¹ Sydney H. Wanzer et. al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844, 848 (1989).

In his 1991 article, Quill detailed the case of Diane, a terminally ill patient with leukemia who refused aggressive treatment and asked for a prescription of barbiturates to enable her to commit suicide, according to a Hemlock Society recipe.⁶² Quill stated:

I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.⁶³

Quill ensured that Diane knew the quantities of drug required to commit suicide, and met with her one final time before she took her life.⁶⁴

When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.⁶⁵

Two days later, having said goodbye to her husband and son, Diane suicided.⁶⁶ Quill certified the cause of death as acute leukemia “to protect all of us, to protect Diane from an invasion into her past and her body, and to continue to shield society from the knowledge of the degree of suffering that people often undergo in the process of dying.”⁶⁷

Following the publication of Quill’s article on “Diane,” the Rochester District Attorney declined to prosecute Quill, noting that prosecutors could not prove a crime without a body. An anonymous tip, however, later revealed the true identity of “Diane.” This enabled investigators to trace her body to a Community College, where it had been stored for dissection.⁶⁸ Quill later appeared before a Grand Jury, which

⁶² Timothy E. Quill, *Death and Dignity: A Case of Individualised Decision Making*, 324 *NEW ENG. J. MED.* 691, 693 (1991).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.* at 694.

⁶⁸ William Glaberson, *Panel to Decide: Should Doctor Who Aided Suicide be Tried?* *N.Y. TIMES*, July 22, 1991, at B1.

refused to indict him.⁶⁹ Assisted by the Seattle-based organization, Compassion in Dying, Quill subsequently sought to overturn New York State law prohibiting assisted suicide on the basis that it violated the Fourteenth Amendment of the United States Constitution. While unsuccessful in the lower courts,⁷⁰ in April 1996, as noted above, the Second Circuit upheld Quill's appeal.⁷¹

It is interesting to note that Quill, who supports the legalization of assisted suicide, but not active euthanasia,⁷² published his account of Diane's experience in order to present an alternative to Kevorkian-style suicides.⁷³ Quill has observed of Kevorkian that "[s]uicide is the sole basis for the relationship he has with his patients, and that is frightening."⁷⁴ As with other admissions of PAS/AVE in the medical literature,⁷⁵ Quill's actions sparked a vigorous response. One well-known opponent of PAS/AVE argued that legalized assisted suicide would gradually lead doctors to progress from "awaiting the patient's decision and readiness, to subtle elicitation of a request for death."⁷⁶ Pellegrino argues that "compassion is a virtue, not a principle," that "[c]ompassion, too, must be subject to moral analysis"⁷⁷ and that the moral psychology

⁶⁹ Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1.

⁷⁰ Quill v. Koppell, 870 F. Supp 78, 84 (S.D. N.Y. 1994); See also *Court Urged to End Ban On Help With Suicide*, N.Y. TIMES, Sept. 2, 1995, at A23.

⁷¹ Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).

⁷² Timothy E. Quill et. al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1381 (1992).

⁷³ Glaberson, *supra* note 68, at B1.

⁷⁴ Tom Morganthau et. al., *Dr. Kevorkian's Death Wish*, NEWSWEEK, Mar. 8, 1993, at 46-48, (quoted in Greg Pence, *Dr. Kevorkian and the Struggle for Physician-Assisted Dying*, 9 BIOETHICS 62, 69 (1995)). Quill and others have published proposed criteria for physician-assisted suicide within the wider context of compassionate palliative care. See Quill, *supra* note 72, at 1381-82. Quill has encouraged doctors to explore the significance of patients' requests for assistance in dying, noting that "[p]atients need our assurance that, if things get horrible, undignified or intolerable, we will not abandon them, and we will continue to work with them to find acceptable solutions." Timothy E. Quill, *Doctor, I Want to Die. Will You Help Me?* 270 JAMA 870, 873 (1993). See also TIMOTHY E. QUILL, M.D., *DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE* 155-75 (1993).

⁷⁵ See, e.g., *It's Over, Debbie*, 259 JAMA 272 (1988). This article provided a first-person account of a gynecology resident rotating through a large private hospital, who was called out in the middle of the night to attend a twenty-year old patient dying from ovarian cancer. The patient had unrelenting vomiting caused by a sedating alcohol drip, her breathing was labored, and she had not eaten or slept in two days. *Id.* "It was a gallows scene," the doctor wrote, "a cruel mockery of her youth and unfulfilled potential. Her only words to me were "Let's get this over with." *Id.* The resident performed euthanasia on the patient, injecting 20mg of morphine sulfate. *Id.* Publication of the article caused a storm of protest and debate. See, e.g., Letters, 259 JAMA 2094, 2094-98 (1988). Also in response to the article, four medical ethicists wrote, "This is, by his own account, an impulsive yet cold technician, arrogantly masquerading as a knight of compassion and humanity." Willard Gaylin et. al., *Doctors Must Not Kill*, 259 JAMA 2139, 2139 (1988).

⁷⁶ Edmund D. Pellegrino, *Compassion Needs Reason Too*, 270 JAMA 874-75 (1993).

⁷⁷ *Id.*

behind the act of killing does not justify the act.⁷⁸ In contrast, other bioethicists argue that "absolutist principles must always be chastened by mercy."⁷⁹

No discussion of PAS/AVE advocacy could be complete without mentioning Jack Kevorkian, the Detroit-based, retired pathologist, who, on September 7, 1996, assisted in his 40th suicide.⁸⁰ Although no stranger to controversy on bioethics issues,⁸¹ Kevorkian's notoriety took a new turn when on June 4, 1990, he drove Janet Adkins, a fifty-four year-old mother of three with recently diagnosed Alzheimer's disease, to a suburban campsite where she committed suicide in the back of Kevorkian's rusty Volkswagen van, using his widely-publicized "suicide machine" to release a lethal cocktail of drugs into her bloodstream.⁸² Prior to this, Kevorkian had scouted southeastern Michigan in vain for a clinic, church or funeral home which would allow him to supervise suicides on its premises.⁸³ The Adkins suicide troubled Hemlock Society founder Derek Humphry, who stated, "[i]t's not death with dignity to have to travel 2,000 miles from home and die in the back of a camper."⁸⁴

Although Kevorkian was charged with first degree murder following Adkin's death, the charge was dismissed because Michigan did not have, at the time, any law prohibiting assisted suicide.⁸⁵ Effective on February 25, 1993, however, Michigan enacted legislation which made it a felony to assist in suicide, with a penalty of up to four years in prison. The legislation was temporary, while a state-appointed Commission studied the issue.

On August 4, 1993, Kevorkian attended his seventeenth assisted suicide, the first after the new law. According to evidence which emerged at trial, Kevorkian picked up Thomas Hyde, a thirty year-old landscaper with Lou Gehrig's disease, drove him into a parking space behind Kevorkian's apartment, and fixed a mask over his face. Although Lou

⁷⁸ *Id.* at 875.

⁷⁹ Kenneth L. Vaux, *Debbie's Dying: Mercy Killing and the Good Death*, 259 JAMA 2140, 2141 (1988).

⁸⁰ *Kevorkian Assists Isabel Correa*, ERGO! NEWS BULLETINS (Sept. 7, 1996) <http://www.islandnet.com/deathnet/ergo_news14.html>.

⁸¹ See Ivar Peterson, *In One Doctor's Way of Life, a Way of Death*, N.Y. TIMES, May 21, 1995, at A14 (profile of Kevorkian).

⁸² Timothy Egan, *As Memory and Music Faded, Oregon Woman Chose Death*, N.Y. TIMES, June 7, 1990, at A1; Melinda Beck et. al., *The Doctor's Suicide Van*, BULLETIN (Austl.), June 19, 1990, at 80.

⁸³ Isabel Wilkerson, *Physician Fulfills a Goal: Aiding a Person in Suicide*, N.Y. TIMES, June 7, 1990, at D22.

⁸⁴ Melinda Beck et. al., *The Doctor's Suicide Van*, BULLETIN (Austl.), June 19, 1990, at 81.

⁸⁵ *Michigan Court Bars Doctor From Using His Suicide Machine*, N.Y. TIMES, Feb. 6, 1991, at A13.

Gehrig's disease causes the eventual loss of all motor function, Hyde could still move his left hand, which he used to remove a clip, thus starting the flow of carbon monoxide gas.⁸⁶ Kevorkian began using carbon monoxide poisoning as a method of achieving suicide after his licence to practice medicine in Michigan was revoked in 1991, thus making it impossible to buy or prescribe the drugs needed for his "suicide machine."

Kevorkian was charged under the new Michigan law for assisting suicide. While on bail, however, he assisted in three more suicides, vowing to go on a hunger strike if jailed.⁸⁷ Kevorkian was jailed on November 30, after refusing to post \$50,000 bond for charges stemming from suicide nineteen, involving a seventy-two year-old woman with Lou Gehrig's disease.⁸⁸ Kevorkian began a hunger strike which continued for over two weeks, and only ended after his bond was reduced to \$100 and paid by a supporter.⁸⁹

In January 1994, a county circuit court declared Michigan's anti-assisted suicide law unconstitutional. All outstanding charges against Kevorkian were dismissed, with the exception of those relating to Thomas Hyde.⁹⁰ At the trial in April 1994, Kevorkian admitted knowledge of the Michigan law which made assisted suicide a felony, but relied upon an exception in the statute, which exempted procedures which hasten or increase the risk of death, where the intent is to "relieve pain and discomfort and not to cause death." After nine hours of deliberations, the Detroit jury of nine women and three men acquitted Kevorkian, citing uncertainties over his motive, the wisdom of the Michigan law, and the place of death.⁹¹

Following the Hyde case came an unsuccessful Kevorkian-sponsored drive to raise the 256,000 signatures needed to qualify for a citizen-initiated referendum on assisted suicide in Michigan.⁹² In late November 1994, Kevorkian performed his twenty-first case of "medicide," his first since the Hyde trial. Kevorkian's assistance to Margaret Garrish, a seventy-two year-old Detroit housewife whose

⁸⁶ Don Terry, *Kevorkian Assists in Death of His 17th Suicide Patient*, N.Y. TIMES, Aug. 5, 1993, at A14.

⁸⁷ *Kevorkian Apartment Used in Suicide*, NEWSDAY, Nov. 23, 1993, at 18.

⁸⁸ *Mixed Kevorkian Rulings*, NEWSDAY, Dec., 15, 1993, at 17.

⁸⁹ David Lowder, *Kevorkian Free, Vows No Deaths*, CHI. SUN-TIMES, Dec. 18, 1993, at 9.

⁹⁰ *Aided-Suicide Law Invalidated Again*, N.Y. TIMES, Jan. 28, 1994, at A17; *Trial is Ordered for Suicide Doctor*, N.Y. TIMES, Feb. 19, 1994, at A9.

⁹¹ David Margdick, *Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide*, N.Y. TIMES, May 3, 1994, at A1; Julia Prodis, *Special State Law Fails to Stop "Dr Death"*, AUSTRALIAN, May 4, 1994, at 16.

⁹² *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, at A14.

ailments included rheumatoid arthritis, advanced osteoporosis and severe colon disorders, came just hours after the expiration of the Michigan anti-suicide law, which had a sunset clause.

By late 1994, state appeals over the issue of whether the (now expired) Michigan law against assisted suicide infringed the United States Constitution finally reached the Michigan Supreme Court. The court held that the law did not infringe the Constitution. Importantly, however, the Michigan Court also stated that assisted suicide could be prosecuted in the absence of a statute, as a common law felony.⁹³

Undeterred by the refusal of the United States Supreme Court to review the Michigan Supreme Court decision, Kevorkian assisted his twenty-second and twenty-third suicides in May 1995, exposing himself to felony charges under common law.⁹⁴ Number twenty-three, Nicholas Loving, a twenty-seven year-old college student from Arizona suffering from Lou Gehrig's disease, died in a "sanctuary house" in suburban Detroit. His body was later left in the parking lot of the County Medical Examiner.⁹⁵ Number twenty-four, a Kansas woman with Lou Gehrig's disease, died in an abandoned building which Kevorkian briefly rented and called a "mercy clinic."⁹⁶ His Volkswagen impounded, Kevorkian's twenty-fifth patient was left under a sheet in the back seat of an old Renault purchased by Kevorkian. The Renault was parked outside the emergency department of a large hospital.⁹⁷

On March 8, 1996, after deliberating for two days, Kevorkian was acquitted for a second time by a jury in Pontiac, Michigan, for assisting the self-administration of carbon monoxide in suicides nineteen and twenty.⁹⁸ Subsequently, protesting a decision to charge him under Michigan common law for suicides two and three in 1991, Kevorkian donned a white wig, tricorner hat, blue britches, gold brocade coat and buckle shoes, saying "[i]t's silly to have modern dress when you're dealing with ancient jurisprudence."⁹⁹ On May 14, 1996, Kevorkian was acquitted in relation

⁹³ The Michigan legislature has since been unable to resolve political differences and to capitalize on this ruling by enacting a new anti-suicide law. *Kevorkian Vows to Keep Fighting Laws Barring Assisted Suicide*, N.Y. TIMES Dec. 18, 1994, at A43.

⁹⁴ James Bennet, *Dr. Kevorkian Assists at His 22nd Suicide*, N.Y. TIMES, May 9, 1995, at A20; *Kevorkian Once Again Aids Suicide*, N.Y. TIMES, May 13, 1995, at A6.

⁹⁵ *Woman Dies at Kevorkian Clinic*, N.Y. TIMES, June 27, 1995, at A12.

⁹⁶ Scoffing at questions, Fieger, Kevorkian's lawyer, told reporters, "I know of no zoning regulations against the prevention of suffering." *Id.*

⁹⁷ *In Assisted Suicide, Body Is Left Near Hospital*, N.Y. TIMES, Aug. 22, 1995, at A13.

⁹⁸ These suicides, performed in 1993, followed the Hyde case, and came after the Michigan felony suicide law was enacted. *Kevorkian Acquitted of All Charges*, ERGO! NEWS BULLETINS, ¶ 1 (Mar. 8, 1996) <http://www.islandnet.com/deathnet/ergo_news8.html>.

⁹⁹ *Kevorkian: Trial or Witch-Hunt?* ERGO! NEWS BULLETINS, ¶ 2 (Apr. 2, 1996) <http://www.islandnet.com/deathnet/ergo_news9.html>.

to these charges by a jury of six men and six women, having assisted in his twenty-eighth suicide between sessions in the witness stand.¹⁰⁰ As the verdict was announced, Kevorkian's lawyer leaned across the table to the prosecutor and proclaimed "You're out of a job."¹⁰¹ On May 6, 1996, Kevorkian assisted the death of Canadian PAS advocate Austin Bastable, who suffered from chronic progressive multiple sclerosis. After his death, Bastable's body was whisked back across the border to Windsor, Ontario.¹⁰²

Kevorkian's crusade shows little signs of slowing. On August 23, 1996, for example, Kevorkian assisted in his third and fourth suicides for the week. The suicides were about nine hours apart. After dropping off a corpse at a local hospital, Kevorkian was stopped by police, and was arrested after calling them Nazis. On September 7, 1996, he assisted in his fortieth suicide, hours after police raided the motel where he was providing counseling.¹⁰³ More recently, however, the Supreme Court refused to hear an appeal from a Michigan court which had issued an injunction against Kevorkian from using his "suicide machine," or any other means, to end human life.¹⁰⁴

More than anyone else, Kevorkian has brought medically-assisted suicide into the American public arena. According to his friend, Dr. Stanley Levy, "[h]e is the only one to do it, because the medical profession won't. The profession's response is the hospice system. It says '[y]ou can die, but you have to take your time doing it.'"¹⁰⁵ While the legal repercussions of Kevorkian's actions are still continuing, an eventual conviction is far from certain.¹⁰⁶ Opinion polls still favour Kevorkian, who says bluntly, "[i]t's all a farce, and I don't care for these legal games. This is not illegal, no matter what they say, and the common people know it and support me."¹⁰⁷

While the Kevorkian crusade is unusual for its intensity and legal maneuvers, it is important to stress that the wider euthanasia debate is not a local or an isolated phenomenon. The debate sparked in Australia by the "Melbourne Seven," in the United States by Quill and Kevorkian, in

¹⁰⁰ *Kevorkian Acquitted—For the Third Time*, ERGO! NEWS BULLETINS, ¶ 6 (May 14, 1996) <http://www.islandnet.com/deathnet/ergo_news10.html>.

¹⁰¹ *Id.*

¹⁰² *Toronto: Austin Bastable Dies with the Aid of Dr. Jack Kevorkian*, LAST RIGHTS' NEWS BULLETINS (May 6, 1996) <http://www.rights.org/~deathnet/last_rights.html>.

¹⁰³ *Kevorkian Assists Isabel Correa*, *supra* note 80.

¹⁰⁴ *Judges Switch Off Dr. Death's Apparatus*, AUSTRALIAN, Oct. 17, 1996, at 9.

¹⁰⁵ Peterson, *supra* note 81, at A14.

¹⁰⁶ Doctor Seeks to Quash Case of Murder in Suicide Deaths, N.Y. TIMES, Aug. 30, 1995, at A12.

¹⁰⁷ *Id.*

England by Cox, and in Canada by the *Rodriguez* case,¹⁰⁸ is the same debate. In each of these countries, the social and jurisprudential debate shares common features. Doctors involved in PAS/AVE are no longer the grotesque embodiments of the freakish fringe. On the contrary, they have been able to confidently confront the traditional Hippocratic injunction against killing while achieving a large measure of public support. Moreover, their ability to largely escape the legal consequences of their actions points to profound changes both within the medical profession, and society generally.

b. *The fragmentation of medical opinion over PAS/AVE*

Quill, Kevorkian and colleagues are the tip of the iceberg; they are spokespersons for the substantial segment of the medical profession that now favors PAS/AVE reform. Nevertheless, this shift in medical opinion is yet to be reflected in the expressed views of professional bodies such as the Australian and American Medical Associations. The participation of these bodies is critical to the process of national law reform, in view of the ownership and control that such bodies seek to exercise over questions of health policy and ethics.

A review of recent studies bears out the fragmentation of medical practitioners' attitudes towards PAS/AVE reform. Lee et al, in a 1996 study of 2761 Oregon doctors, reported that 66% regarded physician-assisted suicide (PAS) as ethical in some cases, and 60% supported legalization in some cases. Forty-six percent indicated they might be willing to prescribe a lethal drug dose for a terminally ill patient if this was legal, although 52% had moral objections. Twenty-one percent (570

¹⁰⁸ National debate over PAS/AVE in Canada was sparked by the case of Sue Rodriguez, a 43-year old secretary from Victoria, British Columbia, who died with the assistance of an unknown doctor on 12 February 1994. Rodriguez began widely publicized legal proceedings, claiming that the prohibition of assisted suicide violated the Canadian Charter of Rights and Freedoms (the Canadian Bill of Rights). Although narrowly unsuccessful (five-to-four) in the Canadian Supreme Court (*Rodriguez v. British Columbia*, [1993] 107 D.L.R.4th 342), Rodriguez met federal MP Svend Robinson during her campaign, who held Rodriguez in his arms as she died peacefully, assisted by a doctor whom he refused to name. Keith Baldrey & Peter O'Neill, *MP Refuses to Name Doctor Who Helped in Suicide Death*, VANC. SUN, Feb. 15, 1994, at A1, B6. In a videotaped appeal to the Commons Standing Committee on Justice in Ottawa in 1992, Rodriguez had argued, "If I cannot give consent to my own death, then whose body is this? Who owns my life?" Robert Mason Lee, *Tributes Pour in as Brave Struggle Finally Ends for Sue Rodriguez: Assisted Suicide Ends Life of Woman Who Galvanized Nation*, VANC. SUN, Feb. 14, 1994, at A3. Following her suicide, a special prosecutor held that there was insufficient evidence to press charges against Robinson. Justine Hunter, *Charges Ruled Out Against MP*, VANC. SUN, June 29, 1995, at B1. The identity of the doctor involved has never been revealed. For further discussion of euthanasia in the Canadian context, see Russel Ogden, *The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying*, 20 CAN. PUB. POL'Y 1 (1994).

doctors) had been asked by a patient for a prescription for a lethal dose and 7% had complied.¹⁰⁹

These levels of support are consistent with a 1996 study by Bachman et al. of 1,119 Michigan physicians.¹¹⁰ Fifty-six percent of physicians preferred the legalization of PAS to an explicit ban (37% opposed), although given a wider range of choices, 40% preferred legalization, 37% preferred no government regulation, and 17% preferred prohibition. Thirty-five percent thought they might participate in PAS if it were legal, and 22% in active voluntary euthanasia.¹¹¹

Similar results emerge from studies carried out within medical specialties. A 1995 study of Michigan oncologists reported 18% and 4% participation in assisted suicide and active euthanasia, respectively, against a background of 21% in favor of 44% unsure of and 35% in opposition to hypothetical legislation legalizing assisted suicide.¹¹² Levels of support amongst anesthesiologists are considerably higher.¹¹³ A 1992 study of San Francisco physicians specializing in AIDS and Human Immunodeficiency Virus ("HIV"), reported that almost a quarter of respondents would be prepared to prescribe a lethal dose of medication to a competent terminally ill patient with AIDS.¹¹⁴ Interestingly, a 1995 survey of members of the Australian Society for HIV Medicine reported that nearly one in five doctors had helped an HIV patient to die, responding to 52% of patient requests for assistance.¹¹⁵

The American experience discussed above is not unique. Ward and Tate in a 1994 English study of 312 doctors reported that 124 of 273 doctors answering the question had been requested by a patient to hasten death; 12% of respondents complied.¹¹⁶ Forty-six percent indicated they would consider taking active steps to achieve a patient's death if it were legal.

¹⁰⁹ Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310 (1996).

¹¹⁰ Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303 (1996).

¹¹¹ *Id.*

¹¹² David J. Doukas et al., *Attitudes and Behaviours on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. CLIN. ONCOL. 1055, 1057-58 (1995).

¹¹³ D. M. Rotherberg & R. J. McCarthy, *Anesthesiologists' Perspectives on Physician-Assisted Death: A Survey of Anesthesiologists in the United States*, 77 ANESTHESIOLOGY A1082 (1992).

¹¹⁴ Lee Slome et al., *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. ACQ. IMM. DEF. SYND. 712 (1992).

¹¹⁵ Justine Ferrari, *Doctors Help in HIV Patients' Suicides*, AUSTRALIAN, Nov. 17, 1995, at 3.

¹¹⁶ B.J. Ward & P. A. Tate, *Attitudes Among NHS Doctors to Requests for Euthanasia*, 308 BRIT. MED. J. 1332 (1994).

In Australia, Baume and O'Malley's 1994 study of 1268 doctors in New South Wales and the Australian Capital Territory reported that 46% of respondents had been asked by a patient to hasten his or her death, 28% of whom had complied with the request (12.3% of all respondents). Eighty percent of the doctors who had performed euthanasia had done so more than once. Fifty-nine percent agreed in principle that active euthanasia is sometimes right, and 58% called for legal change.¹¹⁷ Data from other select Australian studies are summarized in Table 1.¹¹⁸ In each of these studies, an overwhelming majority of doctors who admitted to having performed active euthanasia upon a patient were confident that they had done the right thing.¹¹⁹ The role of nurses in performing euthanasia has been largely ignored in the debate. While not reviewed here, studies show significant levels of involvement.¹²⁰

¹¹⁷ Peter Baume & Emma O'Malley, *Euthanasia: Attitudes and Practices of Medical Practitioners*, 161 *MED. J. AUSTL.* 137, 144 (1994).

¹¹⁸ Helga Kuhse & Peter Singer, *Doctors' Practices and Attitudes Regarding Voluntary Euthanasia*, 148 *MED. J. AUSTL.* 623 (1988); Helga Kuhse & Peter Singer, *Euthanasia: A Survey of Nurses' Attitudes and Practices*, 21 *AUSTL. NURSES J.* 21 (1992); Christine A. Stevens & Riaz Hassan, *Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia*, 20 *J. MED. ETHICS* 41, 43 (1994).

¹¹⁹ Stevens & Hassan reported, however, that 13% of sixty-seven doctors who had performed active euthanasia considered that they had not done the right thing, and 18% did not think such action was ever "right." Christine A. Stevens & Riaz Hassan, *Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia*, 20 *J. MED. ETHICS* 41, 43 (1994).

¹²⁰ See David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 *NEW. ENG. J. MED.* 1374 (1996) (reviewing a number of studies, and reporting on a survey of 1600 nurses, 1139 of whom responded and 852 of whom indicated they practiced exclusively in critical care units. Of the 852, 141 (17%) had received requests for assisted suicide or euthanasia, 129 (16%) had engaged in such practices, and an additional 4% hastened patients' deaths by only pretending to provide physician-ordered life-support).

Table 1			
Health Care Workers' Attitudes to Active Voluntary Euthanasia: Australian Studies			
Study	In-principle Support	Compliance with Patient Requests	Law Reform
<p>Kuhse & Singer: 869 Victorian doctors (1988)</p> <p>*Sample: 1893 (46% response rate)</p>	<p>It is sometimes right for a doctor to take active steps to end a patient's life at the patient's request: 62% to 34% in favour</p>	<p>*40% of doctors (354) asked by patient to hasten death;</p> <p>*29% (107) of 369 doctors had taken active steps to end a patient's life</p>	<p>60% to 37% in favor of pro-euthanasia law reform</p>
<p>Kuhse & Singer: 951 Victorian nurses (1992)</p> <p>*Sample: 1942 (49% response rate)</p>	<p>75% to 25% support in favour of Australia adopting the Netherlands situation permitting active voluntary euthanasia in certain circumstances</p>	<p>*55% of nurses (502) asked by patient to hasten death, 333 nurses received requests for direct assistance;</p> <p>*5% (of 333) took active steps to hasten death without a doctor's request; 25% (of 502) were requested by a doctor to take active measures to end a patient's life and 85% of this number complied</p>	<p>78% of respondents in favor of pro-euthanasia law reform</p>
<p>Stevens & Hassan: 298 South Australian doctors (1994)</p> <p>*Sample: 494 (60% usable returns)</p>	<p>Is it ever right to bring about the death of a patient by active steps? 18% said yes, 26% said yes, but only if requested by the patient</p>	<p>*33% of doctors asked by patient to hasten death by taking active steps; 19% (56) had complied with the request</p>	<p>45% in favor of legalization of active euthanasia (39% opposed)</p>
<p>Baume & O'Malley: 1268 New South Wales and ACT doctors (1994)</p> <p>*Sample: 1667 (76% response rate)</p>	<p>59% agreement that it is sometimes right for a doctor to take active steps to bring about a patient's death</p>	<p>*46.4% of doctors asked by patient to hasten death; of those asked, 28% had complied with the request (12.3% overall); 7% had provided the means for suicide</p>	<p>58% in favor of changing the law to permit active voluntary euthanasia</p>

c. *Issues in the medical debate*

While levels of support for PAS/AVE reform within the medical profession probably do not approach levels of support within the community generally, such support does appear to have reached the critical mass where it can now be said (at least in some States) that a

majority of the medical profession supports reform.¹²¹ The current conservatism of bodies such as the Australian Medical Association ("AMA") is obscuring this fact, while also providing a convenient shield for politicians reluctant to handle a "hot potato." In Australia, for example, the opposition of the Victorian Branch of the AMA is well known, and the Victorian Premier has indicated that he will not consider euthanasia law reform until the medical community shows overwhelming support for it.¹²² Since the process of legalized euthanasia requires doctors to play a central role, legislation introduced over the protest of significant sections of the medical profession could hardly command public confidence. This may explain the reluctance of bodies such as the Victorian Branch of the AMA to survey its own membership.¹²³ A pro-euthanasia result could only fuel the reform process.

Part of the opposition to pro-euthanasia law reform is the perception that palliative care can adequately relieve pain and distress, thereby obviating the need for a "euthanasia escape route."¹²⁴ Conversely, there is also the concern that legalized euthanasia would enable doctors inexperienced in palliative care to "legally eliminate the problem by eliminating the patient."¹²⁵ Baume and O'Malley, reflecting on the implications of their survey study,¹²⁶ conclude that the levels of participation in illegal euthanasia suggest "a substantial level of need among patients for symptom relief which current arrangements do not provide."¹²⁷ Palliative care physicians, however, appear generally opposed to euthanasia. A prominent Australian specialist has noted that "good pain control can be achieved, employing standard techniques as well as input from the multidisciplinary team, for more than 90% of patients with advanced cancer."¹²⁸

One Australian palliative care specialist who has broken ranks is Adelaide hospice physician Roger Hunt, who replies:

But what can be done for those patients who have unresolvable pain? And what about common problems such

¹²¹ See Baume & O'Malley, *supra* note 117. See also *Doctors in Death's Shadow*, AUSTRALIAN, Jan. 9, 1997, at 13.

¹²² Telephone Interview with the Honourable Jeffrey Kennett (Apr. 8, 1995).

¹²³ Rachel Gibson, *Australia: Euthanasia Survey Idea Rejected*, THE AGE (Melb.), Mar. 31, 1995, at 5.

¹²⁴ *Id.*

¹²⁵ Brian J. Pollard, 161 MED. J. AUSTRAL. 572 (1994) (letter).

¹²⁶ Baume & O'Malley, *supra* note 117, and accompanying text.

¹²⁷ Baume & O'Malley, *supra* note 117, at 142.

¹²⁸ Roger Woodruff, *Facts Needed to Balance Doctors' Euthanasia Push*, THE AGE (Melb.), Mar. 30, 1995, at 12.

as weakness, loss of independence, incontinence, loss of dignity and a sense of meaninglessness due to a progressively diminishing quality of life? Such problems cannot be eliminated by palliative care teams.¹²⁹

Conceding that palliative care has its limitations, other specialists point to "inevitable, uncontrollable and probably undetectable abuse,"¹³⁰ that would follow legalized euthanasia, adding that "[k]illing the failures of medical or social care would be negative, in that it would not contribute to finding solutions to their problems."¹³¹ On this view, re-defining the doctor's role to include killing, in addition to the established functions of healing and comforting, will eventually undermine medical skills, and retard medical progress.

Closely associated with this concern is the fear that legalized euthanasia will lead to a devaluation of palliative care, including inadequate development and funding of palliative care services. Many would be alarmed at the statement contained in the Court opinion in the *Compassion in Dying* case; that "we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration."¹³² Nevertheless, the resources to eradicate completely any economic incentive for euthanasia are as remote as ever, particularly in the United States, which lacks a comprehensive, publicly funded, health insurance system.

It is important to distinguish between the issue of economics and medical resources, and the related (although understated) issue of the regulation of medical practice. Euthanasia is already practiced by a substantial number of doctors, many of whom are nevertheless opposed to legalization.¹³³ One critic, for example, asserts that "[t]he Australian Medical Association doesn't like euthanasia because it might lead to increased State regulation of their highly individualistic profession."¹³⁴

¹²⁹ Roger Hunt, *Legislative Reform is Needed*, THE AGE (Melb.), Apr. 7, 1995, at 16.

¹³⁰ Pollard & Winton, *supra* note 26, at 427.

¹³¹ Pollard & Winton, *supra* note 26, at 428.

¹³² *Compassion in Dying*, 79 F.3d at 826.

¹³³ Data emerging from an Australia/Californian qualitative study of PAS/AVE within the HIV community coordinated by the writer confirms the "network" or "underground" in PAS/AVE services. This study, to be published by Melbourne University Press, is due to appear in late 1997.

¹³⁴ Beatrice Faust, *Give Patients Free Will Over Life and Death*, WEEKEND AUSTRALIAN, June 10-11, 1995, at 26.

3. *The Right to Die Societies*

“Right-to-Die” societies and civil liberties groups are at the forefront of the euthanasia debate, campaigning vigorously, funding research,¹³⁵ funding and bringing lawsuits,¹³⁶ in an effort to influence the other players in the debate. While opponents dislike their methods,¹³⁷ they are probably no different from other political lobbying groups.

An interesting 1993 study of the attitudes of members of the Hemlock Society, and the California Pro-Life Council (“CPLC”), confirmed that “[c]hristian religious training most influenced opposition to euthanasia, whereas death-proximate experiences most influenced approval of euthanasia.”¹³⁸ Similarly, “[t]he largest proportion of the CPLC members identified themselves as Catholic and as believers in a consequential afterlife, whereas the largest proportion of Hemlock respondents described themselves as atheist/agnostic and as not believing in an afterlife.”¹³⁹ Broadly speaking, euthanasia societies can be seen as in the vanguard of a new, more secular and individualistic world view, promoting social policies that are ideologically opposed to the more communitarian ethos embodied in the attitude of the Catholic church.

4. *The Churches*

Religion makes sparks fly in the euthanasia debate. Churches are seen, and see themselves, as major players in issues involving morals and ethics. Anderson and Caddell claim that religious opposition to euthanasia, particularly from conservative churches within the Judeo-Christian tradition, focuses around three ideas: resistance to playing God, the moral injunction “Thou Shalt Not Kill,” and the potential spiritual benefits of suffering.¹⁴⁰ The opposition of the Catholic church, in particular, is widely known. In 1980, the Vatican confirmed that “nothing and no one can in any way permit the killing of an innocent human being,

¹³⁵ See, e.g., Baume & O’Malley, *supra* note 117.

¹³⁶ See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 826.

¹³⁷ See, e.g., B.A. Santamaria, *A Prayer for the Dying*, WEEKEND AUSTRALIAN, June 3-4, 1995, at 24.

¹³⁸ J. Holden, *Demographics, Attitudes, and Afterlife Beliefs of Right-To-Life and Right-To-Die Organization Members*, 133 J. SOC. PSYCHOL. 521, 525 (1993).

¹³⁹ *Id.* at 526.

¹⁴⁰ James G. Anderson & David P. Caddell, *Attitudes of Medical Professionals Toward Euthanasia*, 37 SOC. SCI. & MED. 105, 106 (1993).

whether a foetus or an embryo, an infant or an adult, an old person or one suffering from an incurable disease, or a person who is dying.”¹⁴¹

a. *Religion and euthanasia attitudes*

Studies demonstrate a correlation between “depth of religious commitment” and attitudes towards euthanasia. Caddell and Newton, reviewing the General Social Survey conducted by the National Opinion Research Center upon 8,384 American respondents from 1977 to 1988, conclude that acceptance of PAS/AVE “decreased as religious self-perception increased, with those perceiving themselves as having strong religious attachments being the least likely to accept active euthanasia (47.1%) and suicide (27.4%).”¹⁴² In Australia, however, as noted previously, religiosity does not appear to determine euthanasia attitudes independent of level of conservatism.¹⁴³ This is an interesting finding, since Australian culture (perhaps a remnant of convict, rather than puritan origins) is more secular than America culture, with fewer Australians having religious affiliations or attending church.

The world view which underlies a religious commitment also bears some relationship with euthanasia attitudes. Caddell and Newton’s data confirmed their hypothesis that the focus on “this world,” and the perceived importance of social action preventing present human suffering in liberal Protestant thought, would correlate with a greater acceptance of PAS/AVE. In contrast, the focus on moral absolutes and the afterlife in conservative Protestant teaching was found to correlate with the least acceptance to PAS/AVE of any religious group, including Catholics.¹⁴⁴

In Australia, the Anglican and Catholic churches, Judaism and Islam, although not yet the Uniting Church, “disapprove of active voluntary euthanasia and have teachings specifically opposed to euthanasia and to suicide.”¹⁴⁵ Nevertheless, Kuhse and Singer’s 1988 study of doctors in the Australian State of Victoria found that of the 62% of respondents supporting, in principle, active voluntary euthanasia,

¹⁴¹ Sacred Congregation for the Doctrine of the Faith, *DECLARATION ON EUTHANASIA* 7 (Vatican City, 1980), referenced from H. Kuhse, *Sanctity of Life, Voluntary Euthanasia and the Dutch Experience: Some Implications for Public Policy*, forthcoming in K. Bayertz (ed.) *SANCTITY OF LIFE & DIGNITY IN MEDICINE*.

¹⁴² David P. Caddell & Rae R. Newton, *Euthanasia: American Attitudes Toward the Physician’s Role*, 40 *SOC. SCI. & MED.* 1671, 1677 (1995).

¹⁴³ Ho & Penney, *supra* note 39.

¹⁴⁴ Caddell & Newton, *supra* note 142, at 1673, 1676.

¹⁴⁵ Peter Baume et al., *Professed Religious Affiliation and the Practice of Euthanasia*, 21 *J. MED. ETHICS* 49 (1995).

Roman Catholics were the only group not to give majority support.¹⁴⁶ Baume and O'Malley's 1994 replication of this study in New South Wales found Catholic practitioners most opposed to PAS/AVE, agnostic/atheist practitioners most sympathetic, and Protestant practitioners midway between.¹⁴⁷ Interestingly, "non-theists" were more than twice as likely to know of other doctors who practised AVE, and were more than three times more likely to think AVE to be sometimes right, compared to theist practitioners."¹⁴⁸

While Catholic practitioners were significantly different from others in the strength of their opposition to euthanasia, Baume and O'Malley did find a small minority of Catholic doctors prepared to perform AVE (18% of those asked by patients to hasten death).¹⁴⁹ Majority support amongst Catholics in the community for legalized euthanasia further supports the disjunction between official Church teaching and lay views,¹⁵⁰ and may also underscore the creeping influence of the liberal individualist ethic which is central to PAS/AVE reform.

b. *Religion, euthanasia and the media*

The clash between the received wisdom of hierarchal religions, and the individualistic ethic of secular liberals, has sparked some passionate exchanges in the media.¹⁵¹ In Australia, Melbourne's Catholic Archbishop recently expressed his Church's view, as follows:

The word euthanasia should be kept for what it correctly defines, the deliberate killing of another. Euthanasia is simply another name for the crime of homicide. In Victoria, those who commit this crime are subject to the law of the land (and of their conscience). We should not authorize any group to commit homicide on the dying.¹⁵²

He continued,

¹⁴⁶ Helga Kuhse & Peter Singer, *Doctors' Practices and Attitudes Regarding Voluntary Euthanasia*, 148 MED. J. AUSTRALIA 623, 625 (1988).

¹⁴⁷ Baume et al., *supra* note 145, at 50.

¹⁴⁸ Baume et al., *supra* note 145, at 50.

¹⁴⁹ Baume et al., *supra* note 145, at 52.

¹⁵⁰ Baume et al., *supra* note 145, at 53.

¹⁵¹ Frank Little, *There is Nothing Compassionate in a Doctor's "Mercy" Killing*, THE AGE (Melb.), Apr. 17, 1995, at 9

¹⁵² *Id.*

Does our society want the healing profession to become a killing profession? . . . To kill a dying patient is the ultimate abandonment, an irrevocable statement that you will not share their passion any longer, that you are not compassionate I believe our humanity will be seriously eroded if our response to weakness, suffering and the process of dying is euthanasia, that other name for the crime of homicide.¹⁵³

Urologist Mr. Rodney Syme, President of the Voluntary Euthanasia Society of Victoria, and one of the "Melbourne Seven," responded in terms which demonstrate the wider ideological conflict, and bitterness toward traditional religious morality,

The Catholic Church has an impressive history of reactionary behaviour, clinging to ideas pertaining to a society of 2000 or more years ago. Its rigidity and dependence on authority makes it unable to lead in important social issues. Last century it opposed cremation as a pagan practice, and opposed anaesthesia in childbirth, believing it was women's lot to suffer in this process. In this century, it has opposed artificial contraception despite the world's population growth threatening its very existence, and particularly in those Third World countries where the church has great influence. It fails to recognize the justice of women's claims to a true place in its church, based as it is on authority derived from a different time.

He concluded:

The Catholic Church argues much about intent—the intent of the doctor—but ignores the consent of the patient and the motive of the doctor. The primary intention of a doctor in assisting suicide for terminal suffering is to relieve that pain and suffering, but also recognizes that in certain circumstances, this can only finally occur by death. The doctor's motive is pure, based on compassion not, as in homicide, on greed or hate or revenge.¹⁵⁴

¹⁵³ *Id.*

¹⁵⁴ Steve Dow, *Assisted Suicide is not a Synonym for Homicide*, THE AGE (Melb.), May 17, 1995, at 15; see also *Putting Faith in Euthanasia*, THE AGE (Melb.), June 7, 1995, at 4 (discussing the religious convictions of the Melbourne Seven).

Other critics save their harshest words for the theological underpinnings of religious opposition. Columnist Beatrice Faust quips that “[absolutist] religions don’t like euthanasia because it might lead to free will.”¹⁵⁵ One commentator, Raymond Tallis, notes that “[o]nly those theologians who believe that there are more important things than human happiness feel that the dying should earn their death the hard way and go the whole distance along the tunnel of barbed wire.” He adds that one cannot feel safe at the hands of those for whom, after all, “excruciating pains have a deep and inalienable meaning as the ‘kisses of Christ.’”¹⁵⁶

c. *The slippery slope*

It would not be fair to portray the churches’ opposition to euthanasia solely in terms of abstract theology. Social concerns are central to the views held by many religious commentators. A recurrent theme is the “slippery slope” argument, or fear that “if voluntary euthanasia was permitted, it would not stay voluntary for very long.”¹⁵⁷ In its most extreme form, the slippery slope argument is a charge levelled at doctors who would become uncontrollable “rambo-types,” “prone to a lust for killing that could end in a Nazi-like holocaust.”¹⁵⁸ At the social level, the argument conjures up a “parade of horrors”¹⁵⁹ and a wasteland of nihilistic killing. This “parade of horrors” could not occur so long as doctors practiced euthanasia or assisted suicide for the original purposes for which these practices were legalized. Robert Manne argues however, that,

[f]or anyone who understands social process the expansion of the circle of those who can be killed will come as no surprise. For once 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. The slippery slope . . . involves a subtle transformation of ethical

¹⁵⁵ Faust, *supra* note 134, at 26.

¹⁵⁶ Raymond Tallis, *Is There a Slippery Slope?*, TIMES LITERARY SUPPLEMENT, Jan. 12, 1996, at 3 (reviewing EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES (John Keown ed., 1995)).

¹⁵⁷ Robert Goff, *A Matter of Life and Death*, 3 MED. L. REV. 1, 17 (1995).

¹⁵⁸ Roger Hunt, *Euthanasia: An Issue that Won't Die*, GEN. PRACT., Sept. 21-Oct. 4, 1994.

¹⁵⁹ See *Compassion in Dying*, 79 F.3d at 829.

sensibility. Over time we become blind to how we once thought.¹⁶⁰

Manne neglects to mention that the sanctity of life ethic has *already* been significantly watered down by the courts and legislatures of British Commonwealth and American jurisdictions.¹⁶¹ He is right, however, to be concerned that legalization will result in a re-orientation of moral sensibilities. Legalized euthanasia *will* change norms and values. Thus, for example, in a society that has legalized and has become accustomed to assisted suicide, the argument that medically assisted death should be widened to permit active voluntary euthanasia would seem all the more logical because of the changes in social values that accompany legalization of PAS.

Nevertheless, to assert this is not to demonstrate the preconditions for Auschwitz. The social preconditions to "communal moral deterioration" are worth studying. But as Burgess points out, slippery slope theorists bear the burden of proof and need to put forward a detailed case.¹⁶² Even so, the preoccupation which many opponents of PAS/AVE reform have with the slippery slope argument, serves a useful function. It focuses attention upon the bedrock values of society, and upon the gradual and imperceptible changes which have occurred over decades. It is this issue, considered from a legal perspective, which is the focus of Part III of this article.

5. *Politicians*

In Westminster-style democracies whose Constitutions largely lack substantive rights guarantees, such as Australia, or Britain, the prospect of euthanasia law reform is remote in the absence of *legislative change*. This is in contrast to the United States, where PAS reforms have also emerged through private challenges to the constitutionality of legislation criminalising PAS, or through citizen-initiated referenda.

Within a parliamentary context, the reform process ultimately relies upon (i) broad public support; (ii) successful advocacy by major players in the political debate; and (iii) parliamentary facilitators. This creates problems, since euthanasia is generally not a party-political issue, and would therefore, ordinarily, attract a conscience vote. In the Northern

¹⁶⁰ Robert Manne, *The Slippery Slope is a Life and Death Argument*, THE AGE (Melb.), June 14, 1995, at 18.

¹⁶¹ See discussion *infra* Part III.

¹⁶² J. A. Burgess, *The Great Slippery-Slope Argument*, 19 J. MED. ETHICS 169, 170 (1993).

Territory, the passage of the Rights of the Terminally Ill Act (1995) was largely due to the hard work and personal commitment of the former Chief-Minister, whose private member's Bill was backed by his own power and influence.¹⁶³ Other private members' Bills introduced by Independents and Opposition members in the ACT and South Australia, respectively, have failed.¹⁶⁴

In the Australian State of Victoria, by contrast, the inability of the Voluntary Euthanasia Society to find a private member to sponsor a reform Bill is one reason why the euthanasia debate has not gotten beyond the press, and why advocates such as the "Melbourne Seven" have resorted to increasingly high profile—some would say exhibitionist—tactics to get the issue onto the political agenda. It is hardly surprising that politicians should seek to avoid a divisive issue like euthanasia. A former Australian Governor-General's¹⁶⁵ support for euthanasia had politicians from both sides of politics running for cover.¹⁶⁶

6. *Patient Groups: AIDS & Euthanasia*

Increasingly, patient groups, particularly HIV/AIDS groups, are entering the euthanasia debate. Plaintiff/appellants in both the recent Ninth Circuit¹⁶⁷ and Second Circuit¹⁶⁸ cases overturning provisions criminalising PAS in Washington and New York, respectively, included AIDS patients and physicians. There are at least four issues which potentially underlie the involvement of people living with AIDS ("PLWAs") and their advocates in the euthanasia debate: the medical realities of HIV disease, the social construction of AIDS, the demographic features of PLWAs, and the practice of euthanasia within the HIV community.

¹⁶³ Geoffrey Lee Martin, *Euthanasia to be legalised by Australian State*, THE DAILY TELEGRAPH (London), Apr. 12, 1996, at 19.

¹⁶⁴ See Justine Ferrari & David Nason, *States Grapple with Euthanasia*, AUSTRALIAN, May 26, 1995, at 1.

¹⁶⁵ The Governor-General, who represents the British Queen in right of the Commonwealth of Australia, is the Australian Head of State. Tony Abbott, *No Place for an Elected Head of State*, SYDNEY MORNING HERALD, Mar. 20, 1995, available in LEXIS, ASIAPC Library, AUS File.

¹⁶⁶ *A Right to Live, and Die, Without Intervention*, AUSTRALIAN, June 23, 1995, at 12; *PM Ducks in Hayden Uproar*, THE AGE (Melb.), June 23, 1995, at 4.

¹⁶⁷ *Compassion in Dying*, 79 F.3d 790.

¹⁶⁸ *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

a. *The medical realities of HIV disease*

AIDS refers to a series of life-threatening conditions which represent the end-stage of infection caused by the HIV virus.¹⁶⁹ HIV weakens the body's immune resistance causing normally containable illnesses such as tuberculosis to be virtually untreatable. Previously rare diseases such as Pneumocystis Carinii Pneumonia, Kaposi's Sarcoma, or Cytomegalovirus have entered mainstream vocabulary as major AIDS-defining illnesses. AIDS symptoms include chronic diarrhea, emaciation, neurological complications, blindness and dementia. While good palliative care may bring pain under control in many cases, the misery and debilitation of AIDS is well known.¹⁷⁰ As stated on affidavit by Dr Peter Shalit, one of the plaintiffs in the *Compassion in Dying* litigation:

One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares.¹⁷¹

As a spectrum of illnesses which frequently require hospitalization, yet rarely kill straight away, AIDS produces a fluctuating terminal phase which is shot through with uncertainty. While successive bouts of illness are certain, the form they will take is unknown. The psychosocial impact of AIDS is enormous, and may also result in financial problems, discrimination and loss of privacy.¹⁷² Soberingly, some AIDS medications may also contribute to depression or delirium, in turn eliciting suicidal thoughts.¹⁷³

Significantly, the medical realities of AIDS appear to have given greater legitimacy to euthanasia as an option for PLWAs in the terminal

¹⁶⁹ Adam Car, *What is AIDS?*, in AIDS IN AUSTRALIA 1,3 (Eric Timewell, Victor Minichiello & David Plummer eds., 1992).

¹⁷⁰ See *Compassion in Dying*, 79 F.3d at 814.

¹⁷¹ *Id.*

¹⁷² The legal literature dealing with these and other HIV-legal issues is enormous. For an Australian perspective, see Roger S. Magnusson, *A Decade of HIV Testing in Australia: Part 1: A Review of Current Legal Requirements* 18 U. NEW S. WALES L.J. 341 (1995); *A Decade of HIV Testing in Australia: Part 2: A Review of Some Current Debates*, 18 U. NEW S. WALES L.J. 364 (1995).

¹⁷³ Gina Kolata, *Aids Patients Seek Solace in Suicide but Many Risk Added Pain in Failure*, N.Y. TIMES, June 14, 1994, at C1.

stages of disease. In the late 1990s, AIDS has become the disease which most justifies a person's right to die.¹⁷⁴

b. The social construction of AIDS

AIDS remains a highly stigmatized condition. People with AIDS suffer not only the uncertainties of an ultimately lethal illness, but also from a socially constructed "spoiled identity,"¹⁷⁵ which feeds upon fear, ignorance and the need to create a "comforting and differentiating moral rationale to account for the arbitrary tragedy of illness and death."¹⁷⁶

The gay community has borne the brunt of HIV infection in "Pattern I" countries such as the United States and Australia. The burden of AIDS and its fifteen year legacy of communal grief must be understood within the context of a culture of body-consciousness and hedonism, within a community revitalised through the 1970s, and finding a political voice. The physical stigmata of AIDS were the antithesis of tolerance and new-found freedom. Sontag notes in a well-known passage:

[T]o get AIDS is precisely to be revealed, in the majority of cases so far, as a member of a certain "risk group," a community of pariahs. The illness flushes out an identity that might have remained hidden from neighbours, job-mates, family, friends. It also confirms an identity and, among the risk group in the United States most severely affected in the beginning, homosexual men, has been a creator of community as well as an experience that isolates the ill and exposes them to harassment and persecution.¹⁷⁷

The symptoms of AIDS thus have profound moral, social, and physical significance. As one patient reported, "[w]hat I have is fatal Kaposi's Sarcoma, and I wear my disease like a scarlet letter."¹⁷⁸ Justice Michael Kirby, the newest appointee to the Australian High Court¹⁷⁹

¹⁷⁴ Battin, *supra* note 24, and accompanying text.

¹⁷⁵ Marcia Abramson, *Keeping Secrets: Social Workers and AIDS*, 35 SOC. WORK 169, 171 (1990).

¹⁷⁶ William F. Flanagan, *Equality Rights for People with AIDS: Mandatory Reporting of HIV Infection and Contact Tracing*, 34 MCGILL L.J. 530, 549 (1989).

¹⁷⁷ SUSAN SONTAG, AIDS AND ITS METAPHORS 24-25 (1990).

¹⁷⁸ Joan Jacob et al, *AIDS-Related Kaposi's Sarcoma: Concepts of Care*, 5 SEMINARS IN ONCOLOGY NURSING 263, 270.

¹⁷⁹ The High Court is Australia's highest appellate court, the equivalent of the U.S. Supreme Court. The highest appellate courts of the Australian States are called Supreme Courts. See, e.g., Chris, Merritt, *Chief Judge Calls for New Court of Appeal*, AUSTL. FIN. REV., Nov. 8, 1993, at 7, available in LEXIS, ASIAPC Library, AUS File.

observes, “[t]he connection with blood, sex and death presents a metaphor which is vividly etched upon the consciousness of society. If cancer is a predicament causing death which has to be whispered, HIV/AIDS is all too often the condition that dares not speak its name.”¹⁸⁰

Hardly surprisingly, AIDS has become “the great secret,” the stuff of media exposés and speculation, frequently concealed from one’s own family, or dressed up in pseudonyms. In an era of gay pride, the ongoing impact of guilt and unresolved sexuality, silent legitimators both of self-hate and community homophobia, has also been given too little attention. A number of studies have found elevated suicide rates in people with HIV/AIDS when compared with the general population.¹⁸¹ While the area is complex, review studies confirm that suicide risk is particularly high following a diagnosis of HIV or AIDS, and following the onset of HIV/AIDS symptomatology.¹⁸² Uncertainty over when the next life-threatening episode will occur and what it will be; fear of physical decrepitude, ugliness, and dementia; the loss of intimate personal relationships, the shame of becoming an object of gossip, rumour and moralizing; the promise of a hard death, the background subculture of grief—in short, the medical reality and the social construction of AIDS, combine to amplify the desire to go early.

c. *AIDS advocacy, ideology and euthanasia*

The medical realities and the social construction of AIDS, while enough perhaps to distinguish AIDS from other diseases, do not entirely explain the legitimating effect which AIDS has had upon the push for euthanasia reform. Seale and Addington-Hall note that pro-euthanasia advocacy has been associated with “modern, urban cultural conditions;” the AIDS community, in turn, is predominantly urban, young, male and

¹⁸⁰ Justice Michael Kirby, *AIDS: A New Realm of Bereavement*, paper delivered at the Third International Conference on Grief & Bereavement in Contemporary Society, Sydney, July 4, 1991, at 7.

¹⁸¹ See, e.g., Timothy Coté et al., *Risk of Suicide Among Persons with AIDS*, 268 JAMA 2066 (1992) (reporting men with AIDS were 7.4 times more likely to have suicided compared with demographically similar men in the general population); Cesar A. Alfonso et al., *HIV Seropositivity as a Major Risk Factor for Suicide in the General Hospital* 35 PSYCHOSOMATICS 368 (1994); Peter Marzuk et al., *Increased Risk of Suicide in Persons with AIDS*, 259 JAMA 1333 (1988); Brian Kelly & Beverly Raphael, *Psychiatry*, in AIDS IN AUSTRALIA 347 at 353 (Eric Timewell, Victor Minichiello & David Plummer eds., 1992) (reporting preliminary Australian data suggesting suicide rates for HIV infected persons of up to fifty times higher than the general population).

¹⁸² Seth C. Kalichman & Kathleen J. Sikkema, *Psychological Sequelae of HIV Infection and AIDS: A Review of Empirical Findings*, 14 CLINICAL PSYCHOL. REV. 611, 623-625 (1994); see also Fabrizio Starace, *Suicidal Behaviours in People Infected with Human Immunodeficiency Virus: A Literature Review*, 39 THE INTER’L J. SOC. PSYCHIATRY 64 (1993).

liberal or non-religious.¹⁸³ Thus, the philosophical preconditions to pro-euthanasia attitudes are more likely to be present. Many of those with HIV, or at highest risk of contracting it, are gay; they are educated, articulate, and come from an activist community, capable of pursuing this aspect of patient self-determination with the same sort of zest with which other gay law reform and HIV patient issues have been pursued.

Research suggests a high level of support for the option of euthanasia within the HIV community. In a 1993 Sydney study by Tindall and others, 90% of men with either AIDS or AIDS-related complex indicated that they would personally wish to have the option of euthanasia if a life-threatening diagnosis were made. Interestingly, 86% of the 105 subjects stated that they were afraid of suffering, but only 19% feared death itself.¹⁸⁴

The rapid dissemination of information about euthanasia within the gay and HIV/AIDS communities as a result of networking also needs to be recognized. Sometimes the provision of information is explicit. For example, in a highly controversial publication, four Sydney doctors released a leaflet containing a "euthanasia recipe" as part of a series on HIV/AIDS treatments.¹⁸⁵

d. The practice of euthanasia upon PLWAs

It is possible that AIDS will have an even greater impact upon the euthanasia movement in future. In Australia, the next few years will see a peak in the number of AIDS cases, arising from the initial high levels of infections in the early and mid 1980s. The influx of clients, together with falling levels of hospital funding will put further pressure on HIV services. There is a trend towards home nursing, where institutional constraints represent less of a disincentive to involvement in euthanasia.

It is clear that assisted suicide and euthanasia are already practiced within the HIV community.¹⁸⁶ Battin notes that PAS is "so widely accepted that it is virtually legal . . . among people with AIDS in the gay communities of the US west coast."¹⁸⁷ In a Dutch study of homosexual men with AIDS carried out between 1985 and 1992, 22% of men were

¹⁸³ Seale & Addington-Hall, *supra* note 40, at 652-53.

¹⁸⁴ Brett Tindall et al., *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 1069 (1993).

¹⁸⁵ Lyle Chan et al., *This Way Out*, AIDS X (Information Sheet No. 8, Dec. 1994).

¹⁸⁶ Battin, *supra* note 24, at 215

¹⁸⁷ Battin, *supra* note 24, at 215. For articles relating to euthanasia within the San Francisco AIDS community, see, Sheryl Stolberg, *Ending Life on Their Own Terms*, L.A. TIMES, Oct. 1, 1996, at A1; Julian Guthrie, *AIDS Victims Vow to Defy Suicide Ban*, S.F. EXAMINER, Oct. 2, 1996 at A1; George Raine, *Doctor Offers Aid in Dying*, S.F. EXAMINER, Jan. 22, 1995 at A1.

found to have died through assisted suicide or euthanasia,¹⁸⁸ twelve times the national euthanasia rate of 2.1% as estimated in the Rummelink study.¹⁸⁹ Interestingly, life was estimated to have been shortened by less than one month in 72% of the euthanasia cases. The authors point out that the likelihood of euthanasia increased with duration of survival after the AIDS diagnosis, thus linking euthanasia with loss of quality of life and the desire to avoid further suffering.¹⁹⁰

In Canada, on the day that PAS campaigner Sue Rodriguez died, detailed evidence of euthanasia within the HIV community was released by Vancouver social worker Russell Oden.¹⁹¹ Believed to be the first empirical research on assisted suicide and euthanasia in North America, Oden's study, a published form of his Master's thesis, was based on accounts of involvement by physicians, social workers, counsellors, teachers and writers.¹⁹² The study detailed the legacy of PAS/AVE prohibition, including evidence of "botched suicides," resulting from a lack of appropriate medical knowledge. The heady combination of AIDS and euthanasia has not gone unnoticed by the media: in Australia, for example, the trial of a reportedly HIV positive Sydney man who aborted a mutual suicide pact with his lover, formed after listening to the final aria of the opera *Madame Butterfly*.¹⁹³

7. *The Media*

This paper will not consider the discourse of euthanasia through the media beyond noting that here, as elsewhere, the power of the media in shaping the debate is unrivaled. Somerville notes that "[w]e are . . . media societies. We are the first age in which our collective story-telling takes

¹⁸⁸ See Patrick J.E. Bindels et al., *Euthanasia and Physician-Assisted Suicide in Homosexual Men with AIDS*, 347 LANCET 499, 502, 503 (1996).

¹⁸⁹ Paul van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669 (1991). See *infra* note 358, and accompanying text.

¹⁹⁰ Bindels et al., *supra* note 188, at 503.

¹⁹¹ Douglas T. Vansun, *Mercy Killing Secret World Revealed*, WEEKEND SUN (Vanc.), Feb. 12, 1994, at A1, A2; *Suicide Study Attracts Continent Wide Attention*, VANC. SUN, Feb. 15, 1994, at B6; Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. TIMES, June 14, 1994, at C12.

¹⁹² RUSSEL D. OGDEN, EUTHANASIA AND ASSISTED SUICIDE IN PERSONS WITH ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY SYNDROME (HIV) (1994).

¹⁹³ Dominic O'Grady, *Judge Urges Compassion for Gay Couple*, SYDNEY STAR OBSERVER, Sep. 7, 1995, at 1. See also D. Buchanan, *Bond for Man in Euthanasia Case*, 7 HIV/AIDS LEGAL LINK 24 (1996) (\$500 fine and good behaviour bond following guilty plea to charge of aiding and abetting an attempted suicide by crushing fifteen codeine phosphate tablets in a glass of orange juice for lover).

place through television. A terminally ill person, begging for euthanasia, makes emotionally gripping television."¹⁹⁴

As a collective social experience, the euthanasia debate has been largely shaped by media coverage of euthanasia "news stories." Jack Kevorkian is a world-renowned celebrity. It is thanks to the media that he and others like him have been able to effectively promote their cause. The "Linares affair"—where a distraught father kept nurses at bay with a gun while he disconnected the respirator keeping his comatose, fifteen month old son alive—was splashed across televisions and newspapers internationally, not to mention medico-legal journals.¹⁹⁵ The case of George Delury, a prominent New York editor who assisted in his terminally ill wife's suicide, made the newspapers in Australia.¹⁹⁶ As noted previously, HIV/AIDS has accentuated the pathos and urgency of the euthanasia debate,¹⁹⁷ creating images of proud and once-beautiful young men in the prime of their years, asking for death.¹⁹⁸

8. *Players in the Euthanasia Debate: Conclusion*

A variety of factors have converged to give the debate over PAS/AVE particular significance and urgency in the last years of the twentieth century. Making sense of the debate involves listening to the voices of those who have a particular stake in it, including doctors, the churches, the media-informed public, and those able to effect legal change, such as parliamentarians and judges.

Several issues stand out in the review presented above. The public and the medical profession are increasingly supportive of PAS/AVE reform. The true level of medical support is, however, obscured by the

¹⁹⁴ Margaret Somerville, *Sentencing Society to Ethical Death*, THE AGE (Melb.), Nov. 13, 1995, at 13. Few people could have remained unaffected by a 1995 Dutch documentary, screened in England, North America, Australia, and other countries, which showed Dutchman Kees van Wendel de Joode, who suffered from a degenerative muscular disease, being put to death by his family doctor.

¹⁹⁵ See, e.g., Symposium, *Family Privacy and Persistent Vegetative State: A Symposium on the Linares Case*, 17 LAW, MED. & HEALTH CARE 295 (1989).

¹⁹⁶ Phillip McCarthy, *New York Confronts Right-to-Die Case*, THE AGE (Melb.), July 7, 1995, at 8; Carey Goldberg, *A Meal, a Deadly Potion, A Major Legal Test*, N.Y. TIMES, July 6, 1995, at A2; *Death: Chosen, Assisted, at Home*, THE AGE (Melb.), Apr. 17, 1996, at A13. In May 1996, seventy-two year-old Delury was sentenced to six months prison (following a plea-bargain) for assisting in his wife's death, who had multiple sclerosis. *George Delury Sentenced for Aiding Death of his Wife*, ERGO! U.S. NEWS BULLETINS, *supra* note 29, May 17, 1996.

¹⁹⁷ See, e.g., Alana Valentine, *The Long Vigil*, SYDNEY MORNING HERALD, Mar. 3, 1995, at 11.

¹⁹⁸ In Australia, see, e.g., Adam Taor, *HIV Lobby Fuels Euthanasia Fire*, AUSTRALIAN DOCTOR Nov. 25, 1994, at 29; Ebru Yaman & Justine Ferrari, *Lawrence Retreats on Support for Euthanasia*, WEEKEND AUSTRALIAN, Feb. 4-5, 1995, at 9; *Victim Demands Help for a Death with Dignity*, THE AGE (Melb.), Mar. 28, 1995, at 3. In the United States, see, e.g., Gina Kolata, *AIDS Patients Seek Solace in Suicide, But Many Risk Added Pain in Failure*, N.Y. TIMES, June 14, 1994, at C1.

conservatism of some high profile, professional bodies who largely represent the conservative elements of the profession (e.g. the Australian Medical Association). In Australia, as support firms within the medical profession, one can expect that PAS/AVE reform will follow within Australia's more populous states. In the United States, where reform does not necessarily depend upon legislation, much depends upon the decision of the Supreme Court.

It has been argued that underlying the euthanasia debate is an ideological struggle between competing world views.¹⁹⁹ Opposition to legalized euthanasia reflects a perspective which is essentially conservative and communitarian, and which is more likely to be informed by the teachings of an authoritarian and hierarchal church. Advocacy for the legalized killing of consenting, terminally ill patients, on the other hand, reflects a perspective which is essentially liberal, individualistic, and more likely secular.²⁰⁰

Society has prohibited euthanasia for at least two thousand years. This prohibition is embedded not only in the moral teachings of churches, and in the professional codes of doctors, but also in the law. Nevertheless, the ethic of liberal individualism has already, within a few short years, had a significant impact upon individuals' legal rights. It is the changes which have *already occurred*, as explained in Part III, which make the completion of euthanasia law reform inevitable over the next few years.

III. THE DECLINE OF THE SANCTITY OF LIFE ETHIC IN LAW

What has happened to the sanctity of life ethic, that it can now be challenged head-on by doctors, in many cases with apparent impunity, and with broad community support? After all, the idea that all human life is equally and intrinsically precious, and should never be taken, regardless of its value as perceived by others, has been central to the moral foundations of society for many centuries. Although far from secure in the face of war, capital punishment, and religious and ethnic persecution, the sanctity of human life ethic of the Judeo-Christian tradition has been profoundly civilizing. In the words of one New Zealand judge, the preservation of life is an ideal "which not only is of inherent merit in commanding respect for the worth and dignity of the individual but [it] also exemplifies all the finer virtues which are the mark of a civilised order."²⁰¹ By affirming life for

¹⁹⁹ See Holden, *supra* note 138.

²⁰⁰ See Holden, *supra* note 138.

²⁰¹ Auckland Area Health Board v Attorney-General, [1993] 1 N.Z.L.R. 235, 244.

all, we affirm the value and meaning of our own lives and our common humanity.

But times are changing. Traditionally, the law has protected both the individual's right to autonomy and self-determination on the one hand, and the individual's right to physical or bodily integrity on the other. With active voluntary euthanasia, however, these objects of the law's protection come into conflict, creating a tug-of-war between the right of the individual to pursue his or her personal interests without interference, and the prohibition against harming others which is embodied in law for the good of the whole community.

Slowly, however, the sanctity of life ethic is giving ground to a liberal individualist ethic which is gradually yet perceptibly shifting the moral premium from *longevity* and onto *quality of life*. This shifting emphasis is clearly evident when one considers the cumulative effect of:

- the changing definition of death;
- the recognition that patients have the right to refuse medical treatment even where this will result in their death;
- the recognition that there is no duty to maintain life when a patient is permanently unconscious;
- and now, as reflected in recent caselaw and legislation in the United States and Australia, respectively, the recognition that terminally ill patients who are competent may obtain medical assistance to end their life.

Voluntary euthanasia of the terminally ill is thus the most recent (and probably not the last) weigh-station in an ethical journey away from the sanctity of life ethic.

A. *The Silent Retreat From Absolutism*

1. *The Definition of Death*

a. *"Whole-brain" death*

The capacity for artificial respiration and life-support systems to sustain the biological functions of the body almost indefinitely, despite the permanent loss of consciousness, has created problems for the sanctity of life ethic. An extreme or vitalist form of the ethic would require that all possible measures were taken to preserve life, regardless of whether the

brain had, in fact, ceased to function. A subtle way of avoiding the imperatives of a vitalist ethic, therefore, was to re-define death itself.

These days, death is defined either in terms of the permanent cessation of heart-beat, blood circulation and breathing ("heart/lung death"), or as the irreversible cessation of the functions of the entire brain, including the brain stem ("brain death"). The concept of brain death emerged from the work of an ad hoc committee established by the Harvard Medical School in 1968.²⁰² The Committee reported in the *Journal of the American Medical Association* that "responsible medical opinion"²⁰³ was ready to adopt new criteria for pronouncing death in circumstances where an individual had suffered "irreversible coma as a result of permanent brain damage."²⁰⁴ Importantly, the Committee made it clear that it was concerned only with "those comatose individuals who have no discernible central nervous system activity."²⁰⁵ This qualification was crucial. The Committee was advocating new criteria for diagnosing irreversible coma resulting from permanent brain damage which could serve as a new definition of death, but only in respect of patients who had irreversibly lost all brain function, including brain-stem function.²⁰⁶ Nevertheless, by re-labelling as a "ventilated corpse," someone who might otherwise have been thought of as alive, the Harvard Brain Death Committee (as it became known), avoided the ethical injunction to prolong life at all costs.²⁰⁷

In the decades following the Harvard Committee's report, the concept of brain-death has been accepted into the law of most western countries. In 1981, the President's Commission in the United States recommended uniform legislation embodying both heart/lung and whole brain criteria.²⁰⁸ By 1995, thirty-three states had adopted the Uniform Determination of Death Act which gives effect to this recommendation.²⁰⁹ In 1977, the Australian Law Reform Commission also recommended the introduction of a statutory definition of death which included the concept

²⁰² The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Irreversible Coma, *A Definition of Irreversible Coma*, 205 JAMA 337, 339 (1968).

²⁰³ *Id.* at 337.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ The Harvard criteria did not seem to preclude reflex activity originating from the spinal cord, although the Committee noted that loss of function at this level would also frequently be present. *Id.* at 340.

²⁰⁷ *Id.*

²⁰⁸ PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIOURAL RESEARCH, *DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 2* (1981).

²⁰⁹ UNIF. DETERMINATION OF DEATH ACT, 12 U.L.A. 443 (Supp. 1995).

of whole-brain death.²¹⁰ All states except Western Australia have now enacted such legislation.²¹¹

b. "Higher-brain" death

In the 1990s, the push is on for a further re-definition of death to include "higher-brain death." Interest in the concept of higher-brain death has emerged following improvements in the ability of medicine to preserve life in patients who are in a permanent coma, or in a persistent vegetative state. A persistent vegetative state which is regarded as irreversible is called a permanent vegetative state ("PVS").²¹² A PVS may arise following irreversible damage to the cerebrum, which—whether alone or in interrelationship with the brain-stem—is thought to control "higher-brain" functions including consciousness, thought, feeling and memory. Unlike patients in a permanent coma, PVS patients may seem awake, and may follow sleep-wake cycles, although they show no awareness and do not respond to visual, auditory, tactile or noxious stimuli. Because the brain stem continues to function, however, the patient may retain gag, cough, sucking and swallowing reflexes, and may make spontaneous movements or noises.²¹³ A prognosis of PVS implies, however, the permanent loss of consciousness, cognitive function and sensory capacity, although the patient may breath without assistance, and may live for years and even decades with artificial feeding and hydration.²¹⁴

In England, PVS was brought into the public arena through the case of seventeen year-old Tony Bland, whose lungs were crushed and perforated in the fatal crush at the Hillsborough football stadium on April 15, 1989. Bland's cerebral cortex, through prolonged deprivation of oxygen, had "resolved into a watery mass."²¹⁵ In the United States, well-

²¹⁰ THE AUSTRALIAN LAW REFORM COMMISSION, REPORT NO. 7: HUMAN TISSUE TRANSPLANTS, §§ 133-37 (1977).

²¹¹ See, e.g., Human Tissue Act § 33 (1983) (N.S.W.); Human Tissue Act § 41 (1982) (Vict.).

²¹² The prognosis of PVS patients is linked to the cause of the coma. Some patients may regain awareness after 4 months in a persistent vegetative state, although few will ever reach full independence. Keith Andrews, *Recovery of Patients after Four Months or More in the Persistent Vegetative State*, 306 BRIT. MED. J. 1597, 1597 (1993); The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (Pt. 2), 330 NEW ENG. J. MED. 1572 (1994).

²¹³ See generally Robin S. Howard & David H. Miller, *The Persistent Vegetative State*, 310 BRIT. MED. J. 341 (1995); The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (Pts. 1 & 2), 330 NEW ENG. J. MED. 1499, 1572 (1994).

²¹⁴ A 1994 review estimated that there are between 10,000 and 25,000 adults in the United States in a persistent vegetative state, and between 4,000 and 10,000 children. The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (Pt. 1), 330 NEW ENG. J. MED. 1499, 1503 (1994). In Britain the estimate is 1,000 to 1,500. *Bland*, [1993] App. Cas. at 879.

²¹⁵ *Bland*, [1993] App. Cas. at 833.

known cases of PVS patients include Karen Quinlan,²¹⁶ and Nancy Cruzan,²¹⁷ both of whom sustained irreversible injuries as a result of oxygen deprivation (anoxia).

A higher-brain definition of death remains controversial because of its creeping infringement upon the sanctity of life ethic, and the judgment it conveys about the moral status of human beings. One advocate of a higher-brain definition, Professor Robert Veatch, Director of the Kennedy Institute of Medical Ethics at Georgetown University, admits that his preference is based upon the moral judgment that the essence of personhood or "being human" is the integrated functioning of mind and body.²¹⁸ As Justice Stevens stated in his dissenting opinion in the Cruzan case,

for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood Life, particularly human life, is not commonly thought of as a merely physiological condition or function. Its sanctity is often thought to derive from the impossibility of any such reduction.²¹⁹

Although different definitions of higher-brain death are possible, Veatch advocates defining higher-brain death in terms of the "irreversible cessation of the capacity for consciousness."²²⁰ Catholic bioethicists disagree. Dr. Norman Ford, Director of an Australian Catholic bioethics institute, writes that "permanently unconscious patients and new-born babies, including anencephalic infants, are human subjects with personal dignity whose lives are morally inviolable."²²¹

Professor Peter Singer of the Monash University Centre for Human Bioethics, has taken a third view. He is conscious of the argument that it is counter-intuitive to call a PVS patient "dead." Such patients breathe, their bodies are warm; and some, such as Nancy Cruzan, can orally ingest some nutrition. Brain-dead patients can even sustain the life of a foetus for

²¹⁶ In re Quinlan, 355 A.2d 647 (N.J. 1976).

²¹⁷ Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990).

²¹⁸ Robert M. Veatch, *The Impending Collapse of the Whole-Brain Definition of Death*, 23 HASTINGS CENTER REP. 18, 23 (1993).

²¹⁹ *Id.* at 345-46.

²²⁰ Veatch, *supra* note 218, at 23.

²²¹ Norman Ford, *Killing and Caring don't Mix*, THE SUNDAY AGE (Melb.), Oct. 29, 1995, at

several months until birth.²²² Writing about anencephalic infants, Singer argues that it is preferable simply to accept that organs may be removed for transplantation from infants whose lack of a cerebral cortex permanently precludes any capacity for consciousness and feeling.²²³ Singer's logic also implies that it would be acceptable to remove organs and tissues from adult patients in a permanently vegetative state, or indeed to "end the life" or "biological processes" of such patients, regardless of whether such patients could be said to be already "dead." Singer's views on euthanasia and the morality of killing infants have generated heated debate, and he has been accused of advocating infanticide.²²⁴

The simplistic distinction between life and death which Singer wishes to avoid perpetuating could perhaps be overcome by recognising that death is not so much an event, as a *process* which can occur at different levels of organization within the human body.²²⁵ Nevertheless, the view that death is a series of morally significant gradations, instead of an "event," is likely to be rejected as making the law unworkable. A precise and uniform definition of death is critical in areas of law concerned, for example, with homicide, succession and tissue and organ transplantation. Proposals for a "higher brain" definition of death are further muddled by the fact that many advocates believe such a definition should be implemented with a conscience clause so that people can elect in advance the criteria of death they wish to apply to them.²²⁶

If in future PAS/AVE were to become widely legalized, one might speculate that public opinion would more readily acknowledge that euthanasia was justified not only when a person's quality of life was destroyed by terminal illness, but also when a person was unable to experience conscious life at all. Within this environment, social norms would change, and the view that permanently unconscious and insensate individuals should really be regarded as *already dead*, may have greater persuasive force. For the present, however, in the absence of the widespread social consensus necessary for the adoption of higher-brain

²²² See PETER SINGER, RETHINKING LIFE & DEATH 9-11 (1995) referring to the case of Trisha Marshall, a woman from North Oakland, California, who was diagnosed as brain dead on Apr. 19, 1993 following a shooting, yet who sustained the life of her foetus until it was born by caesarean section on Aug. 3, 1993.

²²³ Anencephalic infants are born with only a brain stem and, like PVS patients, are permanently unconscious, insensate and unknowing. *Id.* at 46-56.

²²⁴ For critical reviews of Singer's work, see, e.g., Jenny Teichman, *Humanism and Personism*, QUADRANT, Dec. 1992, at 26; Herlinde Pauer-Studer, *Peter Singer on Euthanasia*, 76 MONIST 135 (1993); Per Sundström, *Peter Singer and "Lives Not Worth Living"—Comments on a Flawed Argument from Analogy*, 21 J. MED. ETHICS 35 (1995).

²²⁵ Linda L. Emanuel, *Reexamining Death: The Asymptomatic Model and a Bounded Zone Definition*, 25 HASTINGS CENTER REP. 27, 32 (1995).

²²⁶ Veatch, *supra* note 218, at 21-22.

death as a legal definition of death,²²⁷ the retreat from the sanctity of life ethic has largely been played out within the context of the withdrawal of medical treatment. The question is not, therefore, "is the patient already dead?" but, "is there a duty to keep the patient alive any longer?"

2. *The Right to Self-Determination and the Withdrawal of Life-Preserving Medical Treatment*

In January 1985, former Australian water-ski champion John McEwan dived into the Murray river at Echuca (a town on the New South Wales/Victorian border), and suffered spinal injuries which rendered him quadriplegic. A year later, when he asked for the withdrawal of the ventilator which was keeping him alive, his doctor's insurers refused, fearing litigation.²²⁸ When McEwan subsequently went on a hunger strike in Melbourne's Austin Hospital, he was certified as insane. That certification was not revoked until he agreed to accept food, take anti-depressant drugs and undergo counselling.²²⁹

a. *Advance directives, living wills and other statutory schemes*

The issues which emerged from the debate accompanying the McEwan case will be familiar to American readers, as the American States have led in the development of statutory models for medical self-determination.²³⁰ The debate in Victoria resulted in the Medical Treatment Act (1988) (Vic), which gives competent adult patients a statutory right to refuse medical treatment generally, or particular kinds of medical treatment.²³¹ This right of refusal operates, however, only in respect of a "current condition."²³² Nor does it extend to the refusal of palliative care, which includes the provision of reasonable procedures to relieve pain, and the reasonable provision of food and water.²³³ Refusals are recorded in a "refusal of treatment certificate."²³⁴ A doctor who ignores the certificate and treats a patient may be guilty of medical trespass.²³⁵

²²⁷ Raymond J. Devettere, *Neocortical Death and Human Death*, 18 LAW, MED. & HEALTH CARE 96, 101 (1990).

²²⁸ Nicholas Tonti-Filippini, *Some Refusals of Medical Treatment which Changed the Law of Victoria*, 157 MED. J. AUSTRAL. 277 (1992).

²²⁹ Peter Ward, *New Life in the Death-with-Dignity Debate*, AUSTRALIAN Oct. 14, 1987, at 11.

²³⁰ See, e.g., CAL. PROB. CODE §§ 3200-3211 (West 1996).

²³¹ Medical Treatment Act (1988) (Vic.).

²³² Medical Treatment Act § 5 (1988) (Vic.).

²³³ Medical Treatment Act § 4 (1988) (Vic.).

²³⁴ Medical Treatment Act § 5 (1988) (Vic.).

²³⁵ Medical Treatment Act § 6 (1988) (Vic.). Similar legislation operates in the Australian Capital Territory. Medical Treatment Act §§ 6-12 (1994).

In Australia, when a patient becomes incompetent, decisions regarding his or her medical treatment are made by the patient's legal guardian, in accordance with the patient's best interests. Before this, an application must be made to the relevant Guardianship and Administration Board for the appointment of the guardian. The guardian's authority is usually described as encompassing those decisions which a parent would be authorized to make on behalf of a child, although consent to certain prescribed, or major medical procedures may still require the consent of the Board.²³⁶ A number of Australian States have followed their American counterparts by enacting legislation which authorizes a spouse, carer, friend or relative to consent to medical treatment on a patient's behalf, a power which would not otherwise exist unless that person was the incompetent patient's legal guardian.²³⁷

Statutes in some States provide for *consent* to be given to medical treatment on behalf of an incompetent person through the appointment of an enduring (medical) power of attorney. This legislation, however, does not on its face authorize the refusal of life-preserving treatment by the attorney on behalf of the patient.²³⁸ Broader legislation exists in Victoria and the Australian Capital Territory, however, that specifically authorizes a patient to confer an enduring medical power of attorney upon an agent, who then has authority to *refuse* medical treatment on the patient's behalf, in circumstances where the patient later becomes incapacitated.²³⁹ An example of this could be a declaration by the agent in the appropriate form that an insensate patient would not have wanted to have particular invasive treatment given, or resuscitation in the event of a medical crisis.²⁴⁰

South Australia and the Northern Territory have recognized incompetent patients' right of self-determination in slightly different terms. Legislation in both jurisdictions enables a competent person to make a "living will."²⁴¹ A "living will" is a formal direction refusing "extraordinary measures" in the event that the person becomes

²³⁶ See, e.g., Guardianship and Administration Board Act §§ 24, 36-42 (1986) (Vict.). Under Australian common law, court approval is required for the sterilisation of an incompetent person. *Secretary, Dep't of Health and Community Servs. v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218.

²³⁷ Guardianship Act §§ 35-37 (1987) (N.S.W.); Guardianship and Administration Act § 59 (1993) (S. Austl.); Guardianship and Administration Act §§ 4, 39 & 43 (1995) (Tas.). Similar legislation exists, for example, in California. CAL. PROBATE CODE §§ 3200-3211 (West 1995).

²³⁸ See Guardianship and Administration Act § 25 (1993) (S. Austl.) (refers to refusal, although unclear whether this extends to withdrawal of life-preserving treatment); Guardianship and Administration Act §§ 4, 32, 36-46 (1995) (Tas.); Powers of Attorney Act § 13 (1956) (Austl. Cap. Terr.).

²³⁹ Medical Treatment Act § 5B (1988) (Vict.); Medical Treatment Act §§ 13-18 (1994) (Austl. Cap. Terr.).

²⁴⁰ See DAVID LANHAM, *TAMING DEATH BY LAW 79-80* (1993).

²⁴¹ Natural Death Act (1983) (S. Austl.); Natural Death Act § 4 (1988) (N. Terr.).

incompetent and suffers from a terminal illness.²⁴² "Extraordinary measures" include artificial ventilation, intravenous hydration and feeding, dialysis, transplants of vital organs, and other procedures which prolong life by "supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation."²⁴³

The Australian legislation thus includes a variety of mechanisms (advance directives, including "living wills," and proxy decision-making under a court appointed guardian or pursuant to an enduring medical power of attorney), which enable patients to exercise—to varying degrees—a right of bodily self-determination encompassing a right to hasten death by refusing life-preserving medical treatment.

In the United States, individual states also retain wide latitude to develop their own law and policy regulating the withdrawal of life-preserving medical treatment. In *Cruzan v Director, Missouri Department of Health*, the United States Supreme Court declined to constitutionalize the withdrawal of treatment issue to a point which limits diversity between states.²⁴⁴ This diversity is evident from a survey of state laws that employ the above identified mechanisms.²⁴⁵ Unlike Australia, United States federal law also requires health care providers receiving Medicare or Medicaid funds to inform competent adult patients in writing of relevant state laws dealing with living wills and other advance directives, and to record in the patient's medical record, and to abide by, any directives the patient has made which comply with state law.²⁴⁶

In California, for example, a person can execute a "living will" that requires the patient's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition where the patient is unable to make the decisions for himself or herself.²⁴⁷ Similarly, patients may appoint a durable power of attorney for

²⁴² Natural Death Act (1983) (S. Austl.); Natural Death Act § 4 (1988) (N. Terr.).

²⁴³ Natural Death Act § 3 (1983) (S. Austl.); Natural Death Act § 3 (1988) (N. Terr.). For further discussion, see Danuta Mendelson, *Medico-Legal Aspects of the "Right to Die" Legislation in Australia*, 19 MELB. U. L. REV. 112 (1993); David Lanham & Belinda Fehlberg, *Living Wills and the Right to Die with Dignity*, 18 MELB. U. L. REV. 329 (1991).

²⁴⁴ *Cruzan*, 497 U.S. at 284.

²⁴⁵ See Judith Areen, *Advance Directives Under State Law and Judicial Decisions*, 19 LAW, MED. & HEALTH CARE 91 (1991).

²⁴⁶ 42 U.S.C.A. § 1395cc(f) (West 1996).

²⁴⁷ Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7194 (West 1996). Life sustaining treatment is "medical intervention that will only prolong the process of dying or an irreversible coma or persistent vegetative state." *Id.* § 7186. California was the first jurisdiction to enact "living will" legislation, in 1977. Henry Weinstein, *Assisted Suicide Deaths Ruled Legal; Ninth Circuit Lifts Ban on Doctor-Aided Suicides*, L.A. TIMES, Mar. 3, 1996, at 1.

health care,²⁴⁸ which confers on the attorney power to consent to, to refuse or to withdraw, on behalf of the patient, any medical treatment related to a physical or mental condition, subject to any limitations contained in the durable power of attorney, and the patient's wishes as made known to the attorney.²⁴⁹ Pursuant to the enduring power of attorney for health care, the attorney is empowered to make such decisions regarding healthcare as the patient could make himself or herself, including the refusal of life-sustaining medical treatment.²⁵⁰ The attorney's decision-making power does not extend to authorising decisions relating to abortion, sterilisation, convulsive treatment and commitment to a mental health facility.²⁵¹ Although the legislation permits what is sometimes called "passive euthanasia" (death resulting from the withdrawal of life-preserving treatment), it does not permit active euthanasia, or any "affirmative or deliberate act or omission to end life."²⁵² The California legislation was unaffected by the Ninth Circuit decision in the *Compassion in Dying* case,²⁵³ which relates only to competent patients. Finally, in the absence of both a "living will," and an enduring power of attorney for health care, a duly-appointed guardian or "conservator" may nevertheless make treatment decisions on the patient's behalf, including the withdrawal of life-support from a permanently unconscious patient.²⁵⁴

b. *The right of self-determination at common law*

Except where excluded by legislation, a right of self-determination may also exist at common law. Courts in the industrialized common law democracies have increasingly affirmed the general principle that competent adult patients have the right to decide for themselves whether to undergo medical treatment.²⁵⁵ British Commonwealth and American courts have recognized that, provided the patient is competent to make the

²⁴⁸ CAL. PROB. CODE §§ 4700-4806 (West 1996).

²⁴⁹ *Id.* § 4703, § 4720.

²⁵⁰ *Id.* § 4724.

²⁵¹ *Id.* § 4722.

²⁵² *Id.* § 4723.

²⁵³ See generally *Compassion in Dying*, 79 F.3d 790.

²⁵⁴ CAL. PROB. CODE § 2355; *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988), *cert. denied*, 488 U.S. 958 (1988).

²⁵⁵ In United States, see, e.g., *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. Ct. App. 1914); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 277 (1990); In Australia, see, e.g., *F. v. R.*, 33 S.A. St. R. 189, 193 (Sup. Ct. 1983) (en banc); *Rogers v. Whitaker*, 175 C.L.R. 479, 486-487 (Austl. 1992); In England, see, e.g., *Sidaway v. Bd. of Governors of Bethlem Royal Hosp.*, [1985] App. Cas. 871, 882, 888; In Canada, see, e.g., *Rodriguez v. B.C. (Attorney-General)*, 107 D.L.R. 4th 342, 398-399 (Can. 1993); In New Zealand, see, e.g., *Smith v. Auckland Hosp. Bd.*, [1965] N.Z.L.R. 191, 219; *Auckland Area Health Bd. v. Attorney-General*, [1993] 1 N.Z.L.R. 235, 245.

decision, and provided his or her wishes have been properly ascertained, the law will respect this right, even if it will have fatal consequences for the patient.²⁵⁶ In January 1996, for example, an anorexic woman was permitted to die in an English hospital, despite the wishes of her family that she receive nourishment through a drip.²⁵⁷ The basis for this right is that medical treatment involves the intentional infliction of physical force upon the body. Subject to emergencies and other exceptions, therefore, medical treatment administered by a doctor is only lawful when the patient consents to it. The right to refuse medical treatment is thus an expression of the right not to be subjected to unlawful assault.²⁵⁸

In the United States, the right of a competent person to refuse unwanted medical treatment is not only a common law right, but an aspect of the "liberty" which citizens enjoy under the Fourteenth Amendment to the United States Constitution.²⁵⁹ This "liberty" interest is not, however, unqualified. Where a state, through legislation or administrative action opposes, burdens or regulates the withdrawal of treatment from a patient in a particular case, courts will determine whether the patient's constitutional rights have been violated by balancing his or her liberty interests against the relevant opposing state interests.²⁶⁰ These state interests include the interest in preserving human life, discouraging assisted suicide, and

²⁵⁶ In United States, *see, e.g.*, *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Fosmire v. Nicoleau*, 551 N.E. 2d 77 (N.Y. Ct. App. 1990); *State v. McAfee*, 385 S.E. 2d 651 (Ga. 1989). In England *see, e.g.*, *In re T (Adult: Refusal of Treatment)*, [1993] Fam. 95, 115, 116-117, 121; *In re C (Adult: Refusal of Treatment)*, [1994] 1 W.L.R. 290, 294-295; *Airedale N.H.S. Trust v. Bland*, [1993] App. Cas. 789, 857-59, 864, 883; *Secretary of State v. Robb*, [1995] Fam. 127 (competent adult's right to self-determination prevails over any countervailing state interest). In Canada, *see, e.g.*, *Nancy B. v. Hôtel-Dieu de Québec*, 86 D.L.R. (4th) 385 (1992).

²⁵⁷ *Woman Suffering from Anorexia Insists on Being Allowed to Die*, 15 MONASH BIOETHICS REV. 4 (1996).

²⁵⁸ *See, e.g.*, *Secretary, Dep't of Health & Community Servs. v. J.W.B. & S.M.B.*, 175 C.L.R. 218, 309-310 (Aust. 1992).

²⁵⁹ *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278-279 (1990). In so holding, the Supreme Court rejected the view that the right to refuse medical treatment was part of any right of privacy recognized under the Federal Constitution. *Id.* at 279 n.7; *cf. Matter of Quinlan*, 355 A.2d 647 (N.J. 1976).

²⁶⁰ As noted elsewhere (*see, e.g.*, James Bopp, Jr., & Thomas J. Marzen, *Cruzan: Facing the Inevitable*, 19 LAW, MED. & HEALTH CARE 37, 38 (1991)), it is significant that the *Cruzan* majority identified the Fourteenth Amendment liberty interest as an "interest," rather than a "fundamental right." The Supreme Court has recognized that liberties regarded as "fundamental" in character cannot, by virtue of the Due Process Clause, be overridden without due process of law, which requires the State to show that its law serves a "compelling state interest" which justifies the encroachment upon personal liberty. *See Griswold v. Connecticut*, 381 U.S. 479, 479-99 (Goldberg, J., concurring), 503-504 (White, J., concurring) (1965); *Roe v. Wade*, 410 U.S. 113, 155 (1973). By contrast, where fundamental liberties are not threatened, a State need only demonstrate a "rational relation" between the legislation, and a legitimate State interest pursued through that legislation. Unlike the abortion cases, which recognized abortion as a fundamental liberty, the right to have life-preserving treatment withdrawn is merely a liberty interest. The Rehnquist court's *Cruzan* decision thus only gives weak support for a "right to die."

ensuring that the patient's choice is informed and unambiguous through heightened evidentiary requirements.²⁶¹ It was assumed in the *Cruzan* court opinion, however, that "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."²⁶²

As a result of the *Cruzan* decision, it is clear that when a patient is *incompetent*, state laws limiting or regulating the withdrawal of life-support may vary significantly without necessarily infringing the patient's constitutionally protected liberty interest.²⁶³ Nancy Cruzan was a PVS patient who had suffered oxygen deprivation for twelve to fourteen minutes after her car overturned in an accident and she was thrown face down into a water-filled ditch. When it became clear that Nancy had virtually no chance of regaining her mental faculties, her parents requested the withdrawal of the hydration and nutrition procedures that were keeping her alive.²⁶⁴ The Supreme Court held, however, that the State of Missouri was justified in continuing treatment in the absence of "clear and convincing" evidence that Nancy would have wished treatment to be withdrawn under such circumstances.²⁶⁵ The "clear and convincing" evidence standard is notoriously difficult to satisfy. In *Cruzan*, for example, the Missouri Supreme Court found that Nancy's previous statement, that "if she were sick or injured she would not wish to continue her life unless she could live at least halfway normally,"²⁶⁶ did not satisfy the clear and convincing standard.²⁶⁷

The *Cruzan* case was thus a set-back for the right to bodily self-determination in Missouri. However, nothing in the case precludes other states from adopting a different approach.²⁶⁸ The Court reviewed a variety of approaches adopted by other states, unified by their general preference for a "substituted judgment" rationale. A substituted judgment approach requires courts to second-guess whether an incompetent patient *would*

²⁶¹ *Cruzan*, 497 U.S. at 280-81.

²⁶² *Id.* at 279. See also *Id.* at 287-89 (O'Connor, J., concurring).

²⁶³ *Id.* at 261.

²⁶⁴ *Id.* at 265-67.

²⁶⁵ *Id.* at 287.

²⁶⁶ *Id.* at 268; *Cruzan v. Harmon*, 760 S.W. 2d 408, 426 (Mo. 1988) (en banc). A "clear and convincing" evidence approach also operates in New York. In re Westchester County Med. Ctr., 531 N.E. 2d 607 (N.Y. Ct. App. 1988).

²⁶⁷ *Cruzan*, 497 U.S. at 268.

²⁶⁸ The decision does not change the law in any state nor require physicians to act differently. George J. Annas, *The Long Dying of Nancy Cruzan*, 19 LAW, MED. & HEALTH CARE 52, 58 (1991). One limitation, as intimated by Justice O'Connor, was that the patient's constitutionally protected liberty interests *could* be implicated if a State simply refused to implement the decision of a duly appointed surrogate, regardless of whether clear and convincing evidence of the patient's previous wishes had been given. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 292 (1990).

have wanted treatment withdrawn, if he or she could have foreseen the injury which was sustained.²⁶⁹ Some states have accepted that while explicit evidence of what the patient would have wanted may be helpful and compelling, it is not necessary for the exercise of substituted judgment by a guardian. In these cases, the guardian tries to decide what the patient would have decided, guided by the patient's general value system.²⁷⁰ Still other courts have accepted that a substituted decision should be made in the patient's "best interests," taking what is known of the patient's attitudes, and his or her medical prognosis, into account.²⁷¹ This approach operates in California.²⁷² Some courts have moulded elements of each of the above approaches, enabling a "best interests" decision to be made only in the absence of trustworthy evidence, or any evidence, of what the patient would have wanted.²⁷³

Enough has been said to show that the legal recognition of a right of bodily self-determination through legislation and under common law, extending as it does to the withdrawal of life-preserving treatment, is a major development which undermines a "life-at-all-costs" approach. Although the exercise of this right is complicated if the patient is incompetent, legislative mechanisms such as living wills and medical powers of attorney, and the substituted judgment approach of the United States courts, all attempt to ensure compliance with "what the patient would have wanted." English courts, by contrast, have rejected the idea of "substituted judgment" to determine whether treatment should be withdrawn from a patient who has become incompetent, focusing instead on what is in the patient's "best interests."²⁷⁴ This focus, in turn, has contributed to a third development undermining the sanctity of life ethic—legal recognition of what amounts to the concept of a "futile life."

²⁶⁹ *Cruzan*, 497 U.S. at 271-73.

²⁷⁰ *See, e.g.*, In re Estate of Longeway, 549 N.E.2d 292, 299-300 (Ill. 1989).

²⁷¹ *See, e.g.*, *Conservatorship of Drabick*, 200 Cal. App. 3d 185.

²⁷² *Id.*

²⁷³ *See, e.g.*, In re. Conroy, 486 A.2d 1209, 1229-33 (N.J. 1985).

²⁷⁴ In *Airedale N.H.S. Trust v. Bland*, [1993] App. Cas. 789, the leading English case, the House of Lords held that the decision to withdraw treatment from a permanently unconscious patient is a medical decision for the doctor, although it required scrutiny by a court, until a sufficient body of experience and practice had grown which obviated this need. *Id.* at 859 (Lord Keith), at 871 (Lord Goff), at 875 (Lord Lowry), at 885 (Lord Browne-Wilkinson). Implicit in this approach was a rejection of the United States' "substituted judgment" approach. *Id.* at 864-65, 871-72, 873-74 (Lord Goff), at 895 (Lord Mustill).

3. "Futile Lives," "Best Interests" and the Withdrawal of Life Support

a. *The Anthony Bland case*

In *Airedale NHS Trust v Bland*, Britain's highest court, the House of Lords, was faced with the case of Anthony Bland, whose liquefied cerebral cortex permanently precluded any return to consciousness, cognition or sensory perception.²⁷⁵ For nearly four years, when the House of Lords handed down its judgment in February 1993, Bland had lain in a persistent vegetative state which doctors had concluded was irreversible. Faced with this situation, Bland's parents wanted the artificial feeding and other measures keeping their son "alive" to be withdrawn.²⁷⁶ Doubts over the criminal law, however, led to litigation and eventually to a declaratory judgment. The law Lords were unanimous that where, in accordance with a responsible body of medical opinion, a doctor concludes that further medical treatment will be of no benefit to a permanently unconscious patient, there is no duty to provide it, and such treatment may legally be withdrawn.²⁷⁷ As Singer has recognized, this decision represents a significant retreat from the sanctity of life ethic, and plants the seeds for further change in the future.²⁷⁸

It is fundamental that in their provision of medical treatment to incompetent patients, doctors owe a duty to act in the patient's best interests.²⁷⁹ When a patient is terminally ill, the patient's best interests may only require sedation or pain relief, to permit the patient to die with dignity.²⁸⁰ It is well accepted that there is no duty to continue medical heroics when death is imminent and inevitable.²⁸¹ But what about a patient who is permanently unconscious, although not terminally ill? The mean survival time of PVS patients like Anthony Bland (provided hydration and

²⁷⁵ *Bland*, [1993] App. Cas. at 789.

²⁷⁶ *Id.* at 789-90.

²⁷⁷ *Id.* at 858-59 (Lord Keith); *Id.* at 867-69 (Lord Goff); *Id.* at 876-77 (Lord Lowry); *Id.* at 883-84 (Lord Browne-Wilkinson); *Id.* at 897-99 (Lord Mustill).

²⁷⁸ Peter Singer, *Presidential Address: Is the Sanctity of Life Ethic Terminally Ill?* 9 *BIOETHICS* 327, 337-342 (1995).

²⁷⁹ *E.g.*, In re F (Mental Patient: Sterilisation), [1990] 2 App. Cas. 1.

²⁸⁰ *Airedale N.H.S. Trust v. Bland*, [1993] App. Cas. 789, 867 (Lord Goff); *see also* Judge Devlin's statement to the jury in the trial of Dr. Adams (*supra* notes 42-45 and accompanying text) that where "the purpose of medicine—the restoration of health—could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer." Palmer, *supra* note 45, at 375.

²⁸¹ *Bland*, [1993] App. Cas. at 858-59 (Lord Keith); *Id.* at 867-69 (Lord Goff); *Id.* at 876-77 (Lord Lowry); *Id.* at 883-84 (Lord Browne-Wilkinson); *Id.* at 897-99 (Lord Mustill).

nutrition are continued) is approximately two to five years, with some patients living for decades.²⁸²

According to Lord Mustill, Anthony Bland had “no best interests of any kind.”²⁸³ Thus, while the termination of Anthony’s life might not have been in his best interests, Anthony’s best interests in being kept alive had also disappeared, together with the justification for the indefinite continuation of life support.²⁸⁴ In a similar vein, Lord Keith observed that where a person has no cognitive capacity whatever, and no prospect of recovery, “it must be a matter of complete indifference whether he lives or dies.”²⁸⁵

To suggest that it was a matter of complete indifference whether Anthony Bland lived or died obviously reflected a moral judgment about the value of his life. In Lord Mustill’s view, the withdrawal of medical treatment was both ethical and legally permissible because “the continued treatment of Anthony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality.”²⁸⁶ While not turning his mind to a higher-brain definition of death, Lord Mustill was adopting the same criterion as a basis for withdrawing treatment in circumstances where death would certainly follow. Each of the other law Lords’ speeches reflected, or were consistent with, Lord Mustill’s reasoning.²⁸⁷ Lord Goff noted,

for my part I cannot see that medical treatment is appropriate or requisite simply to prolong a patient’s life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition . . . But in the end, it is the futility of the treatment which justifies its termination.²⁸⁸

Their Lordships accepted, essentially, that there is no moral value in preserving the life of a permanently unconscious person. Anthony Bland’s life, in other words, was “futile” and this justified the withdrawal of the treatment which was keeping him alive. Two of their Lordships went

²⁸² The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (Pt. 2), 330 NEW ENG. J. MED. 1499, 1575 (1994).

²⁸³ *Bland*, [1993] App. Cas. at 897.

²⁸⁴ *Id.*

²⁸⁵ *Id.* at 858.

²⁸⁶ *Id.* at 899.

²⁸⁷ *Id.* at 869 (Lord Goff); *Id.* at 858 (Lord Keith).

²⁸⁸ *Id.* at 869.

further and held that where treatment can no longer be said to be in the patient's best interests, there is a *duty* to stop treatment.²⁸⁹ The implication from the *Bland* case is that the law does not protect the sanctity of life of patients who are permanently unconscious. By putting *Bland* into practice, doctors not only ensure that such patients will die, but their actions bespeak the view that such patients would be better off dead. In *Bland*, their Lordships justified the withdrawal of intravenous feeding and hydration, which ended a patient's life through dehydration, not through an act of self-determination, but because they considered his life to be futile and meaningless.²⁹⁰

b. The discredited act/omission distinction

Both advocates²⁹¹ and opponents²⁹² of legalized euthanasia have recognized that the *Bland* case represents a significant retreat from the sanctity of life ethic. Furthermore, the reasoning in the case is unstable, and likely to crumble in a way which further undermines this ethic. This is because, while authorising the withdrawal of Anthony's treatment, their Lordships affirmed that euthanasia is unlawful, thus requiring a distinction to be drawn between the two.²⁹³

Lord Mustill, Lord Goff, and (apparently) Lord Keith, resorted to the familiar act/omission distinction. The lawful *withdrawal* of treatment can be regarded as an *omission* to provide treatment which there is no duty to provide, and not as an "active measure," such as murder or non-voluntary euthanasia. Thus, when the patient dies, the doctor cannot be regarded as legally responsible, under the law of homicide.²⁹⁴

²⁸⁹ *Id.* at 876-77 (Lord Lowry); *Id.* at 883 (Lord Browne-Wilkinson).

²⁹⁰ In *Bland*, permanent lack of consciousness was taken to imply that Bland had no "best interests". *Bland*, [1993] App. Cas. At 869. Where a patient is not permanently unconscious, English courts focus exclusively upon the patient's best interests, when deciding about medical intervention upon an incompetent patient. Courts have not accepted, however, that the sanctity of life ethic will always dictate that the patient's best interest require the prolongation of life. In one recent English case, the court accepted that where a newly born yet non-terminally ill baby's deformities, viewed from the perspective of a person able to make a sound judgment, were such that life would be intolerable, then life-preserving ventilation could lawfully be withdrawn. In *re J* (Wardship: Medical Treatment), [1991] Fam. 33, 46-47, 55. "I consider the court is entitled in the best interests of the child to say that deliberate steps should not be taken artificially to prolong its miserable life span." *In re J* at 55.

²⁹¹ *E.g.*, Peter Singer, *supra* note 278.

²⁹² *E.g.*, J.M. Finnis, *Bland: Crossing the Rubicon?* 109 LAW Q. REV. 329, 335 (1993); J.M. Finnis, *A Philosophical Case Against Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 23, 30-34 (John Keown ed., Cambridge University Press, 1995).

²⁹³ *Bland*, [1993] App. Cas. at 859 (Lord Keith); *Id.* at 865 (Lord Goff); *Id.* at 892-93 (Lord Mustill).

²⁹⁴ *Id.* at 858-59 (Lord Keith); *Id.* at 865-66, 873 (Lord Goff); *Id.* at 887; *Id.* at 897-98 (Lord Mustill).

Lord Mustill admitted that to absolve doctors from causing the death of a patient who, quite literally, would die from the withdrawal of fluids, on the basis that withdrawing intravenous hydration and nourishment was an omission, and not an act, was “morally and intellectually dubious,”²⁹⁵ and served only to emphasise “the distortions of a legal structure which is already both morally and intellectually misshapen.”²⁹⁶ Lord Goff conceded that the distinction could lead to a “charge of hypocrisy,”²⁹⁷ and with good reason. Since doctors have the ability to prolong life, the withdrawal of life-preserving treatment shortens life, thereby causing death.²⁹⁸ As Justice Scalia recognized in the *Cruzan* case,²⁹⁹ an “omission” or “withdrawal” of treatment would not be ignored if a nurse turned off a ventilator without permission, or if a parent starved an infant; this would be murder.³⁰⁰ The fact that the doctor has no *duty* to keep administering treatment, because the patient’s life is considered “futile,” should not lead one to think that the doctor has not caused the patient’s death. In their eagerness to distinguish euthanasia, the law Lords were camouflaging the real issue—whether withdrawing life-support and so ending a patient’s life *was justified* in the circumstances. Better to see the withdrawal of life-preserving treatment for what it is—a *form of non-voluntary euthanasia*³⁰¹—and to justify it on ethical or policy grounds, than to pretend that doctors are not, as a matter of law and morality, actually killing the patient.³⁰²

A more honest approach is evident in a recent New Zealand case which concerned the withdrawal of ventilation from a patient with Guillain-Barré syndrome, a disease which destroys the conductivity of the

²⁹⁵ *Id.* at 898.

²⁹⁶ *Id.* at 887.

²⁹⁷ *Id.* at 865.

²⁹⁸ For the purposes of the law of murder, it is irrelevant that a person (the patient) would have died soon anyway. See, e.g., Palmer, *supra* note 45, at 375 (Citing Devlin, J., in Dr. Adam’s trial).

²⁹⁹ *Cruzan v. Missouri Department of Health*, 497 U.S. 261, 297; 111 L Ed 2d 224, 253-54 (1990).

³⁰⁰ *Id.*

³⁰¹ Lord Lowry, in fact, did recognize that the *Bland* case might be seen as an example of “euthanasia in action.” *Bland*, [1993] App. Cas. at 877.

³⁰² Some Catholic commentators employ an additional distinction between “intending” the patient to die and “willing” or “permitting” the patient to die: Moria M. McQueen & James L. Walsh, *The House of Lords and the Discontinuation of Artificial Nutrition and Hydration: An Ethical Analysis of the Tony Bland Case*, 35 CATH. LAW., 363, 370-77 (1994). This is even shakier than the act/omission distinction. Should a doctor who withdraws life-preserving treatment from a “futile” patient and who intends the natural consequences of his or her actions be regarded as acting immorally, and/or illegally, as against the doctor who is oblivious to those consequences, or who shelters in the belief that he or she is passively letting nature take its course? How can this distinction encourage doctors to take moral responsibility for their actions?

nerves between the brain and body, leaving the patient unable to move or communicate.³⁰³ Justice Thomas said,

In my view, doctors have a *lawful excuse* to discontinue ventilation when there is no medical justification for continuing that form of medical assistance. To require the administration of a life-support system when such a system has no further medical function or purpose and serves only to defer the death of the patient is to confound the purpose of medicine.³⁰⁴

If one recognizes, therefore, that the act/omission distinction is spurious, and that doctors are entitled to hasten the death of PVS patients, then why should not doctors be permitted to hasten death by lethal injection, instead of subjecting the patient's family and carers to the stress of watching the patient's (albeit unconscious) body die from acute dehydration or malnutrition?³⁰⁵ Lord Mustill's response: "sadly[,] it is for the best,"³⁰⁶ hardly satisfies. Furthermore, when a patient is competent and in the painful or anguished end-stages of a terminal disease, and clearly is conscious and aware of his or her interests, why should not doctors be permitted to cause death directly? English law provides no satisfying answer to this question. In *Bland*, their Lordships simply affirmed that euthanasia was illegal, that legalization was a question for Parliament, and that under the current law, "the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy."³⁰⁷

Significantly, in the United States, the moral and legal distinction between withdrawing life-support, and causing death through more direct

³⁰³ Auckland Area Health Board v Attorney-General, [1993] 1 N.Z.L.R. 235, 250 (per Thomas, J., emphasis added).

³⁰⁴ *Id.*

³⁰⁵ While the absence of cortical function suggests that PVS patients would not suffer any distress, specialists point out that reflex responses to pain (withdrawing or grimacing) may remain, and that starvation may cause agitation, "presumably due to the release of brain stimulating chemicals in response to hypoglycaemia." Keith Andrews, *Patients in the Persistent Vegetative State: Problems in their Long Term Management*, 306 BRIT. MED. J. 1600, 1601 (1993). Dr. Keith Andrews, who gave evidence in the *Bland* case, notes paradoxically that "[w]e seem to be progressing down the road of accepting involuntary euthanasia before voluntary euthanasia has been accepted legally. It is unlikely that starvation would be regarded as an acceptable way of assisting dying in voluntary euthanasia, so should we even consider this method for involuntary euthanasia?" *Id.* at 1602.

³⁰⁶ *Bland*, [1993] App. Cas. at 898 (Lord Mustill).

³⁰⁷ *Id.* at 893 (Lord Mustill). Lord Goff also noted that "whereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony." *Id.* at 866.

measures, has been rejected by both the Ninth³⁰⁸ and Second Circuit³⁰⁹ Courts of Appeal. In the *Compassion in Dying* case, Judge Reinhardt, delivering the court opinion for the Ninth Circuit stated,

we see little, if any difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.³¹⁰

Similarly, in *Quill v. Vacco*,³¹¹ the Second Circuit regarded the disparity between New York State law which permitted a competent patient to hasten their death by withdrawing life-support, yet prohibited a person from hastening their death by self-administering prescribed drugs, as evidence that the latter provisions, which prohibited assisted suicide, violated the Equal Protection Clause of the Fourteenth Amendment.³¹² It is implicit in this conclusion that there is no relevant legal or moral difference between the omission and the positive act, at least where the positive act consists of prescribing lethal injections for self-administration by a competent and terminally ill patient. The deeper logic which underlies the rejection of the act/omission distinction may eventually persuade U.S. courts to legalize active voluntary euthanasia (AVE), and not merely physician-assisted suicide (PAS).

"Medical futility" can be described as a prognosis that further therapy will not benefit a patient.³¹³ Courts are increasingly accepting that medical futility is a justifiable basis for withdrawing life-preserving treatment.³¹⁴ In *Bland*, however, the House of Lords arguably went further, and held that life-support may be withdrawn, not merely because a patient was dying, or would not improve with further treatment, but because the patient's life itself was futile and meaningless. It was this

³⁰⁸ *Compassion in Dying*, 79 F.3d 790.

³⁰⁹ *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

³¹⁰ *Compassion in Dying*, 79 F.3d 790, 824.

³¹¹ *Quill v. Vacco*, 80 F.3d 716.

³¹² *Id.* at 40-41.

³¹³ Steven H. Miles, *Medical Futility*, 20 LAW, MED. & HEALTH CARE 310 (1992).

³¹⁴ See, e.g., *Barber v. Superior Court of California*, 195 Cal. Rptr. 484, 491 (Cal. Dist. Ct. App. 1983); *Auckland Area Health Board v. Attorney-General*, [1993] 1 N.Z.L.R. 235, 252-53.

moral judgment which Britain's highest Court adopted as a way of ensuring Anthony Bland's demise. In contrast, the American-style "substituted judgment" approach, preserves the fiction of self-determination by trying to determine "what the patient would have wanted."³¹⁵

The decision in *Bland* is likely to be influential in Australia. It is not inconceivable that it might also be influential within the United States.

The *Cruzan* decision does not change the law regulating the withdrawal of medical treatment in any State. As Justice O'Connor intimated, the "social laboratory" is free to continue.³¹⁶ Unlike abortion, Supreme Court decisions have not federalized and constitutionalized the withdrawal of medical treatment issue. It remains open for States to embrace "medical futility" as a basis for withdrawing life-preserving treatment in a patient's best interests, as an alternative to the substituted decision approach. Such an approach would, however, preclude family members from requiring the continuation of life-support systems for PVS patients or anencephalic infants.³¹⁷

B. The Right to Die: An Emerging Jurisprudence

It is no accident that in the late 1990s we are seeing the emergence of a legal right to die. Such a right follows naturally from a jurisprudence which has already significantly undermined the sanctity of life ethic by re-defining death; and by recognizing a right of personal autonomy which extends to the withdrawal of life-support. This right of personal autonomy may be exercised despite supervening incompetence through advance directives and other statutory mechanisms. Additionally, the United Kingdom has accepted that, regardless of previously-expressed wishes, life-support may be withdrawn if one's life is considered "futile" because of permanent unconsciousness.³¹⁸ An interesting variety of forms of the right to die are emerging, reflecting different legal structures, as reviewed below.

³¹⁵ See *Cruzan*, 497 U.S. 261, 271-73, 111 L Ed 2d 224, 250-51 (1990).

³¹⁶ *Cruzan*, 497 U.S. at 292.

³¹⁷ See, e.g., the debate which arose over the case of Baby K, an anencephalic infant whose mother insisted on continued mechanical intervention: Marcia Angell, M.D., *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1524 (1994); George J. Annas, J.D., M.P.H., *Asking the courts to set the Standard of Emergency Care—the Case of Baby K*, 330 NEW ENG. J. MED. 1542 (1994). The US Court of Appeals upheld the mother's right to insist on continued treatment: In re Matter of Baby K, 16 F.3d 590 (4th Cir. 1994), cert. denied, 115 S. Ct. 91, 130 L Ed 2d 42 (1994).

³¹⁸ See *Bland*, [1993] App. Cas. at 789.

1. *Australia's Northern Territory*

In late February 1995, barely three weeks after first announcing his intention to introduce legislation recognizing the right to die,³¹⁹ the Rights of the Terminally Ill Bill was tabled by Chief Minister Marshall Perron in the Northern Territory Legislative Assembly.³²⁰ In the course of his first reading speech, Perron said:

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 for those I love.³²¹

Perron's initiative ushered in three months of frantic lobbying in the Territory, as well as a raucous, nationwide debate. Perron observed wryly after the Bill had been safely passed that in his experience there were few "swingers" in the debate, and that both inside and outside politics, almost everyone retained their original support for, or opposition to, voluntary euthanasia, despite the arguments presented on both sides.³²²

The Rights of the Terminally Ill Act was passed in a conscience vote at 3:15 a.m. on May 25, 1995 by a fifteen to ten majority of the Northern Territory Legislative Assembly.³²³ The passing of such important social legislation within a brief three months must count as some sort of a record. Importantly, the legislation authorizes both active voluntary euthanasia and assisted suicide.³²⁴ The legislation has been stridently criticised by churches. The Australian Catholic Bishops Conference reminded Catholics in a pastoral letter that humans must not play God, and although "there is no virtue in suffering for its own sake . . . the experience of death is a profoundly Christian experience when we go

³¹⁹ Chips MacKinolty & Daniel Lewis, *NT to Vote on Assisted Suicide*, SYDNEY MORNING HERALD, Feb. 2, 1995, at 2.

³²⁰ Marshall Perron, First Reading Speech to the Rights of the Terminally Ill Bill, Northern Territory Legislative Assembly (Feb. 22, 1995.)

³²¹ *Id.*

³²² Marshall Perron, speech given at conference entitled "Death and the State," Centre for Public Policy, University of Melbourne, (Aug. 24, 1995.)

³²³ Justine Ferrari & David Nason, *States Grapple with Euthanasia*, AUSTRALIAN, May 26, 1995, at 1; Gay Alcorn et al., *Kennett Flags Right-to-Die Bill*, THE AGE (Melb.), May 26, 1995, at 1.

³²⁴ Rights of the Terminally Ill Act (1995) (NT) § 7(1)(a).

to meet God at the moment when God chooses to call us.³²⁵ The Australian Medical Association also opposed the legislation,³²⁶ and has since assisted in a failed constitutional challenge to the Act which is now on appeal to the Australian High Court.³²⁷

The Rights of the Terminally Ill Act (1995) has stimulated a growing body of scholarly comment.³²⁸ The Act contains a variety of safety mechanisms designed to prevent abuse. The principal features are as follows:

- Only patients age eighteen or older suffering terminal illnesses can be assisted;³²⁹
- The treating doctor must be satisfied on reasonable grounds that the patient is experiencing pain, suffering or distress to an extent unacceptable to the patient, and that there is no treatment reasonably available to the patient, other than palliative care;³³⁰
- A second doctor must confirm the treating doctor's prognosis;³³¹
- A third doctor, who must be a qualified psychiatrist, must certify that the patient is not suffering a treatable clinical depression;³³²
- The treating doctor must counsel the patient as to treatment options, including palliation, counselling and psychiatric support; must be satisfied that the patient has considered the effect of the decision upon family, and that the decision is freely and voluntarily made. Information about palliative care options must be given either by the treating doctor or another doctor who satisfies legislative criteria ensuring specialist knowledge in palliative care. Following the counselling, the patient must reaffirm his or her decision;³³³

³²⁵ Australian Catholic Bishops Conference, Pastoral Letter to the Catholic People of Australia, May 1995. See also, Graham Downie, *Bishops in Joint Pleas on Euthanasia*, CANBERRA TIMES, Apr. 29, 1995, at 6; Gay Alcorn, *Vatican Condemns NT Euthanasia Law*, WEEKEND AUSTRALIAN, May 27-28, 1995, at 2; Rachel Buchanan & Steve Dow, *Church Bid for Unity Against Law*, THE AGE (Melb.), May 29, 1995, at 5; Harry Goodhew, *Euthanasia Against the Christian Ethic*, SYDNEY MORNING HERALD, May 30, 1995, at 13; Elissa Blake, *Nazi Threat in Euthanasia*, THE AGE (Melb.), July 4, 1995, at 1; Andra Jackson, *Catholics Set up Euthanasia Think Tank*, AUSTRALIAN July 21, 1995, at 3.

³²⁶ Andrew Darby et al, *AMA Push for States to Reject Euthanasia*, THE AGE (Melb.), May 26, 1995, at 6.

³²⁷ Justine Ferrari, *Supreme Court Rejects Challenge on Euthanasia*, AUSTRALIAN, July 25, 1996, at p 7; *Wake v. Northern Territory*, unreported, Supreme Court of the Northern Territory, July 24, 1996, Martin CJ, Angel & Mildren JJ.

³²⁸ See, e.g., 3(2) J. L. & MED. (1995) (special issue on euthanasia).

³²⁹ Rights of the Terminally Ill Act § 7(1)(a) (1995) (N. Terr.).

³³⁰ *Id.* § 4, 7(1)(b).

³³¹ *Id.* § 7(1)(c)(iii).

³³² *Id.* § 7(1)(c)(iv).

³³³ *Id.* § 7(1)(e)-(h).

- A cooling off period of 48 hours applies, and the treating doctor must provide the assistance personally and remain until the patient has died;³³⁴
- Prior to this, the patient's request to die must be documented, signed, witnessed and countersigned by the second doctor in accordance with statutory requirements;³³⁵
- A request may be rescinded at any time;³³⁶
- The Act requires the treating doctor to document in the patient's medical record all aspects of the process, including the paperwork demonstrating compliance with the legislative procedure as it relates to each of the three doctors involved in the process, noting the drugs used to bring about death, certifying death, and reporting to the Coroner, who in turn reports to the Attorney-General;³³⁷
- The Act also requires the use of interpreters holding prescribed qualifications where the patient and any of the three doctors involved in the process do not share the same first language.³³⁸ The interpreter must be present at the signing of a request for assistance, and must not stand to gain anything from the patient's death;³³⁹
- Doctors giving assistance may not receive any reward for their services above a normal fee;³⁴⁰
- The termination of life in accordance with the Act carries immunity from civil or criminal liability, and professional disciplinary action.³⁴¹

Despite some talk of repeal following changes in the composition of the Northern Territory Legislative Assembly, the Act has been in force since 1 July 1996.³⁴² Importantly, however, the Act is under challenge at the federal level. A Catholic backbencher's private member's Bill introduced into Commonwealth Parliament in September 1996 would

³³⁴ *Id.* § 7(1)(n)-(p).

³³⁵ *Id.* § 7(1)(i)-(k).

³³⁶ *Id.* § 10.

³³⁷ *Id.* §§ 12-15.

³³⁸ *Id.* § 7(4).

³³⁹ *Id.* § 7(1)(l)-(m).

³⁴⁰ *Id.* § 6(1).

³⁴¹ *Id.* § 20(1)-(2).

³⁴² Darwin doctor Phillip Nitschke has developed a computer-controlled, Kevorkian-style, self-administering "death machine," with software (entitled "Final Exit") written by collaborator Des Carne. Patients move through three computer screens, the last of which says "If you press *Yes*, you will cause a lethal injection to be given within thirty seconds, and will die. Do you wish to proceed? 'YES/NO.'" Gay Alcom, *Press "Yes" to Die Now*, THE AGE (Melb.), Apr. 17, 1996, at A13. Early prototypes of the machine had a range of CD music to choose from, and ended with the farewell: "Good-bye and good luck."

override the Territory legislation, relying on section 122 of the Australian Constitution, which gives federal Parliament power to make laws for the territories. This Bill, which will attract a conscience vote, is due to be debated in late October. Early indications are that it could well be successful. In the meantime, despite tightened guidelines regulating the qualifications of specialists giving second opinions, on September 22, the first case of legalized euthanasia was carried out under the Act.³⁴³ A second death occurred on January 2, 1997.³⁴⁴

Elsewhere in Australia, private members' Bills introduced in South Australia and the Australian Capital Territory have failed.³⁴⁵ Reform is unlikely in New South Wales, following a Parliamentary debate revealing four-to-one opposition to legalization.³⁴⁶ An Australia-wide response to the regulation of euthanasia is highly unlikely. State health ministers defeated a proposal by a former federal Health Minister for a national taskforce to assess the Northern Territory's legislation and to ensure uniform state laws.³⁴⁷

2. *The British Commonwealth*

Australia is the only member of the British Commonwealth yet to experiment with PAS/AVE law reform. On August 16, 1995, the New Zealand Parliament rejected by a sixty-one to twenty-nine majority a private member's Death With Dignity Bill, which would have legalized voluntary euthanasia for the terminally ill.³⁴⁸ In England, a 1994 House of Lords Select Committee report opposed legalizing euthanasia.³⁴⁹ Similarly, the majority of the Canadian Special Senate Committee on Euthanasia and Assisted Suicide, presented its report to Parliament,

³⁴³ *First Death Under NT Mercy Law*, THE AGE (Melb.), Sep. 26, 1996, at 1; *Euthanasia Splits Nation*, AUSTRALIAN, Sep. 27, 1996, at 1. Sixty-six year old Robert Dent, a former carpenter and pilot, who had suffered from prostate cancer for five years, died following a lethal injection supervised by Darwin doctor Philip Nitschke. *Now More Want to Die*, THE AGE (Melb.), Sep. 27, 1996, at 1.

³⁴⁴ *Mercy Death Renews Outcry*, THE AGE (Melb.), Jan. 7, 1997, at 1. The second case of euthanasia was praised by the Victorian Premier. *Premier Defends the Right to a "Beautiful" Death*, THE AGE (Melb.), Jan. 7, 1997, at 4. The Vatican, however, condemned the act. *Vatican Urges NT Euthanasia Battle*, THE AGE (Melb.), Jan. 9, 1997, at 3.

³⁴⁵ Andrew Ramsey & Ebru Yaman, *MPs Put Brake on Right-to-Die Push*, AUSTRALIAN, July 27, 1995, at 1.

³⁴⁶ *Open House Slams Door on Euthanasia*, AUSTRALIAN, Oct. 17, 1996, at 1; *Historic Debate Full of Emotion*, AUSTRALIAN, Oct. 17, 1996, at 4.

³⁴⁷ Gareth Boreham, *Australia: Tehan in Clash Over Inquiry on Euthanasia Law*, THE AGE (Melb.), June 15, 1995, at 4; see Tim Stevens, *Euthanasia: Nat MPs will Follow Conscience*, AUSTRALIAN, June 19, 1995, at 3.

³⁴⁸ Speden Graeme, *Choice Key to Law's Death Bill*, THE DOMINION (Wellington), Aug. 16, 1995, at 10; see Speden Graeme, *MPs Throw out Euthanasia Bill*, THE DOMINION (Wellington), Aug. 17, 1995, at 1.

³⁴⁹ *Their Lordships on Euthanasia*, 343 LANCET 430 (1994).

opposing euthanasia, on June 6, 1995.³⁵⁰ As noted previously, the Canadian Supreme Court had already determined in the *Rodriguez* case³⁵¹ that the prohibition of assisted suicide does not violate the Canadian Charter of Rights and Freedoms.³⁵² The European Commission on Human Rights reached a similar decision, holding that English legislation criminalising assisted suicide does not violate the right to "respect for private and family life" in Article 8 of the European Convention on Human Rights.³⁵³

3. *The Netherlands*

The Netherlands has been a fierce battleground for advocates and opponents of pro-euthanasia policy.³⁵⁴ Assisted suicide and euthanasia are illegal in the Netherlands.³⁵⁵ Since 1973, however, caselaw has established that a doctor who terminates a patient's life in accordance with certain criteria and then reports the procedure, will not be guilty of any offense and is unlikely to be charged. To remain unprosecuted, the termination must follow a persistent, voluntary and well-informed request from a patient experiencing unbearable pain or suffering, with no treatment or other options for relief available, and the doctor must consult with a colleague.³⁵⁶ If these criteria are satisfied, the doctor may rely successfully upon the defence of necessity or *force majeure*.³⁵⁷ The basis of this defense is that the doctor's duty to preserve life should not conflict with the duty to relieve unbearable suffering.³⁵⁸

³⁵⁰ *Canada May Cut Euthanasia Penalties*, AUSTRALIAN, June 8, 1995, at 9; see SPECIAL SENATE COMMITTEE ON EUTHANASIA AND ASSISTED SUICIDE, FINAL REPORT (Oct. 20, 1996) <<http://www.rights.org/~deathnet/senate.html>>.

³⁵¹ *Re Rodriguez* and Attorney-General of British Columbia [1993] D.L.R. 342.

³⁵² *Id.*

³⁵³ App. No. 10083/82 v. United Kingdom, 6 EUR. H.R. REP. 140 (1984).

³⁵⁴ See, e.g., Els Borst-Eilers et al., *Medical Aspects of Euthanasia*, 155 MED. J. AUSTR. 645 (1991); see also Brian J. Pollard, 155 MED. J. AUSTR. 646 (1991) (letter in reply to Borst-Eilers et al.).

³⁵⁵ Dutch Criminal Code, §§ 293-94.

³⁵⁶ John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?* in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 264 (John Keown ed., Cambridge University Press, 1995).

³⁵⁷ NETHERLANDS MINISTRY OF FOREIGN AFFAIRS, *THE TERMINATION OF LIFE BY A DOCTOR IN THE NETHERLANDS* (1995) (press release on the regulation of euthanasia and assisted suicide in the Netherlands).

³⁵⁸ *Id.*; see also J. Rimmelink, *The Legal Position on Euthanasia in the Netherlands* (1994) (paper given to the 6th Annual Australasian Society for HIV Medicine (ASHM) Conference, Sydney, Nov. 4, 1994). English translation kindly provided by the author.

a. *The Rimmelink report*

In 1990, in order to inform itself over options for euthanasia law reform and regulation, the Dutch government appointed a committee to conduct a nationwide study to quantify the practice of euthanasia in the Netherlands.³⁵⁹ The Committee was chaired by Attorney-General Professor Jan Rimmelink, although the study itself was coordinated by Professor van der Maas from the Department of Public Health at the Erasmus University. The study proceeded as three sub-studies involving mailed questionnaires, in-depth interviews, and a prospective survey.³⁶⁰

Journal articles detailing the findings of the Rimmelink Report indicate that in 1990, the estimated incidence of active voluntary euthanasia, as a percentage of all annual deaths (~129,000 deaths), was 1.8% (~2,300 cases).³⁶¹ Similarly, an estimated 0.3% of annual deaths were the result of assisted suicide (~400 cases). The Report also estimated an annual figure of 1000 deaths (0.8% of annual deaths) which fell into neither of the preceding categories, where life was terminated without the patient's explicit request.³⁶² Referring to these cases of non-voluntary euthanasia, the authors of the study stated that the patients were "close to death and were suffering grievously."³⁶³ In more than half of cases the decision had been discussed with the patient or the patient had indicated in a previous phase of their illness a desire for euthanasia if suffering became unbearable.³⁶⁴ The admission of cases of non-consensual euthanasia has resulted in vehement criticism of the Dutch policy of de-criminalization. What should be remembered, however, is that non-consensual euthanasia also occurs in countries where euthanasia is illegal.³⁶⁵ Until the extent of illegal PAS/AVE is known, therefore, it seems premature to condemn the euthanasia policy of the one country which has opened itself up to inspection.

A final important issue from the Rimmelink study was the low level of reporting. Only 591 of the estimated 2,700 cases of active voluntary

³⁵⁹ Paul van der Maas et al., *supra* note 189, at 669.

³⁶⁰ Paul van der Maas et al., *supra* note 189, at 669.

³⁶¹ Paul van der Maas et al., *supra* note 189, at 670.

³⁶² Paul van der Maas et al., *supra* note 189, at 670.

³⁶³ Paul van der Maas et al., *supra* note 189, at 691.

³⁶⁴ Paul van der Maas et al., *supra* note 189, at 691; *see also* Johannes van Delden et al., *The Rimmelink Study: Two Years Later*, 23 HASTINGS CENTER REP. 24 (1993).

³⁶⁵ *See, e.g.*, Sheryl Stolberg, *Ending Life on Their Own Terms*, L.A. TIMES, Oct. 1, 1996, at A1; Julian Guthrie, *AIDS Victims Vow to Defy Suicide Ban*, S.F. EXAMINER, Oct. 2, 1996 at A1; George Raine, *Doctor Offers AID in Dying*, S.F. EXAMINER, Jan. 22, 1995 at A1.

euthanasia and assisted suicide were reported. This number excludes the 1000 cases of non-voluntary euthanasia.³⁶⁶

b. *The impact of the Rummelink report*

The significance of the Rummelink report has been a matter of heated debate. One line of response is that euthanasia in the Netherlands remains "unnotified, unchecked and invisible to justice."³⁶⁷ While the statistical implications of the Report have been misrepresented,³⁶⁸ the low level of reporting was certainly a cause for concern. The major reasons given for non-reporting included the desire to avoid the hassle of legal investigation, the fear of prosecution, and also the desire to protect the family.³⁶⁹ More recently, the level of reporting has improved.³⁷⁰ In themselves, however, the Rummelink numbers provide no substance for the claim that the decriminalization of euthanasia in the Netherlands is perverting respect for human life, and creating a class of medical killers with "syringes for hire." Any such claim would require comparison with other societies where euthanasia has not been decriminalized.³⁷¹

Partly as a result of the Rummelink report, the Dutch government decided not to introduce legislation that would have explicitly legalized euthanasia.³⁷² Nevertheless, effective on June 1, 1994, a statutory notification procedure has come into operation in the Netherlands that embodies fifty criteria which act as guidelines for assessing the decision of a doctor to terminate the life of a terminally ill patient for whom no prospect of improvement exists. Doctors' reports are verified by the

³⁶⁶ Johannes van Delden et al., *The Rummelink Study: Two Years Later*, 23 HASTINGS CENTER REP. 24 (1993).

³⁶⁷ H. Jochemsen, *Euthanasia in Holland: an Ethical Critique of the New Law*, 20 J. MED. ETHICS 212, 215 (1994).

³⁶⁸ See, e.g., Brian J. Pollard, *Euthanasia in Holland*, QUADRANT Nov. 1992 at 42-46; cf. Johannes van Delden et al., *Dances with Data*, 7 BIOETHICS 323 (1993). As Dr. Helga Kuhse, Director of the Centre for Human Bioethics at Monash University, Australia, has noted, depending on what definition of "euthanasia" is adopted, the Rummelink report provided evidence of between 2,300 and 48,500 cases per year. Helga Kuhse, *Dutch Euthanasia Link Overstated*, AUSTRALIAN, Apr. 12, 1995, at 10.

³⁶⁹ Chris Ciesielski-Carlucci & Gerrit Kimsma, *The Impact of Reporting Cases of Euthanasia in Holland: A Patient and Family Perspective*, 8 BIOETHICS 151, 152 (1994).

³⁷⁰ See van Delden et al., *supra* note 365, at 25 (1,323 cases reported in 1992); see also Jenifer Chao, *Less Fear on Dutch Mercy Killings*, THE AGE (Melb.), Sep. 15, 1995, at 9 (1,319 cases reported in 1993; 1439 in 1994). A more recent survey to investigate the under-reporting of life-terminating actions is under way. Marjanke Spanjer, *Dutch to Do New Survey on Assisted Deaths*, 346 LANCET 833 (1995).

³⁷¹ An Australian study led by Dr. Helga Kuhse of the Monash University Centre for Human Bioethics is replicating the questions asked in the Rummelink study; Australian comparative data should be available in late 1996.

³⁷² Rummelink, *supra* note 358.

municipal pathologist and assessed by the public prosecutor, who also determines whether the doctor can rely upon the *force majeure* defence.³⁷³

It is likely that developments in the Netherlands will continue to challenge and shock those in other countries. In Australia and the United States, the euthanasia debate has mostly focused upon PAS/AVE in relation to terminally ill patients who are competent to choose death. Once society accepts, however, that an individual's right to self-determination justifies medical assistance in dying, what logic limits euthanasia to terminally ill patients?

Those concerned about the "slippery slope" effect point to a highly-publicized recent case in which the Dutch Supreme Court affirmed that a doctor may successfully rely upon the necessity defense in circumstances where the patient's suffering is not caused by a somatic disease.³⁷⁴ In the *Chabot* case, the patient wanted to die after her marriage had broken down, and her two sons and father had died.³⁷⁵ The patient persistently refused treatment, and was described by the Court to be suffering a "depression in a narrower sense without psychotic characteristics, in the context of a complicated grieving process."³⁷⁶ Similarly, opponents of euthanasia point to the *Prins* case, where a gynecologist was convicted of murder for killing a brain damaged spina bifida baby described as "a sleeping plant," after consulting with family and colleagues. The Court said, however, that this decision could "reasonably be considered as justifiable,"³⁷⁷ and no punishment was imposed³⁷⁸.

The criteria which must be satisfied to evade criminal liability for euthanasia in the Netherlands do appear to be less rigorous and precise than those embodied in the Northern Territory Act.³⁷⁹ John Keown, a leading English critic of the Netherlands situation has argued,

³⁷³ NETHERLANDS MINISTRY OF FOREIGN AFFAIRS, *supra* note 357.

³⁷⁴ Marjanke Spanjer, *Assisted Suicide for Mental Distress*, 345 LANCET 246 (1995). For an English-language translation of the Court's decision, see John Griffiths, *Assisted Suicide in the Netherlands: The Chabot Case*, 58 MOD. L. REV. 232 (1995); see also Sjeef Gevers, *Physician Assisted Suicide: New Developments in the Netherlands*, 9 BIOETHICS 309 (1995).

³⁷⁵ John Keown, *Physician-Assisted Suicide and the Dutch Supreme Court*, 111 L. Q. REV. 394, 395 (1995). Dr Chabot was convicted in this case, but on the basis that since the patient was not suffering a somatic illness, he could not establish the necessity defense without ensuring that a second doctor had examined the patient. This had not occurred. However, the Supreme Court imposed no punishment.

³⁷⁶ *Id.*

³⁷⁷ *Dutch Doctor Convicted but not Punished for Euthanasia of Infant*, 14 MONASH BIOETHICS REV. 5 (1995).

³⁷⁸ *See Dutch Court Convicts Doctor of Murder*, 310 BRIT. MED. J. 1028 (1995); see also Jenifer Chao, *Baby Poses Sad Test for Dutch Euthanasia Law*, THE AGE (Melb.), Apr. 14, 1995, at 8.

³⁷⁹ John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 265-66 (John Keown ed., Cambridge University Press, 1995).

it is not even possible precisely to identify the legal criteria, let alone define them: the Supreme Court omitted to lay down a precise list and lower courts have issued sets of criteria which are far from congruent In short, the Guidelines are simply incapable, because of their vagueness and the fact that they entrust the decision-making in the individual practitioner, of ensuring that euthanasia is carried out only in accordance with the criteria they specify.³⁸⁰

Keown cites the case of a leading Dutch practitioner of euthanasia who would not rule out performing euthanasia on an elderly patient who felt he was a "nuisance to his relatives who wanted him dead so they could enjoy his estate."³⁸¹

c. Implications for the United States?

Like the Netherlands, yet unlike Australia, the right to die in the United States has emerged through court decisions.³⁸² Despite their role in interpreting the Constitution, courts are not legislatures. Furthermore, despite the social implications of constitutional decisions, courts make poor social policy planners. Left to develop like other rights, the risk is that a common law right to die will lack the fine tuning and level of detail that is required to protect vulnerable patients and to properly balance patients' wishes with public interests.

One of the prices paid for constitutionally guaranteed rights is ambiguity and uncertainty as to their extent of application. One unfortunate consequence of the Ninth Circuit decision in *Compassion in Dying*³⁸³ is that although it partially invalidated Washington State's prohibition on PAS, it did not, and could not, replace that prohibition with a comprehensive regulatory regime. Had it attempted to do so, the court might well have been criticized for usurping the role of the legislature. Nevertheless, beyond pointing to the kinds of safeguards incorporated within model statutes such as Oregon's defeated Death with Dignity Act,³⁸⁴ it essentially struck down Washington state's prohibition and

³⁸⁰ *Id.*

³⁸¹ *Id.* at 265.

³⁸² See, e.g., *Compassion in Dying*, 79 F.3d 790; *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

³⁸³ *Compassion in Dying*, 79 F.3d 790.

³⁸⁴ See Melinda Lee & Susan Tolle, *Oregon's Plans to legalize Suicide Assisted by a Doctor: How Much More Open Will the Practice Become?*, 310 BRIT. MED. J. 613 (1995); see also Ann Alpers, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483 (1995).

created the possibility of a “free-for-all” until such time as Washington State enacted a regulatory framework for PAS.³⁸⁵ While constitutional rights can defeat state legislation and also force reluctant states to “handle the hot potato” of PAS regulation, they may also facilitate the premature birth of emerging rights in the absence of an adequate regulatory framework.

4. *The United States*

Statutes prohibiting PAS were recently held to be unconstitutional by both the Second and Ninth Circuit Courts of Appeal, in so far as they precluded doctors from prescribing lethal medication for self-administration by mentally competent patients in the terminal phase of illness.

a. *The Ninth Circuit*

In *Compassion in Dying v. State of Washington*, the Ninth Circuit held that the right to determine the time and manner of one’s death, encompassing both (i) a patient’s right to withdraw life-preserving medical treatment, and (ii) the right of a terminally ill person to receive life-ending, physician-prescribed medication, was a liberty interest enjoyed under the Due Process Clause of the Fourteenth Amendment.³⁸⁶ The right to refuse medical treatment, encompassing a right to refuse artificial nourishment and hydration, followed from the *Cruzan* case,³⁸⁷ while the right of a terminally ill patient to PAS was one of the “most intimate and personal choices a person may make in a lifetime,” was “central to personal dignity and autonomy,”³⁸⁸ and thus qualified as a liberty interest.³⁸⁹

The constitutional right to PAS recognized by the court was not, however, any ordinary Fourteenth Amendment liberty interest. The court opinion stressed that “rational basis review” was not applicable for the “important interest” at issue.³⁹⁰ While not necessarily claiming that the right to PAS was a “fundamental” right, which could only be restricted by

³⁸⁵ Any such framework would itself, of course, be open to constitutional challenge if it overburdened the Fourteenth Amendment liberty interest. See *Compassion in Dying*, 79 F.3d 790.

³⁸⁶ *Compassion in Dying*, 79 F.3d at 790. The Fourteenth Amendment provides, relevantly, that no state shall “deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, §1.

³⁸⁷ *Compassion in Dying*, 79 F.3d at 814-17; see also *Cruzan v. Missouri Dep’t of Health*, 497 U.S. 261, 278-79 (1990).

³⁸⁸ *Compassion in Dying*, 79 F.3d at 813-14.

³⁸⁹ *Id.*

³⁹⁰ *Id.* at 804.

a State law narrowly tailored to serve a “compelling state interest,”³⁹¹ the majority effectively rejected the alternative under traditional, two-tiered due process analysis: i.e., that PAS was a mere “liberty interest” which could be restricted so long as the state could demonstrate a “rational relation” between PAS prohibition and a legitimate state interest. In defining PAS as a liberty interest, the Ninth Circuit majority was strongly influenced by *Planned Parenthood v. Casey* where the Court noted that central to Fourteenth Amendment liberty were “choices central to personal dignity and autonomy” and that “at the heart of liberty” was “the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.”³⁹²

The Ninth Circuit opinion was really only consistent with a continuum approach. It rejected the “fundamental vs. non-fundamental” framework in favor of one where the “more important the individual’s right or interest, the more persuasive the justifications for infringement would have to be.”³⁹³ Justice Beezer’s dissent, by contrast, focused on showing that PAS was not a “fundamental right” under traditional tests,³⁹⁴ and that the *Casey* court formulation was not directed towards identifying “fundamental liberties,” having been given, in any event, within the different context of an abortion case, which only survives thanks to *stare decisis*.³⁹⁵ For its part, the majority held that regardless of whether PAS was a *fundamental right*,³⁹⁶ or simply an *important liberty interest*,³⁹⁷ it must be balanced against opposing state interests.³⁹⁸ A controversial aspect of the majority opinion was, however, that it elevated PAS to

³⁹¹ See *supra* text accompanying note 260.

³⁹² *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

³⁹³ *Compassion in Dying*, 790 F.3d at 804.

³⁹⁴ “Substantive due process” rights, according to two regularly cited Supreme Court formulations, are those rights which are “so rooted in the traditions and conscience of our people as to be ranked as fundamental” *Reno v. Flores*, 507 U.S. 292, 303 (1993) (quoting *U.S. v. Salerno*, 481 U.S. 739, 751 (1987) quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934))), or which are so “implicit in the concept of ordered liberty,” such that “neither liberty nor justice would exist if [they] were sacrificed.” *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937)). As Justice Beezer pointed out, history or tradition does not support a legal right to suicide as most States criminalize PAS and allow the State to intervene to prevent attempted suicide. Nor can it “honestly be said that neither liberty nor justice will exist if access to physician-assisted suicide is proscribed.” *Compassion in Dying*, 790 F.3d at 849 (Beezer, J., dissenting). Finally, the right to withdraw life-preserving treatment recognized in *Cruzan* was nowhere recognized as a “fundamental” right. See *supra* text accompanying note 260.

³⁹⁵ *Compassion in Dying* 790 F.3d at 849 (Beezer, J., dissenting).

³⁹⁶ Under which, the state was required to show a compelling, narrowly-tailored State interest justifying restriction under a traditional, Due Process analysis. See *Compassion in Dying* 790 F.3d at 812.

³⁹⁷ Under which, in accordance with a “continuum approach,” the burden of proof in justifying a restriction depended upon the relative importance of that liberty interest. *Compassion in Dying* 790 F.3d at 804.

³⁹⁸ *Compassion in Dying* 790 F.3d at 815-16.

something more than a mere personal liberty, simply on the grounds of it being an intimate personal choice, which was "central to human dignity."³⁹⁹

The majority was on stronger ground in pointing out that a right to PAS was implicit within the limits of existing law, that already allowed patients a right to die by self-starvation and authorized doctors to administer death-inducing medication "so long as they can point to a concomitant pain-relieving purpose."⁴⁰⁰ Existing law also permitted the withdrawal of nourishment from PVS patients, who would starve to death as a result.⁴⁰¹ As noted previously, in reaching this conclusion, the court rejected the notion that there was any relevant difference for constitutional or ethical purposes between "passively" withdrawing life-support, and "actively" causing death.⁴⁰²

The court canvassed a variety of state interests weighing against the liberty interest of a terminally ill patient in PAS. According to the court, the state has an interest in preserving life. The interest in preserving life, however, depends upon relevant circumstances including the medical condition and wishes of the terminally ill patient. The state of Washington had already determined that the interest in preserving life gave way under certain conditions. The Washington Natural Death Act allowed terminally ill patients to give advance directives, or to refuse life-preserving treatment. The court reasoned accordingly that the state interest in preserving life was diminished where a terminally ill patient desired PAS in order to avoid pain and suffering.⁴⁰³

Other state interests include preventing suicide, precluding undue influence on the terminally ill and preserving the integrity of the medical profession.⁴⁰⁴ These risks could be mitigated through the proper regulation of PAS. Fear that legalized PAS would undermine the integrity of the profession ignored the fact that many doctors already supported PAS, terminating life-support systems with patient consent, or administering lethal doses of pain relief under cover of the "double effect" principle.⁴⁰⁵ The court found that history did not support the prophecies of a slide towards nihilistic killing which also accompanied legalized abortion and other changes in the medical profession.⁴⁰⁶

³⁹⁹ *Id.* at 813-14.

⁴⁰⁰ *Id.* at 822.

⁴⁰¹ *Id.* at 822-23.

⁴⁰² *Id.* at 824.

⁴⁰³ *Id.* at 817-20.

⁴⁰⁴ *Id.* at 825-27.

⁴⁰⁵ *Id.* at 827-28.

⁴⁰⁶ *Id.* at 830.

The Ninth Circuit concluded that the liberty interest in PAS reached its peak in the terminally ill, where the State interests identified were for the most part at a low point. Balancing these countervailing interests, the liberty interest prevailed, at least where a terminally ill patient sought to hasten death with physician-prescribed lethal medication.⁴⁰⁷

Although the effect of the Ninth Circuit ruling has been temporarily blocked by a Supreme Court injunction,⁴⁰⁸ the decision confirms the power of the courts to effect important policy changes through constitutional review. The decision gives constitutional protection to terminally ill patients seeking lethal prescriptions in States falling within the Ninth Circuit.⁴⁰⁹ The decision may well spark a challenge to an Oregon District court decision which held that the Oregon Death with Dignity Act⁴¹⁰ was unconstitutional on the ground that it offended the Equal Protection Clause of the Fourteenth Amendment.⁴¹¹ The Ninth Circuit did not decide whether Washington State's blanket prohibition on assisted suicide violated the Equal Protection Clause, although a footnote in the court opinion suggests that it was favourably disposed to this argument.⁴¹²

b. *The Second Circuit*

Interestingly, the Second Circuit held that New York's assisted suicide statute violated the Equal Protection Clause, but not the Due Process Clause.⁴¹³ Considering the Due Process argument, the Second Circuit noted that assisted suicide:

cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to

⁴⁰⁷ *Id.* at 837.

⁴⁰⁸ *Courts Play "Green Light—Red Light" with Assisted Suicide Rulings*, ERGO! U.S. NEWS BULLETINS (May 26, 1996) <http://www.islandnet.com/~deathnet/ergo_news10.html>; see ERGO! NEWS ARCHIVES, *supra* note 29.

⁴⁰⁹ Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington.

⁴¹⁰ See Melinda Lee & Susan Tolle, *Oregon's Plans to legalize Suicide Assisted by a Doctor: How Much More Open Will the Practice Become?*, 310 BRIT. MED. J. 613 (1995); see also Ann Alpers, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483 (1995). The Oregon Death With Dignity Act, which was narrowly voted into law in November 1994 in a citizen-initiated referendum, was the first successful attempt by an American State to legalize PAS. Similar, citizen-initiated laws were voted down in Washington State in 1991 and in California State in 1992.

⁴¹¹ *Lee v. State of Oregon*, 891 F.Supp 1429 (D. Or. 1995). The Equal Protection clause provides, relevantly, that no State shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

⁴¹² *Compassion in Dying*, 79 F.3d at 838, n. 300.

⁴¹³ *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history.⁴¹⁴

As noted above, traditional Due Process Analysis requires rights to be categorized as "fundamental" liberties, or as "mere liberties," and the Appeals Court evidently agreed with the District Court that absent a fundamental right to PAS, New York's prohibition was rationally related to its interests.⁴¹⁵

Turning to the Equal Protection issue, the argument was that terminally ill patients who were not reliant upon life-support were denied equal protection because they were unable to legally obtain assistance in suicide, whereas, patients on life-support could legally obtain such assistance by requiring the withdrawal of life-preserving treatment.⁴¹⁶ The court identified the legislation prohibiting assisted suicide as social welfare legislation, the constitutional validity of which thus depended upon whether the prohibition could be seen to be "rationally related to a legitimate state interest."⁴¹⁷ The court held that it was not.⁴¹⁸ The Second Circuit identified some of the same state interests in opposing PAS which the Ninth Circuit had relied upon in upholding Washington's prohibition of assisted suicide (prior to the re-hearing and reversal before the full court).⁴¹⁹ It held, however, that the New York statute could not be rationally related to these interests. New York law already permitted patients to bring about their death by withdrawing life-support, and required doctors to co-operate with patients in terminating treatment. In other words, if these were the real state interests underlying the PAS prohibition, the state would not have legalized and recognized in legislation the withdrawal of life-preserving treatment.⁴²⁰

As noted previously, this process of reasoning implicitly rejects that there is any significant legal or ethical difference between withdrawing life-support and "actively" assisting patients to die by prescribing lethal drugs. Here, as in *Compassion in Dying*, the retreat from the sanctity of life ethic already evident through laws recognising a right to refuse life-

⁴¹⁴ *Id.* at 724; see also *Compassion in Dying*, 79 F.3d at 848 (Beezer, J., dissenting).

⁴¹⁵ See *Quill* 80 F.3d at 724.

⁴¹⁶ *Id.* at 729.

⁴¹⁷ *Id.* at 726-27.

⁴¹⁸ *Id.*

⁴¹⁹ *Id.* at 730 (citing *Compassion in Dying v State of Washington*, 49 F.3d 586 (9th Cir. 1995), *aff'd en banc*, 79 F.3d 790). State interests include: ensuring that the doctor's role did not include a right to kill; avoiding psychological pressure being placed upon the elderly and infirm to consent to death; avoiding the exploitation of the poor and minorities; and avoiding facilitating assisted suicide or euthanasia simply in response to repeated requests from suffering, competent patients (as was alleged to have occurred in the Netherlands).

⁴²⁰ *Quill v. Vacco*, 80 F.3d at 730.

support, combined with the rejection of the "passive withdrawal/direct action" distinction, compelled courts to recognize a right to PAS through the prescription of lethal drugs. In other words, once the prescription of lethal drugs, at the request of a terminally ill, competent patient is not seen as morally or legally different from withdrawing life-preserving medical treatment from a terminally ill, competent patient, then legislation which has the effect of prohibiting the former, while permitting the latter, will be seen as violating the Equal Protection Clause of the Fourteenth Amendment.⁴²¹ The basis of this violation is the fact that patients who are not on life-support are denied the opportunity to legally commit suicide with medical assistance, which patients dependent upon life-support *can exercise* by requiring doctors to withdraw all treatment.⁴²²

In view of the conflicting rationales of the Circuits, the Supreme Court has agreed to hear appeals from the Ninth and Second Circuit decisions during the current term.⁴²³ The outcome of this appeal is difficult to predict.⁴²⁴ Seen from a broad perspective, however, a legally recognized right to die seems inevitable. An adverse Supreme Court decision could hardly retard the process of change for more than a decade, given the (i) emphasis on personal liberty in American society; the (ii) increasing levels of support for the option of medically assisted suicide for the terminally ill; and (iii) given the other legal developments reviewed in this paper which have already undermined the sanctity of life ethic.

Legalized PAS is, of course, only the beginning. The recognized importance of autonomy in medical decision-making supports a right to direct euthanasia at the doctor's hand, as much as a right to PAS. Indeed, advocates would argue that a prohibition upon the former discriminates against those who are unable, physically, to do what is necessary to achieve their own death, thus providing the grounds for a further Equal Protection Clause challenge.

⁴²¹ *Id.* at 729.

⁴²² *Id.*

⁴²³ *Supreme Court to Rule on Euthanasia*, THE AGE (Melb.), Oct. 4, 1996, at A8. The United States Supreme Court is scheduled to rule on the matter at the end of the term in late June or early July. Linda Greenhouse, *High Court Hears 2 Cases Involving Assisted Suicide*, N.Y. TIMES, Jan. 9, 1997, at A1.

⁴²⁴ However, as Professor Yale Kamisar has noted, the Supreme Court has already intimated that laws against assisted suicide are examples of conduct between consenting adults which are not beyond state regulation. Yale Kamisar, *Physician-Assisted Suicide: the Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED 225, 227 (John Keown ed., 1995). See also, Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725 (1995); cf. Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form* 72 U. DET. MERCY L. REV. 735 (1995).

IV. THE CONTRADICTIONS THAT REMAIN: AN AUSTRALIAN PERSPECTIVE

The developments which undermine the sanctity of life ethic, reviewed in Part III, co-exist uneasily with the law's traditional prohibition upon killing. In their attempt to uphold the sanctity of life ethic, as well as give greater recognition to personal autonomy and quality of life judgments, legal systems are becoming internally inconsistent, and intellectually misshapen. The precise problems which arise will vary between jurisdictions. This Part provides a brief review of some current tensions within Australian law.

A. *Suicide and Murder in Australian Law*

Suicide may be defined as a successful act of deliberate, and intentional self-destruction. Suicide is a crime in the Northern Territory (except where it is carried out in accordance with the Rights of the Terminally Ill Act (1995)), but not elsewhere in Australia.⁴²⁵ It is, however, a crime to aid or abet the suicide or attempted suicide of another person.⁴²⁶ There seems little doubt that Jack Kevorkian's actions in setting up a "death machine," or in rigging up carbon monoxide canisters for self-administration, would amount to the crime of aiding and abetting suicide if performed in Australia. In 1992, a sixty-two year-old Newcastle man was sentenced to two hundred hours community service after a failed suicide pact, in which the man's wife died after they both drank a cocktail of drugs and alcohol prepared by the husband.⁴²⁷ Convictions still occur, and this reflects the fundamental importance of the sanctity of life ethic within criminal law.

Even where suicide is legal, a person is permitted to use reasonable force to prevent a person from committing suicide.⁴²⁸ So there is no *right* to be left alone to commit suicide, even when you do it all yourself.

A person wanting to commit suicide may do so in various ways. There are books which can tell you how, such as Hemlock Society founder Derek Humphry's controversial bestseller *Final Exit*.⁴²⁹ Nevertheless, it is

⁴²⁵ See, e.g., Crimes Act § 6A (1958) (Vict.); Crimes Act § 31A (1900) (N.S.W.). In the United States, suicide and attempted suicide have not been criminal offenses for at least ten years. *Compassion in Dying*, 79 F.3d at 810. A majority of States retain laws prohibiting assisted suicide.

⁴²⁶ See, e.g., Crimes Act (1958) (Vict.) § 6B(2); Crimes Act (1900) (N.S.W.) § 31C.

⁴²⁷ Natalie Williams, *200 Hours Community Service for Suicide Pact*, WEEKEND AUSTRALIAN, Mar. 28-29, 1992, at 5.

⁴²⁸ See, e.g., Crimes Act § 463B (1958) (Vict.); Crimes Act § 574B (1900) (N.S.W.).

⁴²⁹ Derek Humphry, *FINAL EXIT* (1991). Prior to *FINAL EXIT*, Humphry's *LET ME DIE BEFORE I WAKE* (1981) was the major English language guide to voluntary euthanasia throughout the 1980s.

notoriously difficult for a non-medically trained person to suicide efficiently and painlessly, because of lack of access to drugs and ignorance of correct dosage.⁴³⁰ If a person is not able-bodied, or lacks access to drugs, the only way they may have of achieving their own death is by refusing life-sustaining medical treatment, or by convincing someone else to intervene and end their life directly.

Murder in Australia can be committed either by a positive act, or by omission. In addition, a person must have the requisite intention, or *mens rea*.⁴³¹ There is no distinction between “degrees” of murder. In Australia, murder is defined by statute in all states except Victoria⁴³² and South Australia. In New South Wales, for example, the definition of murder includes:

- causing a person’s death with reckless indifference to human life, or with intent to kill or inflict grievous bodily harm upon some person; or
- causing a person’s death during the course of a crime punishable by penal servitude for twenty-five years or life.⁴³³

Manslaughter is the name given for all unlawful homicides other than murder. The act or omission which constitutes the offense is the same in murder as in manslaughter, although the lesser charge may reflect a variety of other mitigating factors. A person may be liable for manslaughter when death is caused by his or her failure to provide necessary assistance,⁴³⁴ including medical treatment, where he or she has a duty to care for another person, or where he or she has undertaken such a duty.⁴³⁵

Against the background of this introduction, we will now focus on two particular issues which have arisen through the uneasy blending within the law of the sanctity of life ethic, and the recognition of personal autonomy and quality of life judgments:

(1) In the first scenario, a patient is dependent upon, but wishes not to receive, life-preserving medical treatment;

⁴³⁰ Rodney R. A. Syme, *A Patient’s Right to a Good Death*, 154 MED. J. AUSTR. 203, 204 (1991).

⁴³¹ Crimes Act § 18(1) (1900) (N.S.W.).

⁴³² Murder under the common law, as in Victoria, requires proof of intent to cause death or grievous bodily harm, or recklessness with respect to the same. See Crimes Act §3 (1958) (Vict.); R. v. Russell, (1993) V.L.R. 59.

⁴³³ Crimes Act § 18(1) (1900) (N.S.W.).

⁴³⁴ See, e.g., R. v. Russell, (1993) V.L.R. 59.

⁴³⁵ See R. v. Taktak, (1988) 14 N.S.W.L.R. 226; *Regina v. Stone*, 1 Q.B. 354 (1977).

(2) In the second scenario, a patient requires such large amounts of drugs to control pain or discomfort that the patient's life will, in consequence, be shortened.

B. Suicide and the Refusal of Life-Preserving Treatment

As discussed above, the right not to be subjected to unlawful assault is the basis for the right to refuse medical treatment, and this right is reflected in legislation in Australia and the United States, as well as under the common law. Courts in England, Canada and the United States have acknowledged that this right of self-determination may be exercised even if the patient dies as a result. As one English judge, Lord Browne-Wilkinson said, "a mentally competent patient can at any time put an end to life support systems by refusing his consent to their continuation."⁴³⁶ In one Canadian case, a doctor who administered blood to an unconscious Jehovah's Witness, ignoring the card in her purse which stated that she did not want blood to be administered under any circumstances, was held to be guilty of battery. \$20,000 damages were awarded for mental distress.⁴³⁷

Despite such graphic illustrations of the right to self-determination, the right to refuse life-preserving treatment remains on a potential collision course with the criminal law. What is the liability of a doctor whose patient refuses the treatment upon which their life depends? If the doctor does nothing, is the doctor aiding and abetting suicide if the doctor knows that this is the patient's intention? This would depend on whether a person can commit suicide by *omission*, for example, by not eating or by refusing intravenous feeding.⁴³⁸

In the medical context, where a terminally ill patient refuses life-preserving treatment, it is nowadays less likely that courts would regard this as suicide, or would regard a doctor who respected the patient's desire to forego life-sustaining treatment as aiding and abetting suicide. But the issue becomes more sharply focused when a patient refuses food and water. Refusing artificial nourishment and hydration is, after all, one of the few ways patients have of speeding up their dying process when they are terminally ill, yet wasting slowly. Naso-gastric feeding and intravenous hydration are sometimes regarded differently from other forms of medical treatment. The right to refuse treatment contained in Victoria's Medical Treatment Act (1988), for example, excludes the reasonable

⁴³⁶ Airedale N.H.S. Trust v. Bland, [1993] App. Cas. 789.

⁴³⁷ Malette v. Shulman, [1987] 47 D.L.R. (4th) 18.

⁴³⁸ See Lanham, *supra* note 240, at 11-12.

provision of food and water.⁴³⁹ A more absolute right of refusal may operate, however, under the common law of some countries.⁴⁴⁰ Nevertheless, if patients have the right to starve themselves to death, isn't that suicide?

In 1983, a New South Wales court refused to grant an injunction which would have prevented prison authorities from force-feeding a prisoner who had been on a hunger strike. The Court refused the injunction both because the prisons legislation permitted force-feeding, and because any such injunction would have amounted to aiding and abetting the prisoner's attempt to commit suicide.⁴⁴¹ Similarly, in 1989 a Victorian judge refused to grant an injunction which would have prevented hospital doctors from operating on an unconscious man to discover the source of bleeding in his throat. The man's wife said he wanted to die, and he had taken a drug over-dose. Under the circumstances, however, an injunction preventing the operation would have aided and abetted the man's suicide.⁴⁴² One can speculate whether the judge would have decided differently if the man had previously made an advance directive refusing medical treatment under the Medical Treatment Act (1988) (Vict.).⁴⁴³ As they stand, however, these cases are examples of how an otherwise established, legal right of self-determination was curtailed because of the underlying intention with which the act was done.

The facts of these cases demonstrate the doctor's dilemma—torn between respecting the patient's legal right to self-determination as embodied in case law and legislation on the one hand, and respecting the sanctity of life ethic as embodied in the criminal law's prohibition on aiding and abetting suicide, on the other.⁴⁴⁴ These cases suggest that, in Australia at least, the right to self-determination will not necessarily win every time.⁴⁴⁵ At present, the most that can be said is that much depends

⁴³⁹ Medical Treatment Act §4 (1988) (Vict.).

⁴⁴⁰ See *Bland*, [1993] App. Cas. 789. The right to refuse intravenous food and water was "assumed" (but also apparently accepted), by the United States Supreme Court in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990), and by the Ninth Circuit in *Compassion in Dying*, 79 F.3d at 814-816.

⁴⁴¹ *Schneidas v. Corrective Services Comm'n*, 7 CRIM. L. J. 353 (1983).

⁴⁴² *In re Kinney*, (S.Ct. Victoria, Dec. 23, 1988) (unreported opinion by Justice Fullagar); Loane Skene, *The Fullagar Judgment*, 14 LEGAL SERVICE BULL. 42 (1989).

⁴⁴³ Medical Treatment Act (1988) (Vict.).

⁴⁴⁴ To resolve this problem, legislation authorizing the force-feeding of a patient against his or her will has sometimes been enacted; for example, where the patient is suffering a mental disorder (*B. v. Croydon Health Authority*, 1 All E.R. 683 (1995)) or is under detention (*Secretary, Dep't of Immigration, Local Gov't and Ethnic Affairs v. Mok*, No. 4982 (S.Ct. New South Wales, Sept. 30, 1992)).

⁴⁴⁵ Recent English cases, by contrast, indicate that the right of self-determination *will* prevail, and will permit a patient (or prisoner) to refuse food and water for so long as they retain mental capacity to do so. *Secretary of State for the Home Dep't v. Robb*, 1 All E.R. 677 (1995). As noted

on the intention with which the treatment is refused. If the patient's intention in refusing treatment, food or water, is to suicide, rather than merely to avoid the burden of invasive treatment, or the pain associated with treatment, the suicide provisions may be relevant. Similarly, if the doctor's intention is to assist the patient in dying, rather than to ensure that the patient's last days are dignified and free from pain or distress, then the assisted suicide provisions may be relevant. In so far as these distinctions make any sense, they send a message to those with terminal illnesses about how they should frame their request for termination of life-sustaining treatment, and to doctors about how they should describe any resulting action which they take.

C. *Murder, and Pain Relief*

In the trial of Dr Adams, Justice Devlin told the jury that it is not murder to hasten a patient's death by administering drugs when the doctor's purpose and intention in giving the medication is to relieve pain and suffering and when nothing else can be done.⁴⁴⁶ The dividing line between intending to relieve the pain of an exhausted and dying patient, however, and intending to expedite their inevitable death, is as thin as onion skin. As one leading Oregon physician commented: "[d]ying patients are given larger and larger doses of morphine. We talk about the 'double effect,' and know jolly well we are sedating them into oblivion, providing pain relief but also providing permanent relief, and we don't tell them."⁴⁴⁷

In Australia, administering a drug overdose in order to kill a terminally ill patient is illegal (outside of the Northern Territory), regardless of the patient's desire for it. In the eyes of the law, euthanasia is murder.⁴⁴⁸ In this respect, as the *Bland* court recognized, "the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy."⁴⁴⁹ In 1992, an eighty year-old Melbourne man was put on a good-behavior bond for cutting his partly paralyzed wife's wrist after

previously, it was on this basis that an English woman with anorexia nervosa was recently allowed to die. See *Woman Suffering from Anorexia Insists on Being Allowed to Die*, *supra* note 257.

⁴⁴⁶ See Palmer, *supra* note 45; see also *supra* notes 42-45 and accompanying text.

⁴⁴⁷ Paul Cotton, *Medicine's Position is Both Pivotal and Precarious in Assisted-Suicide Debate*, 273 J. AM. MED. ASS'N 363 (1995). Grimley Evans, Professor of Geriatric Medicine at Oxford University, once said "doctors shrink from active euthanasia because they are trained to kill only by accident." Tallis, *supra* note 156, at 3.

⁴⁴⁸ The fact that a victim is terminally ill has never been recognized as a defence for homicide. *The King v. Dyson*, 2 K.B. 454, 457 (1908); *R. v. Pankotai*, CRIM. L.R. 546 (1961).

⁴⁴⁹ *Bland*, [1993] App. Cas. at 893.

she had suffered a stroke.⁴⁵⁰ Mercy killing cases crop up far more regularly than one might expect.⁴⁵¹

The problem for health care workers is that as a patient's condition worsens, such a quantity of sedatives may be needed to relieve pain or distress that the doctor (or more frequently, the nurse) will inevitably come to a point where they realise that the next injection will probably kill the patient. At this point, an act of palliative care tumbles over the line to become an act which precipitates death. While the doctor's intention is the distinguishing characteristic, many health care workers and ordinary people nevertheless have difficulty understanding the moral and legal difference ten to thirty semi-lethal injections causing death over three to seven days (perfectly legal pain relief), and death within an hour after one lethal injection (euthanasia, murder).⁴⁵²

D. *Other Anomalies*

There are, of course, other consequences of the clash between the traditional ethics of sanctity of life, and the new ethics of personal autonomy and liberal individualism. Able bodied individuals may lawfully commit suicide, but physically disabled individuals may not.⁴⁵³ The ethics of the sanctity of life prevents an individual from assisting others, whereas the ethics of self-determination allows individuals to kill themselves. Similarly, the distinction relied upon in the *Bland* case—between the withdrawal of life-support and active euthanasia—persists in most countries. Furthermore, the *Bland* case also illustrates how English law permits the withdrawal of nourishment from patients in a permanent vegetative state, thus permitting them to starve to death.⁴⁵⁴ But to do anything more than this, according to the courts, is to “cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering”.⁴⁵⁵ Family and friends can only watch, often in great distress, as the life force of their loved-one slowly fades.

Some will ask—where is the mercy? Where is the dignity? They see the legal system in disarray, torn between competing ethical demands,

⁴⁵⁰ Peter Gregor, *Bond for Husband in Mercy Killing Bid*, THE AGE (Melb.), June 30, 1992, at 1.

⁴⁵¹ See Margaret Otlowski, *Mercy Killing Cases in the Australian Criminal Justice System*, 17 CRIM. L.J. 10 (1993).

⁴⁵² See Syme, *supra* note 430, at 204.

⁴⁵³ *Euthanasia a Right, Given Safeguards*, THE AGE (Melb.), Apr. 4, 1995, at 14 (letter).

⁴⁵⁴ *Bland*, [1993] App. Cas. at 869.

⁴⁵⁵ *Id* at 865.

compelling a result they regard as cruel and unnecessary. It is their *crie de coeur* which is fuelling the euthanasia debate.

IV. CONCLUSION

Should assisted suicide and euthanasia be legalized? A right to PAS/AVE within a procedural framework embodying appropriate safeguards may be preferable to the current abuses, personal tragedies and primitive killings which constitute an alarming proportion of deaths in the current, unregulated "euthanasia underground."⁴⁵⁶ As with prostitution in jurisdictions where it remains illegal, what is prohibited cannot be regulated. Health care workers currently practicing euthanasia are accountable to no one. On the other hand, they are, in many cases, beating or ignoring the legal system.⁴⁵⁷

The central argument of this paper, however, is that legalized PAS/AVE is an *inevitable development*. Society and the law are moving steadily in this direction. Levels of popular support, and to a lesser extent, support within the medical profession, are now reaching levels where PAS/AVE is widely seen as a human right. The Christian churches, many of whom oppose euthanasia, themselves have declining influence in matters of social policy and at least in Australia, are unlikely to successfully retard the process of law reform for very long. Australia and the United States provide interesting comparative models for euthanasia law and policy. Both countries are industrialized, federal democracies with a tradition of freedom and personal liberty. Both have legal systems which have retreated in a variety of ways from the sanctity of life ethic to the point where we are now witnessing an assault, unparalleled in history, upon the legal relics which prohibit direct intervention to end the lives of suffering patients.

Having come this far, the law can now only deny a legal right to die by relying on distinctions such as the discredited act/omission distinction in *Bland*.⁴⁵⁸ Accordingly, the logical movement of the law is towards legalizing a right-to-die within a framework of safeguards.

⁴⁵⁶ The writer's view was formed largely during the process of ongoing interview-based research on the practice of euthanasia in four Australian cities and San Francisco.

⁴⁵⁷ See, e.g., *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

⁴⁵⁸ *Bland*, [1993] App. Cas. at 898.

A. *The Slippery Slope and a Stable Philosophical Basis for PAS/AVE Reform*

Important implications follow from this trend towards PAS legalization. As Kamisar notes, within the American context, the right of a terminally ill patient to PAS will not exhaust the push for a right to die.⁴⁵⁹ The logic of personal autonomy also demands AVE. Furthermore, as community perceptions change, perhaps over time, there will also be a right to die if one is *constantly miserable*, and a right to hasten the death of incompetent persons who are perceived to be living in unbearable agony. The long-term social consequences of tampering with the sanctity of life ethic are serious and will not be easily undone. Doomsday rhetoric aside, it is fundamental to articulate a stable philosophical basis for PAS/AVE which will provide a clear basis for any further, incremental derogations from the sanctity of life ethic.

The survey of developments undermining the sanctity of life ethic in this paper suggests two quite different philosophical underpinnings of the right to die. The first is personal autonomy. Seen through libertarian lenses, the conflict generated by the euthanasia debate is between a "communitarian" world view where social goals and values circumscribe aspects of individual freedom, and a more individualistic world view where personal choice within the personal sphere trumps social values. Society's increasing moral commitment to personal autonomy is reflected in caselaw and legislation recognizing a right to refuse medical treatment, including life-support where death will inevitably follow. Personal autonomy as a basis for the right to die provides no logical basis for limiting that right to patients in "unbearable pain," or in the "terminal stages" of an illness. If anything, the fixation upon pain and suffering as a justification for PAS/AVE merely sweetens the thin end of the wedge; it provides a selling-point for a radical philosophy of individual autonomy whose logical conclusion is a right to assisted suicide *simpliciter*. If personal autonomy is the only justification for PAS/AVE reform, then the deep implications of this should be frankly acknowledged and debated in a way which has not occurred to date.

Personal autonomy does not, however, explain all the legal developments which have undermined the sanctity of life ethic. The re-definition of death to include "whole-brain death," and the legal permission to withdraw life-support from patients in a permanent

⁴⁵⁹ Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED 225, 233-36 (John Keown ed., 1995); Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 737, 739 (1995).

vegetative state is more paternalistic in character, since it has nothing whatsoever to do with the known wishes of the individual. These developments constitute, essentially, a judgment imposed from outside that in certain circumstances life itself is futile, or has become so attenuated that further existence would serve no useful purpose.

If the personal autonomy basis for euthanasia points to a radical and distressing notion of liberty which devalues our intuitions and beliefs about the value and goodness of life, a judgment about the quality or futility of life, imposed upon the individual from outside, might be thought to carry even more chilling implications. This need not be the case, provided a "paternalistic quality of life" judgment that justifies the withdrawal of life-support operates only where an individual is permanently unconscious and unaware. On the other hand, if this "paternalistic judgment" model operates for life and death decisions in circumstances where the individual *is* conscious and competent, then it may provide a useful check against the implications of an ethic of radical personal autonomy. For example, the judgment that no useful purpose is served by enduring the excruciating pain and suffering accompanying certain terminal illnesses may provide one context where society chooses to recognize an individual's otherwise expressed desire to die.

This paper seeks to offer little to the philosophical debates over euthanasia except to demonstrate how the law already embodies two different models of "justification" for PAS/AVE reform. More work is needed to draw out the philosophical implications of current legal developments, and to develop philosophical models which might limit further derogations from the sanctity of life ethic within boundaries society considers to be acceptable. It is important to recognize, however, that PAS/AVE reform is currently being sold to the public on the basis of personal liberty operating, albeit, within limited circumstances where terminal disease and extreme pain compromises quality of life. As the Ninth Circuit majority concluded its opinion in *Compassion in Dying*:

Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.⁴⁶⁰

⁴⁶⁰ *Compassion in Dying*, 79 F.3d at 893.

B. The Need for Euthanasia Policy to be Informed by Research

If it is true that society is steadily moving towards PAS/AVE reform, then in addition to being clear over the legal and philosophical bases on which legalization is premised, it is also important to ensure that any regulatory regime is informed by research. More research is needed on the current practice of euthanasia, both legal and illegal, in order to generate deeper understanding of the respective advantages and disadvantages of prohibition. American and Australian survey studies were useful in making generalizations about trends in attitudes and behaviour.⁴⁶¹ However, they provide little understanding of the complexity of attitudes towards euthanasia generated by close involvement in end of life decisions, the conditions under which euthanasia is practiced, how it is carried out, and its impact upon HCWs. This kind of data, obtained best through interview-based techniques, is useful in pointing out the price of prohibition, and in identifying issues which would need to be considered in a responsible regulatory regime. The myths of euthanasia should be exposed, and unrealistic fears soothed. Good social policy must proceed on knowledge, and if PAS/AVE reform proceeds, such knowledge must be built into protective regulatory regimes. The appropriate vehicle for creating such a regime is, in the writer's view, the legislature. Such a controversial change in the moral and legal fabric of society as PAS/AVE entails deserves nothing less than *democratic* reform.

In conclusion, one would hope that the fragility of patients in the midst of pain and existential anguish will be recognized, and that as a society, regardless of law reform, we will seek to emphasize the value and meaning of life, and to provide the best available care. The provision of palliative care, and the development and funding of this speciality provides a telling basis for judging society's commitment to life in an era when a growing, aging population is taking longer to die.

⁴⁶¹ *Supra* notes 109-20 and accompanying text.

