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Life, Death and the Transformation of the Western Jurisprudential Tradition:

A comparative critical analysis of constitutional, legislative and judicial strategies

PhD Thesis

2013

Frank J. Dunlop, BA, DPA, LL.B, LL.M

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Abstract

of

Ph.D Thesis submitted by Frank J Dunlop, BA, DPA, LL.B, LL.M

for examination by Trinity College Dublin

A comparative analysis of the constitutional, legislative and judicial strategies employed in the intentional recalibration of the traditional Western embodiment of the principle of the sanctity of life in order to legitimate earlier than natural death.

Two approaches are examined:

1. The transparent legislative approach – exemplified in the Netherlands, Belgium, Switzerland, Luxembourg and the American states of Oregon and Washington - where existing law is either amended or new law is enacted to allow for the termination of life on request when performed by a doctor in accordance with defined protocols.

2. The unheralded judicial approach – exemplified by the endorsement of novel legal mechanisms, such as *'best interests'* and *'substituted judgement'*, at common law in England, the United States, Canada and Ireland – whereby life, in certain circumstances, can be deemed to be no longer of benefit to an individual.

In spite of formal differences a common philosophical and normative perspective underlies both the legislative and judicial approaches.

The legislatures and the courts in most of the countries examined share broadly the same view as to the circumstances in which life may be ended.

Apparent differences can be explained, not as reflecting deep opposition but rather a shared desire that the law be changed pragmatically to bring this about.

2013

Declaration

This thesis has not been submitted as an exercise for a degree at this or any other University and is entirely my own work.

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I am extremely grateful to my supervisor, Professor William Binchy, for his unfailing courtesy, generosity of spirit and willingness to listen, advise and guide. His insightful and challenging perspectives provided the impetus for deeper intellectual investigation of the subject matter. Now that the thesis is completed I will miss our engaging and wide-ranging exchange of views.

This work is dedicated to the memory of my son Cathal (1982-1998).

Summary

This thesis is a comparative analysis of the various constitutional, legislative and judicial strategies employed in the intentional recalibration of the traditional Western embodiment of the principle of the sanctity of life in order to legitimate earlier than natural death.

It compares the transparent approaches adopted through legislation to allow for assisted dying with the unheralded judicial endorsement of novel legal mechanisms at common law, those of *'best interests'* in England and Ireland, and of *'substituted judgement'* in North America, whereby life, in certain circumstances, can be deemed to be no longer of benefit to an individual.

The transparent approach is exemplified in the Netherlands, Belgium, Luxembourg and Switzerland, and in the American states of Oregon and Washington, either by the amendment of existing law, or the introduction of new law, allowing for the termination of life on request when performed by a doctor in accordance with defined protocols.

The evidence for the unheralded approach in England is provided by an examination of the judicial reasoning adopted and followed in a number of iconic cases, beginning with those in which the continued life, or death, of new-born babies with severe physical handicaps was in issue, together with its subsequent application in the case of incompetent adults. The incorporation of this approach into Irish law, with its distinctive constitutional tradition is also analysed.

In the American context the contention that the law has been recalibrated as suggested is supported by an examination of the reasoning underpinning decisions in two State Courts of Appeals – vacated ultimately by the Unites States Supreme Court – that state laws banning assisted suicide violated the 14th Amendment of the Constitution. The thesis argues that, while the Supreme Court seemed to have taken a conservative position, in fact its core principles favour rather than oppose the process of legislative transformation.

The thesis concludes by arguing that, in spite of formal differences, a common philosophical and normative perspective underlies both the legislative and judicial approaches. The legislatures and the courts in most of the countries studied share broadly the same view as to the circumstances in which life may be ended; their apparent differences can be explained, not as reflecting deep opposition but rather a shared desire that the law be changed pragmatically to bring this about.

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Chapter 1

Introduction

What ordinance? How? When? Where? Quote the words. Show us even by deduction that the Lord has intended that we should keep old men alive in these miseries.

- Anthony Trollope, '*The Fixed Period*'.[1]

The issue of third party assistance with death has never been anything other than an existential conundrum of seemingly intractable proportions for civilised society. Universal accord in the matter is likely to be as unattainable at any time in the near future as it has been in the past.

Perceived difficulties with resolution, however, have not deterred those who believe that the timing and manner of death is a matter of individual choice from making determined efforts to reconstitute traditional jurisprudential and ethical approaches to the question of when and how life should end.

While some of these efforts have been successful, the vast majority have failed. Some, based on the application of logical reasoning, are possessed of an initial intellectual allure. On examination, however, the allure almost always turns out to be meretricious.

Other endeavours, particularly in Germany and the United States, have espoused, albeit historically, social engineering concepts, such as eugenics and social-Darwinism, with the

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[1] *Trollope (1881), 'The Fixed Period', ed. RH Super, Ann Arbor: Univeristy of Michigan Press, 1990.* I am indebted to Kenneth Boyd for bringing Trollope's science-fiction novel to my attention. See his '*Euthanasia: Back to the Future*', in Keown, J, (ed)., '*Euthanasia Examined: Ethical, clinical and legal perspectives*', Cambridge University Press, 1995, at 72. Trollope's work was first published in 1881 but was set a century later on the imaginary island of Britannula, somewhere off New Zealand. The constitution of Britannula, originally a British colony but now a prosperous republic, provides compulsory euthanasia for all of its citizens on reaching the age of 67½ - Trollope's own age when he wrote the novel. There were two underlying principles: euthanasia would relieve those who had lived out their '*Fixed Period*' of active life from having to suffer the miseries and indignities of old age; and it would relieve their families and the republic of the cost of maintaining them. When the measure was passed none of Britannula's citizens was aged much above 30. Thirty years later, the first of them to reach his allotted time span is about to be '*deposited*' at the '*College*' where he will enjoy 12 months' preparation for euthanasia. But he is as fit as a fiddle and most unwilling to go – as are the next few citizens in line. However, the President of the Republic, Mr Neverbend, insists that the law, which they had all agreed to, must be upheld. The impasse is broken when the British government sends a gunboat to depose the President, re-annex Britannuala and repeal the euthanasia law. Mr Neverbend goes into exile to write his memoirs, convinced that, while he may have got some of the details wrong, the '*Fixed Period*' is an idea whose hour will come. Whether he was right is a moot point! See also fn. 10, Chapter II on the Netherlands. Not unlike George Orwell's '*1984*', Trollope's '*The Fixed Period*' has uncanny resonances with approaches to third party assistance with death from the early 1980s onwards.

objective of relieving society of the burden of caring for those suffering from mental illness. While the history of Nazi eugenic practices in Germany has been well documented it is a matter of no small surprise, especially to American citizens, that involuntary sterilisation of the mentally disabled was an officially endorsed policy in the majority of American states up to and including the early years of World War II. The pursuit of racial purity, therefore, was not an exclusive Nazi concept. Undoubtedly, the realisation that Adolph Hitler wrote to Madison Grant praising his *The Passing of the Great Race*[2] – an outrageous eugenic tract - as "*his Bible*"[3] would be a source of intense embarrassment to those latter-day Americans who campaign for the legalisation of assisted death based on the philosophy of rights.

It would be impossible to achieve an understanding of the turmoil which accompanied the various cultural, social, political and jurisprudential stances adopted in respect of non-natural death throughout the nineteenth and twentieth centuries in the United States without recognising the impact which the positivist Auguste Comte,[4] the evolutionist Charles Darwin[5] and the eugenicist Francis Galton,[6] together with the influence of Progressivism,[7] had on the

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[2] *(1916).*

[3] See Hitler's Debt to America, The Guardian, 6 February, 2004, available at http://www.guardian.co.uk/g2/story/0,3604,1142027,00.html reviewing Edwin Black's *'The War against the Weak: Eugenics and America's Campaign to Create a Master Race'*, Four Walls Eight Windows, 2003, cited in Gorsuch, N, *'The Future of Assisted Suicide and Euthanasia'*, Princeton University Press, 2009 (paperback printing), at 36-37. Crediting American eugenic experiments, Hitler acknowledged: *"[now that] we know of the laws of heredity it is possible to a large extent to prevent unhealthy and severely handicapped beings from coming into the world. I have studied with interest the laws of several American states concerning prevention if reproduction by people whose progeny would, in all probability, be of no value or be injurious to the racial stock."* Ibid.

[4] **Auguste Comte (1798-1857)** was a French positivist philosopher. Positivism was the belief that the human race had developed through two stages of development by the nineteenth century. The first was the theological one, when people tended to attribute all natural phenomena to the acts of the gods. The second was the metaphysical one, when people ceased invoking gods and instead believed in abstract theories divorced from observation. Comte announced that the nineteenth century would inaugurate a new stage, in which individuals would subscribe to the positivist philosophy, the notion that all sciences, including the social sciences, should be based on rigorous observation and the scientific calculation of the mathematical laws that governed the world. See *'Early Writings (1820-1829); the Course On Positivist Philosophy (1830-1842, 6 vols); the System of Positivist Philosophy, or Treatise on Sociology, Instituting the Religion of Humanity (1851-1854, 4 vols).*

[5] **Charles Darwin** published his evolutionary theories in the *Origin of the Species (1857)* and the *Descent of Man (1871).* In his *Descent of Man* Darwin displayed little enthusiasm for philantropic efforts to provide asylums, hospitals and therapeutic care for those who were not endowed with the genetic abilities requisite for success. Such efforts interfered with the process of natural selection which, unimpeded, would eliminate the *"reckless, degraded, and often vicious members of society."*

[6] **Francis Galton**, a cousin of Charles Darwin, published his *'Inquiries into Human Faculty and its Development'* in 1883. He propounded a new science, that of *'eugenics'* (the word is derived from the Greek for 'well-born'): *"the science of improving stock, which is by no means confined to questions of judicious mating, but which, especially in the case of man, takes cognizance of all influences that tend in however remote a degree to give the more suitable races or strains of blood a better chance of prevailing over the less suitable than they otherwise would have had."* Cited in *Paul, D, 'Controlling Human Heredity: 1865 to the Present', 1996.* Galton believed that society would have to adopt a

development of the totality of the national psyche up to and including the early years of World War II.

While the intellectually choreographed right-based contours which have characterised the legal discourse on assisted dying over the past twenty-five years are not remotely reflective of the prior, officially endorsed, social policy criteria which were consciously employed in determining who should be allowed to continue to live and who should be let die in America, the genesis of the rights-based philosophy in the matter is traceable to the uncomfortable comparisons which began to be made, in the early 1940s, between the practice of stat-sponsored involuntary sterilisation of institutionalised mentally ill patients and empirical reports of the assiduous implementation of the eugenic recommendations of *Hoche and Binding*[8] by the authorities in Nazi Germany. These are matters not alone of historical importance but also of legitimate academic inquiry. They are addressed in greater detail in Chapter VII on America.

In summary, a variety of strategies are now employed in the endeavour to have a right to assisted death recognised as a corollary to that of the absolute right to refuse medical treatment even where this leads to death. The criminalisation of assisted suicide is challenged on the grounds that it violates particular constitutional provisions, including privacy, autonomy, bodily integrity and dignity. This is the case in both Ireland and the United States of America.

In Canada, alleged violations of the Charter of Rights and Freedoms are invoked. In England - and in Ireland - provisions of the European Convention on Human Rights and Freedoms, particularly *Article 8* which entitles every person to respect for private and family life, are called in aid to buttress the contention that the continued criminal proscription of assistance

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specific measures to control the disparity which he believed existed between productive members of society and those whom he regarded as human defectives.

[7] A loose system of social and political ideas prevalent in the United States between the depression of 1893 and the US entry into World War I in 1917. It was a response to the fundamental social and economic changes which occurred during the first decades of the 20th century, including urbanisation, industrialisation, mass immigration, labour unrest, racial tension mobilisation for war and the exploitation of the country's natural resources. A darker side of Progressivism was its attitude to immigration. An associate body, the *American Protective Association*, lobbied for health and literacy tests to be applied to immigrants and for the passage of restrictive legislation such as *the Emergency Quota Act 1921* and the *National Origins Act 1924.*

[8] In 1920 Alfred Hoche, a professor of psychiatry, and Karl Binding, a professor of law, published *'Permitting the Destruction of Unworthy Life'*, arguing, like their social Darwinist counterparts in America, not alone that individuals have a right to choose assisted suicide or euthanasia freely, but that non-voluntary euthanasia of the mentally defective was also necessary, justified by the fact that these individuals are *"not just absolutely worthless, but [are] even of negative value"*, and thus, *"eliminating those who are completely mentally dead is no crime, no immoral act, no emotional cruelty, but is rather a permissible and useful act."*

with death is not alone incompatible with this right but also impinges disproportionately on the right of an individual, suffering from an incurable illness, to die at a time of his or her choice in order to avoid further pain and suffering.

The requirement that the Director of Public Prosecutions for England and Wales, following the decision in *Purdy*[9], promulgate the policy criteria employed in determining whether or not to prosecute in a case of assisted suicide has opened up a new front for attack on the part of those who wish to have the law changed. This was particularly evident recently in *Fleming v Ireland*[10] where the Irish High Court, in the event that the statutory criminal proscription of assistance with suicide was found constitutionally valid and compatible with the European Convention on Human Rights and Fundamental Freedoms, was asked to make an order directing the Irish Director of Public Prosecutions to issue similar guidelines.[11]

Unquestionably, the boundaries of the debate will continue to expand as more and more hard cases come before the courts in an attempt to have earlier than natural death added to the list of those personal rights already recognised and established. While attempts to date have been unsuccessful – apart, that is, from those jurisdictions where euthanasia or assisted suicide, or both, have been legalised, such as the Netherlands,[12] Belgium,[13] Switzerland[14] and Luxembourg[15] and in the American states of Oregon,[16] Washington,[17] Vermont[18] and Montana[19] - it might be tempting to view the possibility of any future success as distinctly remote.

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[9] *[2009] UKHL 45.*

[10] *[2013] IEHC 2.*

[11] See Chapter IX on Ireland for examination and appraisal of both High Court and Supreme Court decisions in the Fleming case.

[12] *The Termination of Life and Assisted Suicide (Review Provisions) Act, 2002.*

[13] *Act Concerning Euthanasia, 2002.*

[14] Euthanasia is a criminal offence in Switzerland. However, under Article 114 of the Swiss Penal Code, if anybody kills another person, at the latter's "*serious and urgent request*", the punishment is less severe than that which applies to intentional homicide, provided the perpetrator, irrespective of professional status or none, acts from "*honourable motives*." Article 115 deals with inciting and assisting another person to commit suicide. Such an act is not illegal if the person providing help is not motivated by self-interest, and in most cases the permissibility of *altruistic assisted suicide* cannot be overridden by a duty to save life.

[15] *Law on Euthanasia and Assisted Suicide, 2009.*

[16] *Death with Dignity Act 1994.*

[17] *Death with Dignity Act 2009.*

[18] *Act No.39: An Act Relating to Patient Choice and Control at End of Life 2013.*

[19] In *Baxter v Montana No ADV-2007-787* in the First Judicial Court the plaintiffs asked the court to establish a constitutional right "*to receive and provide aid in dying*." It was held that a terminally ill, competent patient has a legal right to die with dignity under Atticle II, sections 4 and 10 of the Montana Constitution. That includes the right to "*use the assistance of his physician to obtain a prescription for a lethal dose of medication that the patient may take on his own if and when he decides to terminate his life*." It was further held that the right protects physicians who aid such

It is suggested, however, that not alone would this be complacent, it would also be foolhardy in the extreme. Why?

Historically, the common law, as Toulson LJ stated in the recent *Nicklinson* case, has displayed an inordinate ability to develop *"incrementally in order to keep up with the requirements of justice in a changing society."*[20] While it is impossible to predict what the requirements of justice might be in any given circumstance in the future, nonetheless it should not be thought completely beyond the bounds of probability that while courts formally adhere to respect for what they consider to be the sanctity of life the common law, in practice, may already be in a process of reformulation to the extent that this principle is in fact deprived of its original meaning and purpose, namely to preserve life.

Is this a Cassandra-like dystopian perspective? Or is it a matter which, on the basis of what has already occurred within the common law - and which can be empirically identified – is indicative of a pragmatic willingness on the part of the courts to accommodate novel criteria for the resolution of the dilemma of who should be let live and who should die or be killed?

It is the contention of this thesis that the latter is the case.

In order to identify the genesis, development and introduction of these new legal mechanisms, as well as highlighting the differential between a strictly judicial approach and that followed by jurisdictions where specific statutory provision for the killing of human persons has been enacted, it is proposed to contrast what has occurred in four countries, the Netherlands, Belgium, Switzerland and Luxembourg, with the consciously nuanced recalibration of the common law in England, the United States, Canada and Ireland.

Particular attention will be devoted to the introduction of a new paradigm, that of *'best interests'* in both England[21] and Ireland, and that of the *'substituted judgement'* test in the United States of America.[22]

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patients by prescribing a lethal drug for the patient. The Attorney General of Montana appealed the ruling to the Montana Supreme Court. The Court, in *Baxter v Montana 2009 MT449*, stated that *"we find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy"* and therefore, the physician who provides such assistance is shielded from criminal liability by the patient's consent.

[20] *Nicklinson v Ministry of Justice [2012] EWHC 2381 (Admin).*

[21] *'Best interests'* requires that decision-makers consider what the overall welfare of the patient demands. It is, in theory at least, an objective test. The law relating to decision-making on behalf of people who lack mental capacity is now to be found in the English *Mental Capacity Act, 2005* which came into force in 2007. *'Best interests'* continues to be the benchmark against which lawful treatment of a patient lacking capacity is normally to be judged. See Chapter VI on England.

[22] *'Substituted judgement'* demands an attempt to discern what a patient would want were he/she able to decide for him/herself. See *Re Quinlan 355 A 2d 664 NJ 1976* where the Court endorsed the

Comparative critical analysis:

For the avoidance of doubt this is a comparative critical analysis of constitutional, legislative and judicial strategies adopted in selected jurisdictions. It does not purport to be an in-depth jurisprudential exegesis of the normative concepts underpinning the various approaches to third party assistance with death. Instead it seeks to assess how these concepts have been used and applied as the building blocks of the law in respect of third party assistance with death in the various jurisdictions selected.

The thesis traverses the derivative nature of the law in identified central European countries (**the Netherlands, Belgium, Luxembourg** and **Switzerland**) together with a critical perspective of the invocation of normative concepts in other jurisdictions (**the UK, Canada, America** and **Ireland**). The focus is not on the concepts *qua* concepts but rather on how they have fed into the development of the law.

A derivative/normative matrix, therefore, is maintained throughout.

In essence, the thesis is an exploration of the laws relating to both assisted suicide and, where appropriate, '*letting die*', in those jurisdictions where there has been direct legislative overhaul of the area (**the Netherlands, Belgium, Luxembourg** and **Switzerland**). It also examines those jurisdictions where the law has developed as a result of either judicial activism (such as **Canada,** and, it is argued, **the UK**) and where there has been both judicial and legislative treatment of the question of third party assistance with death (for example, in the **United States of America**).

While such an exercise has not been undertaken previously nonetheless the specific jurisdictional selection for consideration and analysis requires justification.

There has been a direct overhaul of the law in respect of third party assistance with death in each of the central European countries chosen for examination and analysis – the Netherlands, Belgium, Switzerland and Luxembourg. The historical reality is that the evolution of the laws permitting third party assistance with death in these jurisdictions, while not consciously abrogating the normative criteria espoused by the Western jurisprudential tradition, was derived more from a judicial, cultural and prosecutorial acceptance, which

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test and granted the patient's father, her next of kin, power to act on her behalf. In many civil law jurisdictions, as well as in some states in America, the law allows next of kin to make decisions on behalf of adults who lack mental capacity. See *Respondent Michael Schiavo's Opposition to Application for Injunction, Case No 04A-825, 24 March, 2005, US Supreme Court*. See Chapter VII on America. English law refuses to endorse any notion that next of kin should automatically enjoy proxy powers of consent. See Brazier & Cave, '*Medicine, Patients and the Law*', 4th ed., Penguin, 2007, at 130.

eventually leaked into the political bloodstream – and this was the case particularly in the Netherlands – that the prolongation of life against the stated wishes of an individual who was enduring unbearable suffering was bordering on the inhumane.

The Netherlands:

The law in the Netherlands in respect of euthanasia and assisted suicide falls firmly on the derivative side of the methodological matrix.

Traditional discrete approval over many years by the medical profession and by the prosecutorial authorities in the Netherlands of end-of-life practices – notwithstanding their undoubted criminal character – culminated in their eventual statutory endorsement in 2002.

This was a unique and carefully choreographed collaborative endeavour on the part of the Dutch judiciary, the prosecutorial authorities, the medical profession and, ultimately, the legislature in the matter of the legitimation of third party assistance with death. Notwithstanding the fact that the termination of the life of one person by another, even at the victim's earnest and express request, has always been, ever since the codification of its criminal law in 1886, a specific offence in the Netherlands, prosecutions were extremely rare, even though the prosecutorial authorities were aware, albeit anecdotally, that euthanasia and assisted suicide were matters of common practice by members of the medical profession.

Over the past quarter of a century there has been an enormous growth in the quantum of Dutch law regarding voluntary active euthanasia and assisted suicide. This began with a number of iconic decisions in the 1980s by the Dutch courts, including the Supreme Court's ground-breaking decision in the *Schoonheim* case,[23] and culminated in the enactment of *The Termination of Life and Assisted Suicide 2002* which, inter alia, established Regional Review Committees to adjudicate on whether reported acts of euthanasia conformed with statutorily endorsed "*due care*" protocols.

The Dutch experience has become the touchstone against which other jurisdictions argue, either for or against, the desirability of permitting changes to laws prohibiting assistance with earlier than natural death. No study of value of either euthanasia or assisted suicide, or both, therefore, could credibly ignore the Dutch template. Hence its inclusion here.

[23] *Netherlandse Jurisprudentie 1985, no. 106.*

Belgium:

Notwithstanding a deep-seated Catholic allegiance the transition from criminal proscription of third party assistance with death to medicalised euthanasia surprisingly evinced more of an imitative jurisprudence than one governed solely by normative principles.

Beginning in the early 1980s there were a number of attempts - the genesis of which, in all probability, was influenced by jurisprudential, prosecutorial and medical developments in the Netherlands – although this has been consistently denied - to have a variety of forms of third party assistance with death, including euthanasia, legalised in Belgium. These endeavours led eventual, as a result of a change of Government in which the Christian Democrats were no longer participants, to the passage of the *Act Concerning Euthanasia* in 2002. (A *Palliative Care Act* was enacted also in 2002). The *Euthanasia Law* legalised the practice of euthanasia by doctors, but, curiously, not of assisted suicide,[24] contingent on the fulfilment of detailed substantive and procedural requirements which are overseen by a Federal Control and Evaluation Commission. With the enactment of this legislation Belgium – a predominantly Catholic country - became only the second country in the world, after the Netherlands, where the termination of the life of a person by a doctor could be effected licitly at that person's voluntary and repeated request.

Apart from a recommendation by the Government appointed Advisory Committee on Bioethics, which had been established in 1993, the segmented socio-political structure of Belgium in which ideological divisions were deeply institutionalised at both national and local levels and where religion was a dominant and influential consideration with regard to ethical matters, had provided little, if any, indication – and certainly none as far as non-Belgians were concerned – prior to 1997 (when the Advisory Committee published its report), of the existence of any prevalence, however tentative, for the legalisation of euthanasia. The non-inclusion of the Christian Democrats in the Government (comprising the Liberals, the Socialists and the Green Party), formed after the 1999 general election, meant that the main political opposition to the introduction of legislation allowing for euthanasia by doctors was removed.

Euthanasia as defined at Belgian law – "*the intentional life-terminating action by someone other than the person concerned, at the request of the latter*" - is not normal medical behaviour such as the refusal of treatment either by way of advance directive or in the form

[24] Unlike the 2002 Dutch *Termination of Life and Assisted Suicide (Review Provisions) Act* the Belgian *Act Concerning Euthanasia* does not expressly apply to assisted suicide. For further discussion in this matter see Chapter II on the Netherlands and Chapter III on Belgium.

of a current request; the withholding or withdrawing of treatment which is deemed to be medically futile; pain relief with life-shortening effects or palliative and terminal sedation.

The new Belgian Law recognises a right to request euthanasia. It does not recognise a right to euthanasia *per se.* No doctor can be compelled to perform euthanasia; nor can other persons be compelled to assist in its performance.

The example of how the law was changed in Belgium – via a convenient exercise in political opportunism on the part of a new Government – merits examination and review. Hence, its selection for examination here.

Switzerland:

The evolution of private right-to-die organisations in Switzerland can be traced to specific provisions of its Penal Code which exculpates third party assistance with death that is not motivated by self-interest.

The altruistic approach employed at Swiss law in ascertaining culpability arising from the requested participation by one person in the self-induced death of another is unique. All such actions other than in those instances where self-interest is involved are non-criminal. However, voluntary active euthanasia is specifically proscribed and non-natural death is not trivialised in Switzerland.

The apparent incompatibility of the Swiss embrace of the principle of the sanctity of life – which is not in doubt – and the liberal approach which authorities evaluate non-attributable criminal guilt for assistance in the suicide of another, is a matter which has exercised, and doubtless will continue exercise, jurisprudential commentary. In particular, the applicability of the specific provision in the Swiss Penal Code – *Article 115* - which governs the specific offence of inciting and assisting suicide, *other than for altruistic reasons*, occurs in the absence of clear and explicit criteria. The law is applied in a relatively inconsistent manner currently. Private right-to-die organisations, on the one hand, require their *"members"* to meet specific requirements, such as mental capacity, earnest and repeated requests, incurable diseases, bleak diagnosis and intolerable suffering, before assistance with death is provided. On the other hand, certain institutions, such as nursing and retirement homes, refuse to consider requests from patients or residents for assistance with suicide in order to avoid further pain and suffering.

Commercial right-to-die organisations in Switzerland provide, with impunity, assistance with death to both Swiss nationals and citizens of other countries. They are enabled to do so for a

number of reasons including (a) the legal endorsement of altruism as a criterion of non-culpability in the provision of such a service; (b) a non-intrusive regulatory regime established to oversee the provision of assistance with death and (c) the fact that the medical profession blithely accepts that because doctors do not perform the final act of death – they only supply the means by which this can be achieved by the person wishing to die – such behaviour is excluded from criminal prosecution.

These factors, together with the international identification of Switzerland as a death tourism location, guaranteed its inevitable consideration and evaluation in this study.

Luxembourg:

In March 2009, the *Law on Euthanasia and Assisted Suicide*, in somewhat dramatic circumstances,[25] came into effect in the Duchy of Luxembourg. As a result Luxembourg became only the third European country, after the Netherlands[26] and Belgium,[27] to permit third party assistance with death, specifically voluntary active euthanasia and assisted suicide. Both actions are only decriminalised, however, when performed by a doctor at the repeated request of a terminally-ill patient, who is suffering constant and unbearable physical and mental anguish, and in accordance with the formal and procedural protocols established under the 2009 *Law*. Specific grounds for doctors being excluded from the possibility of criminal proceedings have been inserted into Luxembourg's Criminal Code.[28] Therefore, assisted dying is wholly medicalised. There are no provisions in the new law allowing for euthanasia or assisted suicide to be performed by anybody other than a doctor.

The argument posited by those who claim that the balance between the autonomy of the individual to choose not to suffer un-necessarily, and to opt for earlier than natural death, and the duty of a member of the medical profession to relieve pain and suffering - but only to the degree that does not encompass intentional killing - engenders automatic legitimation of euthanasia or assisted suicide, or both, was not in evidence in the political arguments leading to the enactment of the 2009 *Law*.

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[25] See Chapter V on Luxembourg. In December, 2008, two bills were passed in Parliament – the *Bill on Palliative Care* and the *Bill on Euthanasia and Assisted Suicide.* On the grounds of conscience the Grand Duke refused to sign the latter. To give effect to the passage of the bill Parliament was required to enact legislation removing the Grand Duke's veto power.

[26] The law in the Netherlands permits both voluntary active euthanasia and assisted suicide. See Chapter II on the Netherlands.

[27] The 2002 Belgian *Law on Euthanasia* is silent in the matter of assisted suicide. The reality, however, is that both active voluntary euthanasia and assisted suicide are legally condoned in Belgium. For further discussion see Chapter III on Belgium.

[28] Article 397-1: *"The fact of a doctor responding to a request for euthanasia or assisted suicide shall not fall within the scope of application of the present section if the fundamental conditions of the Law of 16 March, 2009, on euthanasia and assisted suicide are met."*

Rather, the balance which was identified was one between respect for the *'freedom of conscience'* of a doctor to accede, or not, to a request for euthanasia or assistance with suicide and, in doing so not to bring about a situation in which a terminally ill patient is forced to await a natural death with unbearable pain and suffering. The underlying ethic was one which encompassed simultaneous respect for the freedom of conscience of a doctor and respect for the freedom of choice of a patient wishing to die an earlier than natural death. The Luxembourg legislative authorities decided that the only feasible way in which this balance could be achieved was by the exclusive decriminalisation of acts of assisted death when performed by doctors.

Whether the intention of enacting a law on palliative care simultaneously with the passage of the *Euthanasia and Assisted Suicide Law* was a calculated manoeuvre to reassure those who feared either that an indiscriminate regime of assisted dying would ensue or that incompetent or disabled persons would be subjected to involuntary euthanasia in the absence of an organised system of palliative care is unclear. What is clear, however, is that assisted death has now been added to the list of national characteristics which are invoked as evidence of a modern and sophisticated jurisdiction. How this came about, together with the protocols established to prevent abuse, are matters of legitimate academic inquiry. Luxembourg, therefore, could not be ignored.

Judicial activism:

It will be recalled that the contention is that the lawful termination of life in certain jurisdictions has been facilitated directly by legislative measures. As has been indicated above this applies in particular to the Netherlands, Belgium, Switzerland and Luxembourg. It is contended also that the same outcome, namely the legitimation of third party assistance with death, and notwithstanding the invocation of normative principles, particularly that of the sanctity/inviolability of life, has been achieved in common law jurisdictions as a result of judicial activism, such as in Canada, and arguably in the United Kingdom (and Ireland), and where there has been both judicial and legislative treatment of the matter, such as in the United States of America.

Canada:

The debate as to the consistency of specific criminal law provisions, most especially section 241(b) of the Canadian Criminal Code which prohibits assistance with suicide, with the *Canadian Charter of Rights and Freedoms*, was highlighted by the enormously detailed and

comprehensive finding in *Carter v Canada.*[29] Section 241(b) was struck down on the grounds that it infringed particular sections of the Charter[30] and as a consequence was unconstitutional. Lynn Smith J held that the criminal prohibition of assisted suicide was unconstitutional because it was inconsistent with the principles of fundamental justice and was disproportionate.

This was a dramatic departure from the authority of the Canadian Supreme Court in *Rodriguez v Canada* [31] where it had been determined that, notwithstanding the fact that the plaintiff's right under s.7 of the Charter was engaged by the prohibition nonetheless it was justified because it was not a breach of fundamental justice. Lynn Smith J provided two reasons for her departure from *Rodriguez*. First, proportionality analysis had been significantly developed since the decision in *Rodriguez.* Second, she was satisfied that new evidence from jurisdictions in which the ban on assisted suicide had been relaxed, which was not available to the Supreme Court in *Rodriguez,* had since become available.

The likelihood is that the decision in *Carter* will ultimately be appealed to the Supreme Court of Canada. It is of interest to note that counsel for the appellant in *Fleming v Ireland*[32] argued that as the most recent authority in the field it was the most persuasive of the relevant foreign authorities because it undertook the most in-depth assessment of recent evidence regarding the risks associated with any relaxation of the criminalisation of assisted suicide. The Irish High Court was unconvinced, as was Ireland's Supreme Court on appeal.[33]

The judicial reasoning adopted and followed in *Rodriguez,* and distinguished in *Carter,* is instructive from the differing jurisprudential perspectives followed in respect of the rights guaranteed under the Canadian Charter of Rights and Freedoms.

In *Rodriguez* the validity of the prohibition on assisted suicide had been upheld by a majority of the Supreme Court of Canada. Delivering the decision of the majority, Sopinka J held that the "*most substantial issue*" to be determined by the court was whether the impugned provision infringed the appellant's liberty and security of the person interests under s.7 of the Charter. He held that these interests could not be divorced from the sanctity of life, the third

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[29] *2012 BCSC 886.*

[30] Specifically section 7 which provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principle of fundamental justice, and section 15(1) which provides that every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental of physical disability.

[31] *[1993] 3 SCR 519.*

[32] *[2013] IEHC2; [2013] IESC 19.*

[33] See Chapter IX on Ireland.

value protected by s.7. The court rejected the argument that for the terminally ill the choice is one of time and manner of death rather than death itself since the latter is "*inevitable*". He stated:

"Death is, for all mortals, inevitable. Even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice of death over life. It follows that life as a value is engaged even in the case of the terminally ill who seek to choose death over life."[34]

The court found that a blanket prohibition on assisted suicide akin to that contained in the Canadian Criminal Code was the "*norm among Western democracies*" and that such a prohibition had never been adjudged to be unconstitutional or contrary to fundamental human rights. Sopinka J was satisfied that the impugned provisions was "*valid and desirable*" and pursued the government's objectives of "*preserving life and protecting the vulnerable.*" The court determined that, given the risks of abuse in a system that permits assisted suicide and the difficulty in creating safeguards to prevent such risks, it could not be said that the blanket prohibition was arbitrary or unfair, or that it was not reflective of fundamental values at play in Canadian society.

In *Carter* Lynn Smith J found that the prohibition on assisted suicide was "*more burdensome*" and had *"very severe and specific deleterious effects on persons with physical disabilities*." She rejected the argument for a distinction between the withdrawal of treatment to bring about the end of a person's life and the act of physician assisted suicide. Rather, she was of the opinion that such a *"bright-line ethical distinction is elusive."* She concluded that, due to its unqualified nature, the impugned provision did not impair Charter rights as little as possible. Rather, on the evidence before the court, and summarising her findings in relation to her examination of legislation, Lynn Smith J stated:

"Less drastic means of achieving the legislative purpose would be to keep an almost absolute prohibition in place with a stringently limited, carefully monitored system of exceptions allowing persons in Ms Taylor's situation - grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress – to access physician assisted death."[35]

Thus, it was held, the legislation did not meet the requirement of minimal impairment, and it was found that the absolute prohibition on assisted suicide fell "*outside the bounds of*

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[34] *[2012] BCSC 886 at para 586.*
[35] *Ibid at para 16.*

constitutionality." Section 241(b) of the Criminal Code was declared invalid and struck down by the court. The operation of such declaration, however, was suspended for one year in order to afford the Parliament an opportunity to amend the impugned provision accordingly. A constitutional exemption was granted to the appellant, allowing her to avail of physician assisted suicide during the period of suspension, subject to a number of court-imposed conditions. However, on 4th October, 2012, Ms Taylor passed away unexpectedly due to the contraction of an infection.

Curial treatment of third party assistance with death in Canada – irrespective of any future decision on appeal by the Canadian Supreme Court - exemplifies how the law can be developed in such a sensitive matter by judicial activism. The exclusion of the judicial reasoning adopted and followed in both *Rodriguez* and *Carter* from consideration in this study would have been unconscionable.

The United Kingdom:

A number of principles, such as the medical exception, the requirement of informed consent, the right of refusal of medical treatment, individual autonomy and self-determination, capacity and incapacity, and most especially that of medical futility, are inextricably interwoven with an intricate filigree of evolved legal mechanisms in the approach adopted and followed at English law over the past quarter of a century in the matter of third party assistance with death.

Of significance, but not exclusively so, among these mechanisms are those which incorporate specific moral values, including the principle of the inviolability of life at common law – which, in doctrinal terminology, is referred to as the sanctity of life – and the traditionally established legal construct of double effect, the essence of which is the distinction drawn between intention and foresight.

Similarly, the applied legal differential between acts and omissions is of crucial significance in any appreciation of how the lawfulness of death resulting from either medical action or inaction can be readily accommodated within the legal architecture governing the prohibition of the deliberate termination of the life of one person by another.

Historically, these constructs have provided, and continue to do so, the philosophical and intellectual foundation on which the edifice of prevailing orthodoxy regarding the common law proscription of intentional assistance with earlier than natural death has been firmly established.

Their influence is clearly discernible in the judicial reasoning adopted and followed in a number of cases, particularly those in which incapacity, together with a medical prognosis of futility, predominate and where the lawfulness or otherwise of the withdrawal of life-sustaining medical treatment was in issue. *Airedale NHS Trust v Bland*[36] and *Re A (Conjoined Twins)*[37] are but two examples of such cases.

The contention here, however, is that in the last decades of the twentieth century a new philosophical orientation began to emerge, the defining contours of which were the diminution of medical paternalism and the recalibration of the concept of individual rights, particularly those of informed consent and refusal of unwanted medical treatment, even in circumstances where death is the inevitable outcome. A subtle, but nonetheless discernible, relegation of the common law principles underpinning findings as to who should be let live and who should be permitted to die occurred. The patient's *'best interests'* became the new curial criterion. Thus, a *'quality of life'* benchmark emerged as an integral and authoritative element in end-of-life decision-making at English common law. The genesis of this new criterion can be traced to findings in specific cases, beginning in the late 1980s, in which the lawfulness or otherwise of the non-treatment, or the discontinuance of life-sustaining medical treatment of incompetent children suffering with disabilities, including those of an uncomplicated character, was in issue.

It is contended, therefore, that traditional Western jurisprudential criteria were subjected to a type of constructive judicial ambiguity, resulting in the gradual discontinuance of their automatic invocation as the exclusive and unassailable reference points in the determinative matrix regarding continued life or guaranteed death.

Similarly, it is contended that apart from those rare cases in which doctors are prosecuted for the crime of the attempted unlawful killing if a patient, and in which the efficacy of the doctrine of double effect can be demonstrated, or where a hospital authority seeks curial guidance as to whether a particular procedure, if followed, will result in criminal charges, the common law as practiced is symptomatic of its innate ability to accommodate a suite of alternative and novel criteria, referred to in emollient terms by judges as the *'best interests'* test.

Unquestionably, these contentions require substantiation based on probative empirical data. This can only be achieved by a comprehensive review of English case law, together with an

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[36] *[1993] AC 789.*
[37] *[2001] Fam 147.*

analysis of the history and application of the jurisprudence underpinning determinations in specific cases. This thesis would have been incomplete without such a review and analysis.

United States of America:

In the USA there has been both judicial and legislative treatment of third party assistance with death. Four states have legalised physician-assisted suicide – Oregon (by way of Ballot Measure 16, resulting on the *Death with Dignity Act, 1994*, effective since 1997), Washington (by way of Ballot Initiative 1000, resulting in the *Death with Dignity Act, 2008*), Montana (where the Supreme Court, in *Baxter v Montana,*[38] held that a terminally ill patient's consent to physician assistance with death constitutes a *"statutory defence to the* charge *of homicide against the aiding physician when no other consent exceptions apply"*[39] and Vermont (via *Act No.39: An Act Relating to Patient Choice and Control at the End of Life, 20 May, 2013*). 46 states, and the District of Columbia, consider assisted suicide illegal. 38 states have laws prohibiting assisted suicide, 3 (Alabama, Massachusetts and West Virginia) prohibit assisted suicide by common law and 4 (Nevada, North Carolina, Utah and Wyoming) have no specific laws regarding assisted suicide, may not recognise common law, or are otherwise unclear on the legality of assisted suicide. Euthanasia is prohibited in all fifty states.

The approach adopted towards both euthanasia and assisted suicide since independence is redolent, however, of some of the less attractive features which the general debate on assisted dying can evoke. While American jurisprudence might prefer not to have these less palatable perspectives highlighted nonetheless they are deserving of historical contextualisation and examination. More recently there has been evidence of a strategically choreographed invocation of more acceptable principles – those of individual autonomy and person rights – aimed at having assistance with suicide recognised as a constitutional prerogative. These, too, are deserving of forensic jurisprudential analysis, not alone from the point of view of their importance in the on-going legal debate in the United States in the matter of assisted dying but also because their relevance in other common law jurisdictions, such as the United Kingdom and Ireland, where state Supreme Court decisions, and those of the Supreme Court of the Unites States itself, are cited liberally in the attempt to have the prohibition on assisted suicide removed on the grounds of unconstitutionality.

Since the first attempt to have assisted suicide decriminalised in Ohio in 1906, there have been numerous endeavours, either by way of voter initiative, legislative challenge or court action to have the law changed in order to facilitate physician-assisted death. In the period

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[38] *2009 MT 449.*

[39] *Ibid, at 50.*

1990-2012 alone, there were 91 proposals, including 4 ballot initiatives, in 25 states, to legalise assisted suicide. By virtue of this level of legal activity alone the inclusion of the United States of America in this study was inevitable.

In reality, the current American disposition in the matters of euthanasia and assisted suicide is emblematic of the tensile strength which exists between a rights-based federal constitution and the independence with which individual states apply particular laws. The question, however, is whether a future Supreme Court will recognise as legitimate an *as applied* challenge to a state law prohibiting assisted suicide. Notwithstanding their subsequent vacation by the Supreme Court the decisions - by State Supreme and Appeals Courts - in cases such as *Compassion in Dying v Washington* [40]and *Quill v Vacco,*[41] both of which recognised, albeit on different grounds, a constitutional right to assisted suicide, are redolent of the rights-based philosophical and jurisprudential approach which has characterised repeated attempts, from the 1960s onwards, to have the law in America changed in respect of the availability of assistance with suicide and is likely to continue to inform future endeavours.

The Supreme Court decision in *Washington v Glucksberg*[42] provides the definitive touchstone currently for the evaluation by lower courts of any future applications for declaratory judgments of a putative constitutional right to assisted suicide. The Court held that assisted suicide was not a *facially* guaranteed right under either the *Due Process* or *Equal Protection* clauses of the Fourteenth Amendment to the Constitution. The notion that *due process* creates a constitutional guarantee of *"self-sovereignty"* which encompasses all *"basic and intimate exercises of personal autonomy"* was firmly rejected. The reliance which the District Courts and the Courts of Appeals in both Washington and New York, in *Compassion in Dying v Washington* and *Quill v Vacco* respectively, had placed on the *"mystery-of-life"* passage in *Planned Parenthood v Casey*[43] was wrong.

The decisions in *Compassion in Dying v Washington, Quill v Vacco* and *Washington v Glucksberg* demonstrate the acute difficulties which courts in the United States, at all levels, are confronted by when striving to achieve an appropriate balance between the recognition of individual personal rights, such as autonomy and privacy, and the duty of the state to preserve life. The possibility that the Supreme Court could, at a future date, recognise an as applied constitutional challenge to a state statute banning assisted suicide, is indicative of the

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[40] *85 F.3d.1440 (9th Cir.1996)(en banc).*
[41] 80 F.3d.716 (This case began in the United States District Court for the Southern District of New York as *Quill et al v Koppell 870 F Supp.78 (1994)*).
[42] *521 U.S.702 (1997).*
[43] *505 U.S.833 (1992).*

underlying jurisprudential uncertainty attaching to the issue of the inviolability of life in that jurisdiction.

The totality of the jurisprudential approach to third party assistance with death in the Unites States of America, therefore, is of significant relevance and importance and merits attention.

Ireland:

Ireland is included among those jurisdictions for consideration from the point of view of judicial activism in the area of third party assistance with death not because of any overt determination by the courts to subvert the provisions of the Criminal Law (Suicide) Act, 1993, which, under section 2(2), criminalises assisted suicide, but because of the imitative nature of the judicial reasoning adopted and followed in the small number of cases that have arisen in respect of third party assistance with death.

Prior to 2012 Irish courts had never been asked to adjudicate on the legitimacy or otherwise of assistance which was intended to bring about an earlier than natural death in the case of a competent person who had expressed a voluntary wish to die by suicide but could only do so with the help of another. The jurisprudential approach to third party assistance with death was informed solely by the Supreme Court finding in *In re a Ward of Court*[44] that withdrawal of artificial nutrition from an incompetent adult did not impermissibly or disproportionately impinge on the rights of the ward, particularly that of her right to life and, being in her *'best interests'* (a concept imported directly from English jurisprudence), was legal.

In *Fleming v Ireland*[45] the High Court was asked for a declaration of invalidity in respect of section 2(2) of the Criminal Law (Suicide) Act, 1993, having regard to the provisions of the Constitution. Similarly, a declaration of incompatibility with the rights of the claimant pursuant to the European Convention on Human Rights and Fundamental Freedoms was requested. In the alternative, an order directing the Director of Public prosecutions, within such time as the Court would consider just and appropriate, to promulgate guidelines stating the factors that could be taken into account in deciding, pursuant to section 2 (2) of the Criminal Law (Suicide) Act, 1993, whether to prosecute or to consent to the prosecution of any particular person in circumstances such as those that would affect a person who assisted the appellant in the ending of her life.

The High Court held that the criminalisation of assisted suicide was neither unconstitutional nor incompatible with the convention on Human Rights and Freedoms. These findings were

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[44] *In re a Ward of Court (withholding medical treatment)(No.2), [1996] 2 IR 73.*
[45] *[2013] IEHC 2.*

confirmed on appeal by the Supreme Court.[46] Of particular jurisprudential interest, however, were the somewhat gnomic observations by the three judge panel in the High Court in the matter of the future role of the Director of Public Prosecutions, and whether it might be appropriate for her – in exercising her discretion to prosecute, or not – in a case of assisted suicide, to give *"full and careful consideration"* to evidence of compliance with those prosecutorial policy factors invoked in other jurisdictions, particularly those of the English Crown Prosecution Service. This matter was not addressed by the Supreme Court on appeal.

In re a Ward of Court both the Irish courts availed readily of the judicial reasoning which had been adopted and followed in *Airedale NHS Trust v Bland*.[47] Even a cursory analysis of the judgments in both the High Court and Supreme Court exudes a palpable sense of relief on the part of the judges that a jurisprudential template had been established whereby the withdrawal of nutrition could legitimately be deemed in the ward's *'best interests'*, based on the categorisation of tube-feeding as medical treatment. In the Supreme Court, for example, the Chief Justice, in satisfying himself that the treatment being afforded the ward constituted medical treatment and not merely medical care noticeably failed to offer anything by way of substantive jurisprudential evidence to sustain this conclusion. He merely reprised, unquestioningly, the statement in *Airedale* at first instance that *"the provision of artificial feeding by means of a nasogastric tube 'is medical treatment'"*, and in something of a giant jurisprudential leap, averred that there was no conflict between the exercise of the ward's rights and the right to life.

Together with the invocation of English jurisprudential concepts the Supreme Court also turned to American case law for guidance and support in confirming the finding of the lower court in *Re a Ward of Court*. Doubtless this trans-Atlantic dimension was introduced in order to disabuse any suggestion that the Supreme Court was following English jurisprudence exclusively!

In essence, therefore, the principles which were distilled in other jurisdictions – including those in the United Kingdom, the Unites States of America and Canada – are brought to bear on the consideration of Irish law in respect of third party assistance with death in this thesis.

Non-inclusion of certain jurisdictions:

For reasons of both space and specificity the legislative, judicial and constitutional strategies in the eight jurisdictions chosen were preferred over a more encyclopaedic dynamic.

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[46] *[2013] IESC 19.*
[47] *[1993] AC 789.*

Consequently, it was not deemed of over-arching relevance to include those jurisdictions that have either made legislative provision for euthanasia, such as the Northern Territory in Australia,[48] - albeit of short duration only - or where a decision of a Constitutional Court, such as that of Colombia, provides apparent judicial approval for the introduction of laws allowing for third party assistance with death.[49]

Likewise, it was not considered necessary to address the likelihood of legislative changes that might occur in jurisdictions, such as France, for example, where Presidential support for the decriminalisation of voluntary euthanasia is in evidence, notwithstanding objections from the French National Consultative Ethics Committee (Comite National Consultatif d'Ethique) which alleges that "*abuses*" have occurred in adjacent jurisdictions that have decriminalised and regulated either voluntary euthanasia or physician-assisted suicide (e.g. the Netherlands, Belgium, Switzerland and Luxembourg).

Consideration of the legal status of passive euthanasia in India, Mexico, New Zealand, New South Wales and Japan, while of undoubted interest and importance, was not deemed

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[48] On 25 May 1995, the Northern Territory became the first place in the world to pass right to die legislation. *The Rights of the Terminally Ill Act* came into effect on 1 July, 1996. It allowed terminally ill patients to commit medically assisted suicide, either by the direct involvement of a physician or by the procurement of drugs. It required a somewhat lengthy application process, designed to ensure that the patient was both mentally competent to make the decision and in fact terminally ill. Under the Act (a) a patient had to be over 18 and be mentally and physically competent to request his/her own death; (b) the request had to be supported by three doctors, including a specialist who confirmed that the patient was terminally ill and a psychiatrist who certified that the patient was not suffering from treatable depression and (c) once the paperwork was complete, a nine day cooling-off period was required before the death could proceed. While the Law was in force, four people committed suicide under its provisions. On 25 March, 1997, the Federal Parliament passed the *Euthanasia Laws Act 1997* which, although not technically repealing *The Rights of the Terminally Ill Act*, for all practical purposes rendered it of no legal effect. Rather than repeal *The Rights if the Terminally Ill Act* –which it could have done - the Commonwealth Parliament instead amended the *Northern Territory Self-Government) Act* (the Act under which the Commonwealth Parliament delegated legislative power to the Northern Territory Legislative Assembly) removing the Territory's constitutional power to pass any law permitting euthanasia. Technically, *The Rights of the Terminally Ill Act* remains in force in the Northern Territory, but to the extent that it permits euthanasia it is constitutionally invalid and of no legal effect. Although passed as a reaction to the situation in the Northern Territory, the *Euthanasia Laws Act 1997* made similar amendments with respect to Australia's two other self-governing territories, the Australian Capital Territory and Norfolk Island, preventing them from passing a law permitting euthanasia. The *Euthanasia Laws Act 1997* has no effect on the power of an Australian *state* to pass any law permitting euthanasia and it expressly leaves open the possibility of a *territory* passing laws regarding the withholding of life support. It is of interest to note that Dr Philip Nitschke, the first doctor in the world to administer legal, voluntary euthanasia, founded *EXIT INTERNATIONAL* in response to the overturning of *The Rights of the Terminally Ill Act 1995.*

[49] On 29 May, 2010, in a 6-3 decision, Colombia's Constitutional Court ruled that "*no person can be held criminally responsible for talking the life of a terminally ill patient who has given authorisation to do so.*" The Court defined "*terminally ill*" persons as those with diseases such as "*cancer, AIDS, and kidney and liver failure if they are terminal and the cause of extreme suffering.*" The ruling specifically refused to authorise euthanasia for people with degenerative diseases such as Alzheimer's, Parkinson's or Lou Gehrig's disease.

justifiable in the context of the concentrated comparative analytical approach adopted in this study. It is not that a forensic appraisal of the approaches adopted to third party assistance with death in these jurisdictions would prove valueless. Unquestionably, such an appraisal would contribute to a greater understanding of the multi-faceted legal, constitutional and cultural dimensions which attach to the pursuit of particular jurisdictional strategies. Their inclusion, however, would have had the potential to defocus the core objective of this thesis, namely, that of highlighting the two different approaches to earlier than natural death graphically evident in the jurisdictions selected – that of legislative reformulation to allow for assistance with death in the four European countries chosen (the Netherlands, Belgium, Switzerland and Luxembourg) on the one hand, and, on the other, of the pragmatic curial willingness, in the absence of legislative initiative, to embrace novel jurisprudential criteria for the resolution of the aforementioned dilemma of who should be let live and who should die or be killed which characterises the normative approach adopted in the United States of America (apart from those states that have either enacted legislative measures permitting third party assistance with death or whose Supreme Courts have ruled that a terminally ill, competent patient has a legal right to die with dignity under relevant sections of the state's constitution))[50], Canada, UK and Ireland.

While eschewing the opportunity to review the approaches in those countries not chosen for examination it is of value nonetheless to note in passing that in March, 2011 the Supreme Court of India legalised passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state. However, all forms of active euthanasia, including the administration of lethal compounds, remain illegal.[51]

In Mexico, active euthanasia is illegal but since 2008 the law allows a terminally ill person – or, if unconscious, his/her closest relatives – to refuse medication or further medical treatment to extend life in Mexico City,[52] in the central state of Aguascalientes[53] and in the

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[50] Physician assisted suicide is legal in four states – Oregon (1994), Washington (2008), Montana (2009) and Vermont (2013). See Chapter VII on America.

[51] See the *Aruna Shanbaug* case in which the Supreme Court recognised the legality of passive euthanasia.

[52] See *Publica GDF Ley de Voluntad Anticipada (http://www.eluniversal.com.mx/notas/4724474.html).*

[53] See *Solo falta reglamentar la voluntad anticipada para aplicarla:Ruvalcaba (http://lajornadaaguascalientes.com.mx/index.php?).*

Western state of Michoacan.[54] A similar law extending the same provisions at national level has been approved by the Senate.[55]

Assisted suicide and voluntary euthanasia remain illegal in New Zealand under Section 179 of the New Zealand *Crimes Act, 1961*, which renders it a criminal offence to "*aid and abet suicide*". There have been two attempts at decriminalisation – the *Death with Dignity Bill, 1995* and the *Death with Dignity Bill, 2003*. However, both attempts were unsuccessful, the latter by a mere three-vote margin. In 2012 a private member's bill was introduced into the ballot box – the *End of Life Choices Bill* – which may mean that debate on the issue will be deferred for a considerable period, given that selection of private member's bills from the ballot box is a random process.

At the time of writing a private member's Bill, the *Rights of the Terminally Ill Bill*, was defeated in the New South Wales Upper House by a margin of 23 votes to 13.[56] This Bill, while principally an assisted suicide bill, contained the option of euthanasia if the patient was found to be unable to take the requisite drugs him/herself. An *Australia 21* Report[57] had earlier recommended change to the current law prohibiting euthanasia.

There are no specific laws in respect of euthanasia in Japan and the Japanese Supreme Court has never been called upon to rule on the matter. Rather, Japan's euthanasia policy, to date, has been decided by a number of local court cases, one in Nagoya in 1962, and another after an incident at Tokai University in 1995. The first case involved passive euthanasia – allowing a patient to die by turning off life support – and the other active euthanasia whereby death was brought about by the injection of a lethal drug. The judgments in these cases established a legal framework and a set of conditions within which both passive and active euthanasia could be legal. In both of these particular cases the doctors involved were found guilty.

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[54] See *Michoacan aprueba Ley de Voluntad Anticipada (http://eleconomista.com.mx/notas-online/politica/2009/09/01/michoacan-aprueba-ley-anticipada).*

[55] See *Senado Mexico aprueba a enfermos terminales rehusar- tratamientos (http://ecodiario.eleconomista.es/noticias/noticias/885713/11/08/Senado-Mexico-aprueba-a-enfermos-terminales-rehusar-tratamientois.html).*

[56] The vote was taken in late April, 2013.

[57] In April 2013 the Australian research organisation, *Australia 21*, published a report which sought to chart the core issues surrounding third party assistance with death and to present dispassionately the diversity of views in the matter. The lead author of the report, Emeritus Professor Bob Douglas, stated that worldwide views on voluntary euthanasia and assisted suicide were changing rapidly and that Australian politics *"must reflect the wishes of the majority of Australians. National polls make it clear that Australians want to have this possibility available to them as they approach the end of their lives. The issue has been extensively debated in the past in both state and federal parliament, but has been heavily opposed by a small but highly influential segment of the Australian population."* Co-author of the report, Professor Ben White, stated that the current law on voluntary euthanasia and assisted suicide is flawed. *"The law lacks coherence and there is a body of evidence that shows it is not being followed. Reform is needed."*

However, as the findings of these courts have yet to be upheld at national level, their precedential status is not necessarily binding. Nonetheless, there is a tentative legal framework currently for implementing euthanasia in Japan.[58]

Each of these jurisdictions – the Northern Territory of Australia, Colombia, France, India, Mexico, New South Wales, New Zealand and Japan – merits forensic examination in their own right. However, their inclusion in this work would result in an unnecessarily unwieldy composition and one which would deprive the less expansive approach adopted of its inherent coherence and focus.

Two Approaches:

In summary, the underlying contention of this work is that while there are two radically different jurisprudential approaches to the issue of third party assistance with death, the end result is identical, namely the lawful termination of life: in the one as a result of legislative enactment, and in the other as a result of pragmatic judicial determinations.

The **first** approach is that which had been adopted and followed by those jurisdictions where euthanasia or assisted suicide, or both, has been legalised. For convenience, and not indicative of either approbation or disapproval, this can be termed the ***transparent*** route. Existing law has either been amended, or new law introduced, allowing for the termination of life on request when performed by a doctor in accordance with defined protocols, the Netherlands being the most commonly invoked template.

The context, together with the varying curial, prosecutorial, medical and political influences which contributed to this legalisation, is of fundamental relevance to an appreciation of the differences which lie at the core of the two different approaches. A chapter is devoted to each of the Netherlands, Belgium, Switzerland and Luxembourg, while the legitimisation of physician-assisted suicide in Oregon, Washington, Montana and Vermont is considered in the chapter on America.

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[58] In the case of passive euthanasia, three conditions must be met: (a) the patient must be suffering from an incurable disease, and be in the final stages of the disease from which there is little likelihood of recovery; (b) the patient must give express consent to stopping treatment, and this consent must be obtained and preserved prior to death. If the patient is unable to give clear consent, his/her consent may be determined from a pre-written document such as a living will or from the testimony of his/her family; (c) the patient may be passively euthanised by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drop, etc.
For active euthanasia, four conditions must be met: (a) the patient must be suffering from unbearable physical pain; (b) death must be inevitable and drawing near; (c) the patient must give consent (unlike passive euthanasia, living wills and family consent are not deemed sufficient); (d) the physician must have exhausted all other measures of pain relief.

The **second,** and less than transparent, disposition is that which has been adopted in a number of common law countries such as England, the United States, Canada and Ireland where, notwithstanding the continued criminal proscription of euthanasia and assisted suicide, the law, over the past thirty years, has been recalibrated to the degree that the licit killing of incompetent children and adults is an accepted reality. For convenience, this can be described as the ***unheralded*** route – ***unheralded*** because it is has evolved not as a result of any legislative enactment but because of the application of new, judicially divined legal principles in hard cases. The judgments in these cases are, of course, publicly available and are widely discussed when handed down but their impact in the public forum tends to be transient – sometimes confined to a matter of days before they recede into the obscurity of law reports.

The contention that the common law in these jurisdictions, over a relatively short period of time, has been consciously and deliberately transformed, albeit subtly, from one in which unlawful killing was traditionally anathematised to one where assisted death is judicially facilitated requires nothing less than clear and convincing proof.

The requisite evidence to sustain this claim is provided by an analysis of the judicial reasoning adopted and followed, particularly at English law, in a number of iconic cases, beginning with those in which the continued life, or the death, of new born babies with severe physical handicaps was in issue, together with its subsequent application in cases of incompetent adults. Similarly, the contention is bolstered by an examination of the judicial reasoning – following that contained in the US Supreme Court decision in *Planned Parenthood v Casey*[59] - underpinning the decisions in *Vacco v Quill*[60] and *Compassion in Dying v Washington*[61] that a state ban on assisted suicide violated the 14th Amendment of the American Constitution. Notwithstanding the fact that these findings were vacated by the Supreme Court in *Washington v Glucksberg*[62] they are symptomatic of how constitutional provisions can be successfully invoked - at least in U.S. state Courts of Appeals - to permit of legal assistance with death. In addition, the reasoning adopted and followed in the more recent case of *Carter v Canada*, and its rejection in the Irish case of *Fleming v Ireland*, will be addressed.

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[59] *505 US 833 (1992).*

[60] *Quill v Koppell 870 F.Supp.78 (S.D.N.Y.1994), rev'd sub nom. Quill v Vacco, 80 F.3d 716 (2d Cir.1996), rev'd Quill v Vacco, 521 US 793 (1997)(Vacco v Quill).*

[61] *850 F.Supp.14454 (W.D. Wash.1994), rev'd 49 F.3d 586 (9th.Cir.1995), aff'd, 79 F.3d 790 (9th Cir reh'g denied, 85 F.3d 1440 (9th Cir.1996) rev'd sub nom.Washington v Glucksberg, 521 US 702 (1997)(Washington v Glucksberg).*

[62] *521 US 702 (1997).*

Arising from a claimed inherent jurisdiction, an English court[63] in *Re B*[64] in 1981 settled the fundamental principle governing the withholding of life-saving treatment from young children.

***'Best Interests'*:**

The *locus classicus* in respect of an incompetent adult patient is *Airedale NHS Trust v Bland*[65] in which it was held by the House of Lords[66] that, notwithstanding the fact that the patient was not terminally ill and could breathe independently, it was not in his *'best interests'* to continue to live in his existing state. In short, it was held that it was in his *'best interests'* that his life be ended.[67]

The newly-minted principle of *'best interests'* is at the heart of the recalibrated law in England and Ireland, as is the *'substituted judgement'* criterion at American law. On the basis of a medical indication of the futility of further treatment, allied to a negative quality of life estimation – arrived at solely by judges - the *'best interests'* paradigm has been allowed to enter the matrix of criteria available to courts when life and death are in issue.

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[63] It is of interest to note that while it was claimed, at the time of the judgment, that the court appeared to be exercising *"a non-existent inherent jurisdiction"* (See Stone, J, *'Withholding Life-sustaining Treatment: The Ultimate Decision'*, New Law Journal 144, 1994, at 205; Bridgeman, J, *'Declared Innocent?'*, Medical Law Review 3, 1995, at 117) this was subsequently cured by the enactment of the *Mental Capacity Act, 2005*. The Law Lords had also used their civil jurisdiction to settle a question of criminality, a matter which was contested, albeit unsuccessfully, in *R v Bingley Magistrates' Court, ex p Morrow [1995] Med L Rev 86.*

[64] *Re B (A Minor) (Wardship: Medical Treatment) [1981] 1 WLR 1421, CA*. It concerned an infant girl, Alexandra, born suffering from Down's syndrome and an intestinal obstruction. In a normal child, simple surgery would have been carried out swiftly with minimal risk to the baby. Without surgery, the baby would die within a few days. Her parents refused to authorise the operation. They argued that God or nature had given their child a way out. The doctors contacted the local authority and the child was made a ward of court. A judge was asked to authorise the operation. He refused to do so. The authority appealed, and the Court of Appeal ordered that the operation go ahead. The Court rejected the submission that in a case of this kind the view of responsible and caring parents must be respected and that their decision should decide the issue. See Chapter VI on England.

[65] *[1993] AC 789.*

[66] Now known as the Supreme Court of England and Wales.

[67] See Chapter VI on England and Chapter IX on Ireland. It was accepted by the House of Lords that the intention to kill the patient in *Bland* was undeniably present. Yet, to accelerate his death – in effect to kill him – by the withdrawal of life-sustaining treatment would not be murder. Withdrawing his life-sustaining treatment would not be a deliberate act. It would be an omission. Consequently, the strictures of the criminal law in respect of intentional killing would not apply. Lord Mustill expressed his *"acute unease"* about resting his decision on this distinction which had been drawn by Lord Goff. *"However much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable"*, at 887. See also 865 *per Lord Goff;* 877 *per Lord Lowry;* 885 *per Lord Browne-Wilkinson*. In following *Bland* a short time afterwards the Irish Supreme Court, in *Re a Ward of Court (withholding medical treatment)(No.2) 2 IR 79*, did not find it necessary to voice a similar degree of unease.

Whether a patient is allowed to continue with life or, in effect, to be killed is now the exclusive prerogative of judges and one which, it would appear, legislators are content not to challenge. In this matter the courts and legislators have a common purpose. In most of the countries studied the legislatures and the courts share broadly the same view as to the circumstances in which life may be ended; their apparent differences can be explained not as reflecting deep opposition but rather a shared desire that the law be changed pragmatically to bring this about.

The suggestion that the transformation of traditional legal principles has occurred as claimed is not conspiratorial. Rather, it is a matter of incontrovertible proof. Case law in England is replete with instances where continued life has been deemed not to be in patients' *'best interests'*. Similarly, the *'substituted judgment'* test has been applied in a number of iconic cases in the United States.[68]

At issue, therefore, is whether there is any difference in substance, as distinct from approach, between what is legally permitted in those jurisdictions that have introduced legislation concerning third party assistance with death and what has occurred as a result of the principle of the sanctity of life being judicially transformed as suggested.

The question is one of jurisprudential honesty. If the criminal law prohibits the intentional taking of life – a disposition which the vast majority of democratic legislatures adamantly refuse to alter or amend - how is it possible, at common law, that the termination of the life of an incompetent patient, who is not terminally ill and who can breathe unaided, can be deemed legal?

Rather than indulging in semantical contortions as to what is, or is not, an act or an omission, or whether artificial nutrition and hydration is, or is not, medical treatment, would it not be more honest to acknowledge that the withdrawal or the withholding of life-sustaining treatment is what it appears to be, namely an overt act of assisted death?

Before the *'best interests'* test was judicially divined and applied in cases where life and death were in issue it could have been argued with a reasonable degree of conviction that the

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[68] Despite its being found not to be applicable at both English and Irish law – albeit there were indications of its influence in the early application of the *'best interests'* test, particularly by Lord Donaldson MR (See Chapter VI on England) – the courts in both jurisdictions have relied heavily on the judicial reasoning adopted and followed in American case law to sustain their conclusions that in certain circumstances death is preferable to life.

common law tradition was so deeply imbued with the principle of the sanctity of life[69] – in secular terminology, the inviolability of life[70] – that its jurisprudential status was impregnable.

Intrinsic not instrumental:

For millennia life has been regarded as an intrinsic, not an instrumental,[71] good and is deemed to be possessed of a dignity which immunises it against intentional termination. That this continues to be so is exemplified by the continued criminalisation of both euthanasia[72] and assisted suicide, notwithstanding the fact that suicide itself has been decriminalised.[73]

The principle is deeply embedded in the legal systems of the vast majority of jurisdictions, is recognised in international human rights documents and is basic to common morality.

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[69] See Boyle, J, *'Sanctity of Life and suicide: tensions and developments within common morality', in Brody, B (ed), 'Suicide and Euthanasia',* Dordrecht: Kluwer, 1989; Clouser, K, *'The Sanctity of life: analysis of a concept',* Annals of Internal Medicine 78: 1973; Donagan, A, *'The Theory of Morality',* Chicago University Press, Chicago, 1977. Within Christian morality the so-called *'sanctity of life principle'* rests on two complementary sources: revelation (*theology*) and reason (*natural law*). Human beings are accorded great dignity and are created uniquely in God's image and likeness. Life is a trust given to human stewardship by God and killing is contrary to that ethos. Even if motivated by *'mercy'* or a concern for the *'best interests'* of someone who is thought to be *'better off dead'*, no one should assume the role of the author of life and death. The theological answer to the question should death be hastened – in circumstances where a person asks to be killed or where there is a permanent state of unconsciousness? – is a resounding no. The argument that every person's life should be respected *in principle*, but that in some situations it might legitimately be compromised to serve other important *'values'* such as the supposed *'best interests'* or *'well-being'* of the patient is not favoured by a strict interpretation of the *sanctity of life* principle.

[70] Difficulties attaching to the use of the expression the *'sanctity of life'*, with its allegedly religious overtones, within a secular context have been identified by Honecker, M ,*'Dignity in law and morality'*, in Bayertz, K (ed), *'Sanctity of Life and Human Dignity',* Dordrecht: Kluwer Academic, 1996, at 271. Price argues that any misunderstanding of the principle of the *'sanctity of life'* that there may be *"emanates entirely from the lack of coherence or clarity pertaining to the doctrine itself, in addition to an absence of transparency in its application. The use of limited, very selective examples contributes in particular to its opacity."* See Price, D, *'My View of the Sanctity of Life: A rebuttal of John Keown's Critique',* Legal Studies 27, No.4, December 2007, at 549.

[71] Essentially, the instrumental good argument is that a person who is enduring what others deem to be a poor quality of life would be better off dead. The judgment is a relative one: the patient's life is or will be very poor, relative to their previous good health or, sometimes, to the good health of others. See *Huxtable, R, 'Euthanasia, Ethics and the Law: From Conflict to Compromise',* Routledge-Cavendish, 2007, at 15. The instrumental argument appeals to consequentialist philosophers (see fn.80 below) who claim that ending a life of suffering is the best outcome for both the patient and the community. See Singer, P, *'Practical Ethics',* 2nd.ed., Cambridge University Press, 1993 and his *'Rethinking Life and Death: The collapse of Our Traditional Ethics'*, St Martin's Press, New York, 1994; Rachels, J, *''Euthanasia'*, in Regan, T (ed) *'Matters of Life and Death: New Introductory Essays in Moral Philosophy',* McGraw Hill, New York, 1993.

[72] The commonly accepted definition of *'euthanasia'* is the active, intentional termination of a patient's life by a doctor who believes that death is a benefit to the patient.

[73] Suicide *per se* has been decriminalised in virtually all countries within the Western jurisprudential tradition, including Ireland, England and the United States of America. In France assisted suicide has been deemed traditionally not to be a criminal offence even though it is not specifically alluded to in that country's Penal Code. The view is that it is a logical corollary to the decriminalisation of suicide contained in the Penal Code of 1791.

Likewise it has informed medical ethics from the time of Hippocrates – doctors and medical personnel ought not act as public executioners.[74]

Traditionally, it has also disavowed both active and passive euthanasia. No choice intentionally to bring about the death of an innocent person, whether by act or omission, is considered morally justifiable.[75] The fact that foreseen, but not intended death is permitted – as per the doctrine of double effect - *"demonstrates the influence of sanctity of life thinking has over our current law."*[76] However, judgments, both in the cases of new born children with severe disabilities and of incompetent adults, based on a patient's poor quality of life – and that it is in his or her *'best interests'* to die – *"do represent a real challenge to the principle."*[77]

The evidence adduced in this thesis as to the repositioning of the principle of the sanctity of life at common law demonstrates clearly the success of this challenge to date. In reality, from the time the concept of *'best interests'* was invoked as a legitimate mechanism to resolve the issue of life and death the principle of the sanctity of life at common law became a devalued coinage.

Few appear to be willing to acknowledge the logic attaching to what has taken place in common law courts. This may well be because the sanctity of life, with its religious overtones, may not sit comfortably with the prescripts of an increasingly secular society. It may also be the case that the rights-based philosophy which has flourished since the 1960s, and which is predicated essentially on the principle of autonomy, has led to a re-affirmation of the Millean principle that, in the absence of harm to others, autonomous acts, which are not in conflict with regulatory norms are to be permitted and condoned. An invocation, therefore, of the sanctity of life as a principle governing the totality of human behaviour, including whether life can be taken either at its beginning or at its end, might be regarded as an unwelcome reminder that intentional death continues to be proscribed and cannot easily be gainsaid.

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[74] See Emanual, E, *'The Ends of Human Life'*, Harvard University Press, Cambridge MA, 1991.

[75] *See Donagan, A, 'The Theory of Morality'*, Chicago University Press, Chicago, 1977*; Finnis, J, 'Natural Law and Natural Rights'*, Oxford University Press, 1980*; Grisez, G, 'Christian Moral Principles'*, Franciscan Herald Press, Chicago, 1983, Chs.5, 7, 9; *Grisez, G, 'Living a Christian Life'*, Franciscan Press, Quincy, Ill., 1993, Ch.8*; Pollard , B, 'Euthanasia: Should We Kill the Dying?'*, Mount Press Sydney, 1989; *Keown, J, 'Euthanasia, Ethics and Public Policy: An Argument against Legalisation'*, Cambridge University Press, 2002*; Huxtable, R, 'Euthanasia, Ethics and the Law: From Conflict to Compromise'*, Routledge-Cavendish, 2007; *Bayertz, K (ed) 'Sanctity of Life and Human Dignity'*, 52 Philosophy and Medicine, Dordrecht: Kluwer Academic Publishers, 1996*; Gormally, AJL, "Prolongation of Life: The Principle of Respect for Human Life'*, Linacre Centre Papers, 1: 1-28, 1978; *Gormally, AJL, 'The BMA Report on euthanasia and the case against legalisation', in Gormally, L (ed) 'Euthanasia, Clinical Practice and the Law, 117-192,* London: The Linacre Centre for Health Care Ethics.

[76] Huxtable, op.cit., fn.71 supra, at 135.

[77] Ibid at 136

Other than in the Netherlands, where euthanasia was practiced by doctors for many years before it was either judicially or statutorily approved, proponents of the legalisation of euthanasia or assisted suicide have long recognised that the potential for success lies in the area of constitutionally-protected personal rights rather than in any attempt to have the provisions of the criminal law, including the principle of the sanctity of life, altered to provide for an exception for assisted dying.

The contention that life is possessed of an intrinsic value *"provided the spur for its critics to articulate alternative accounts of the value of life."*[78] In the main, these accounts espouse the notion that human reason alone can establish the intrinsic value of life, a value which is deemed to be self-determined and is epitomised in the principle of individual autonomy.[79]

Irrespective of its origins, however, the principle of autonomy has not only become the bedrock of modern medical ethics but also sustains an over-arching rationale for the view that the law should be changed to allow for individual choice as regards the manner and timing of death. Obviously, the proposition that the individual has the right to determine when and how he or she should die is a less contentious matter than any attempt to create an exception to the proscription of unlawful killing which would allow for death at will.

Those who propound the view that the end of life is solely a matter of voluntary individual choice approach the matter from a range of perspectives, including the deontologial, the consequentialist and/or the virtue ethical.[80]

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[78] Ibid at 10.

[79] *See Singer, P, 'Practical Ethics', 2nd. Ed. Cambridge University Press, 1993; Harris, J, "The Value of Life: An Introduction to Medical Ethics',* Routledge & Keegan Paul, London, 1985*; Dworkin, R, 'Life's Dominion: An Argument about abortion and euthanasia',* Vintage Books, New York, 1993*; Brock, D W, 'Life and Death: Philosophical Essays in Biomedical Ethics',* Cambridge University Press, 1993*; Doyle, L, 'Medical Ethics and moral indeterminacy',* Journal of Law & Society, 17(1): 1-16, 1990*; Doyle, L, 'Dignity in dying should include he legalisation of non-voluntary euthanasia',* Clinical Ethics, 1:65-67, 2006; *Doyle, L, 'Why active euthanasia and physician-assisted suicide should be legalised',* BMJ, 323:1079-1080, 2001*; Gillon, R, 'Ethics needs principles – four can encourage the rest – and respect for autonomy should be "first among equals"',* Journal of Medical Ethics, 29:307-312, 2003. In Beauchamp & Childress, *'Principles of Biomedical Ethics',* 5th ed. Oxford University Press, 2001, at 133-139, *'autonomy'* is described as the first among equals of the four principles which health professionals are enjoined to respect. The others are beneficence, non-maleficence and justice.

[80] The *deontologists,* following Kant, argue that everybody has a right to *'self-determination'* and that there is a corresponding duty to respect other's decisions. See Hare, RM, *'Euthanasia: A Christian view',* in *'Essays on Religion and Education',* Oxford University Press, 1975, at 72 et seq. and his *'Utilitarianism and deontological principles'* in Gillon, & Lloyd (eds), *'Principles of Healthcare Ethics',* John Wiley & Sons, Chichester, 1994, at 149 et seq*; Beyeveld & Brownsword, 'Human Dignity in Bioethics and Biolaw',* Oxford University Press, 2001. *Consequentialists* reject the principle of *'double effect'* because they judge the morality of an action solely by its consequences, whether or not those consequences are intended. See Harris, J, Chs.1, 3 & 5 in Keown, J (ed), *'Euthanasia Examined: Ethical, Clinical & Legal Perspectives',* Cambridge University Press, 1995. See also Williams, G, *'Euthanasia legislation: A Rejoiner to the non-religious objections',* in Downing, AB (ed) *'Euthanasia and the Right to*

While these perspectives, in the main, are unconvincing, it is contended, nonetheless, that they have penetrated common law thought processes to the degree that a recalibration of the criteria historically employed in the determination of the ethics of non-natural death, has been permitted to evolve.

Undermining of the sanctity of life principle:

In summary, the sanctity of life principle has been, and continues to be, undermined on two fronts - first, by judges themselves in cases where death is deemed to be in the *'best interests'* of the patient and second, by plaintiff claims that constitutionally-protected personal rights of autonomy, privacy, dignity and the right to bodily integrity are being violated by the prohibition of assisted suicide.

Unquestionably, considerable ground has been ceded with regard to the first. Assisted death is accommodated under new legal paradigms. The assault on the second front is equally unrelenting. In the ever-increasing number of cases - where superior courts are confronted by requests for rights-based declarations that statutory prohibitions of assistance with death are either disproportionate or unconstitutional - judicial ingenuity is required not only to enable a distinction to be made between acts which are deemed not to breach the law and those which hover on the boundaries between legality and illegality, but also to define the boundaries between the duty of the state to preserve life and the autonomous wish of an individual to receive assistance with death.

To date, judicial ingenuity has not been found wanting.

The declaration that the principle of the sanctity of life was not absolute[81] and could be overridden by the principle of autonomy was a seminal moment in the history of modern jurisprudence. When the House of Lords deemed it legal to intentionally act in a manner which eventuated in the death of an incompetent individual it not alone signalled a radical transformation of traditional principles of law but it also opened a Pandora's box which it has been impossible to close ever since.

Death: The Case for Voluntary Euthanasia', Peter Owen, London, 1958, at 134; Glover, J, *'Causing Death and Saving Lives'*, Penguin, London, 1977; Rachels, J, *'Euthanasia'*, in Regan, T (ed|), *'Matters of Life and Death: New Introductory Essays in Moral Philosophy'*, McGraw Hill, New York, 1993, at 30-68; Singer, P, *'Practical Ethics'*, 2nd ed.,Cambridge University Press, 1993. Virtue ethicists argue, like Aristotle, that the virtuous person should live life in a manner that is respectful of others' choices. See van Zyl, L, *'Death and Compassion: A Virtue-based Approach to Euthanasia',* Ashgate, Aldershot, England, 2000.

[81] In *Airedale NHS Trust v Bland [1993] AC 789, per Lord Goff.*

There is, it is suggested, one overriding explanation for the recalibration of the common law that has occurred, namely that the traditional legal mechanisms employed to avoid assisted death in certain circumstance being categorised as unlawful killing - either murder or manslaughter - were no longer capable of carrying this burden with any credibility. The elasticity traditionally attaching to these mechanisms finally snapped when courts were asked for declarations that the withdrawal and withholding of artificial nutrition and hydration from a person in a persistent vegetative state would be legal, notwithstanding the fact that such action would lead to his or her death.

The courts bent accordingly.

The invocation of the doctrine of double effect, while of inestimable value in previous cases where medical personnel, accused of the deliberate killing of patients, were deemed not to have done so intentionally on the grounds that they merely foresaw that the patient might die, proved no longer of use in circumstances where it was clear, as was the case in *Airedale HNS Trust v Bland* and in *Re a Ward of Court,* that the intention was to kill the patient.

Notwithstanding robust views to the contrary, it is beyond question, therefore, that *Airedale NHS Trust v Bland* represented a significant retreat from the sanctity of life ethic.[82] The judges themselves acknowledged that the withdrawal of life-sustaining treatment was intended to cause death[83] – an admission which could not be regarded as other than a complete contradiction of the principle at the core of the principle of the *'sanctity of life'*, namely to prohibit intentional killing. Likewise, the holistic orientation of the ethic[84]- that every person, regardless of incompetence, disability or inability, should enjoy the same rights as more able individuals, including an equal claim on the right to life – was cast aside.[85] Bland was not seen as a unified person: some judges explicitly adopted the Cartesian distinction between body and personality.[86]This, conveniently, enabled the conclusion that Anthony Bland's personality

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[82] See Magnusson, R, *'The Future of the Euthanasia Debate in Australia',* Melbourne University Law Review, 20(4) (1996), at 1108; Keown, J, op.cit., fn.75 supra.

[83] Per Lords Lowry, Browne-Wilkinson and Mustill.

[84] See Finnis, J, *'Bland: Crossing the Rubicon?',* Law Quarterly Review 109, 1993, at 329; Robertson, D, *'The Withdrawal of medical treatment from patients: Fundamental legal issues',* Australian Law Journal 70, 1996, 70, at 723; Keown, J, *'Restoring moral and intellectual shape to the law after Bland',* The Law Quarterly Review 1134, 1997, at 481.

[85] Similarly, the holistic nature of the ethic was abandoned in the subsequent Irish case *Re a Ward of Court (Withdrawal of Medical Treatment)(No.2) [1996] 2 IR 79.*

[86] See Huxtable, *op.cit., fn.*71 *supra, at 134.* The Cartesian distinction was drawn by Hoffmann LJ, *at 355F-G,* and Lord Mustill, *at 400 B-C.* The distinction is also identifiable in the judgment of O'Flaherty J in *Re a Ward of Court (Withdrawal of Medical Treatment)(No.2) [1996] 2 IR 79.*

was irretrievably lost. In turn, this meant that his *'quality of life'* was such that continued treatment would be *'futile'* and not in his *'best interests'*.[87] Euphemisms abounded.

Differential Matrix:

The process of highlighting the differential in the approaches adopted by those countries that have introduced legislation permitting third party assistance with death and those that have opted for a reformulation of the common law begins in **Chapter II** where the history, practice and control of euthanasia and assisted suicide in the *Netherlands* is traversed in detail. In **Chapter III** the *Belgian Act Concerning Euthanasia, 2002*, is reviewed together with the political circumstances which enabled its enactment. **Chapters IV** and **V** deal with Switzerland and Luxembourg respectively.

The case law history of how the *'best interests'* test was introduced into the common law of England is outlined in **Chapter VI.** The American proscription of third party assistance with death – other than in the states of Oregon and Washington – and confirmed in *Washington v Glucksberg,* together with a review of that country's espousal of eugenic principles between the publication of Darwin's *Origin of the Species* in 1857 and its entry into World War II in 1941, is outlined extensively in **Chapter VII.** The finding that the criminal prohibition of assisted suicide in Canada - upheld in 1993 in *Rodriguez v British Columbia* - was found to violate the Charter of Rights and Freedoms in *Carter v Canada*, is examined in **Chapter VIII.** Finally, the approach to third party assistance with death in Ireland, demonstrated in *Re a Ward of Court* and *Fleming v Ireland* is dealt with in **Chapter IX**. John Keown's jurisprudential analysis of the judicial reasoning adopted and followed in the English case *Airedale NHS Trust v Bland* and in the Irish case *Re a Ward of Court* is evaluated in this chapter also. In particular, the analysis conducted by the Irish High court in *Fleming v Ireland* of the reasoning in *Carter v Canada* is also included in **Chapter IX.**

Chapter X marks the conclusion of this study.

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[87] Per Lord Browne-Wilkinson: Bland was said to be enduring a life of *"no affirmative benefit"*; per Lord Mustill: he had *"no best interests of any kind."* See similar comments by O'Flaherty J, in *Re a Ward of Court (Withdrawal of Medical Treatment)(No.2) [1996] 2 IR 79.*

Chapter II

Euthanasia and Assisted Suicide in the Netherlands – History, Practice and Control

"The behaviour of doctors which leads to the earlier death of patients is more highly regulated in the Netherlands, and more recently in Belgium, than anywhere else, and this is not limited to euthanasia itself."[1]

"The Dutch situation is a regulatory Potemkin village, a great façade hiding non-enforcement."[2]

1. Introduction

Dutch guidelines on the policy and practice of euthanasia were described recently as being *"far from stringent."*[3]

While the truth or otherwise of this claim, or of those made by Griffiths and Callahan, is solely a matter of empirical comparative research, nonetheless they do highlight one irrefutable fact: while there has been an enormous growth in the quantity of Dutch law in respect of voluntary active euthanasia and assisted suicide over the past quarter of a century, beginning with a number of iconic decisions in the 1980s by the Dutch courts, including the Supreme Court,[4] and culminating in the passage of *The Termination of Life and Assisted Suicide (Review*

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[1] Griffiths, Weyers & Adams, *'Euthanasia and law in Europe'*, Hart Publishing, Oxford and Portland, 2008, at 51/52.

[2] Callahan, D, *'The Troubled Dream of Life'*, Simon & Schuster, *New York, 1993, at 115. It is to be noted that Callahan's work was published some nine years prior to the enactment of The Termination of Life and Assisted Suicide (Review Provisions) Act in 2002.*

[3] Cohen-Almagor, R, *'Euthanasia in the Netherlands: The Policy & Practice of Mercy Killing'*, Kluwer Academic Publishers, Dordrecht/Boston/London, 2010, at xii: *"Indeed they are loose enough to allow non-voluntary (when patients are incompetent) and involuntary (when patients are competent and made no request to die). They do not provide effective safeguards against abuse and, in short, they simply do not work. Virtually every guidelines has been breached or violated."*

[4] Known as the *'Hoge Raad'*. The most important decision was that in the *Schoonheim* case, *Netherlandse Jurisprudentie 1985, no 106.* Dr Schoonheim administered a lethal injection to a patient after repeated requests. The patient was 95 years old, had difficulties with both sight and hearing, was bedridden and experienced bouts of dizziness. However, she was not terminally ill. The Supreme Court held that notwithstanding the absolute prohibition of euthanasia in the Dutch Penal Code (*Wetboek van Strafrecht Titel XIX. Misdrijven het leven gericht*) euthanasia by a doctor might be legally justifiable on the basis of necessity or *overmacht (circumstances beyond one's control – a defence contained in Article 40 of the Penal Code).* For an English translation of the *Schoonheim* case see Griffiths, Bood & Weyers, *'Euthanasia and Law in the Netherlands'*, Amsterdam University Press, 1998, at 322. For an English translation of the Dutch Penal Code see Sneiderman & Verhoef, *'Patient Autonomy and the Defence of Medical Necessity'*, (1996) 34 Alberta Law Review 374. For an analysis of the defence of necessity see Keown, J, *'Euthanasia, Ethics and Public Policy: An Argument against Legalisation'*,

Provisions) Act, 2002,[5] which gave formal legal recognition to the existing practice of voluntary active euthanasia, there has been very little change in its actual substance. [6]

This is apparent from even a cursory historical examination of the development of a process which, beginning with the traditional discrete approval of end-of-life procedures - notwithstanding their criminal character[7] - culminated in their statutory endorsement.

The genesis and development of this carefully choreographed and collaborative Dutch endeavour on the part of the judiciary,[8] the prosecutorial authorities,[9] the medical

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Cambridge University Press, 2002, at 83 et seq. See also Griffiths, Bood & Weyers, op.cit, supra. Ten years before *Schoonheim* the decision in the *Postma* case, *Nederlandse Jurisprudentie 1973, no 183,* established the template as to how the courts would deal with physician-assisted death. After repeated requested that she do so, Dr Postma injected her 78-year-old mother with a lethal dose of morphine. Her mother was not terminally ill but she did suffer from partial paralysis, deafness and incontinence. Under the provisions of the *Penal Code (Article 293): "It is an offence for anyone to take the life of any person at his express and serious request."* The maximum sentence is twelve years imprisonment. Dr Postma was found guilty of killing on request. The District Court in Leewarden, however, acknowledged that in certain circumstances, and provided certain conditions were fulfilled, doctors were not required to prolong a patient's life and that it could be permissible to administer pain relief even at the risk that this might hasten the patient's death. The conditions of *"incurable illness", "unbearable suffering"* and *"a voluntary request"* by the patient were alluded to. Notwithstanding the fact that the court held that Dr Postmna's actions were not reasonable it sentenced her to a symbolic sentence of one week in prison (suspended) and one year's probation. In a report following the *Postma* decision the *Royal Dutch Medical Association (KNMG)* condoned euthanasia in cases where there was no other relief for unbearable suffering. See *'The Problem of Euthanasia' (1973)* 28 Medisch Contact 857.

[5] Wet toetsing levensbeeindiging op verzoek en hulp bij zelfdoding. Staatsblad van het Koninhrijk der Nederlanden 2001. The Law came into effect on 1 April, 2002. <wetten.overheid.nl/BWBR0012410/geldigheidsdatum_10-02-2009> accessed 27 August, 2012. An English translation of the 2002 Act can be found at KU Leuven *<www.kuleuven.be/ep/viewpic.php?LAN=E&TABLE=EP&ID=58> accessed 27 August, 2012.*

[6] See Younger, S, & Kimsma, G, *'Physician Assisted Death in Perspective',* Cambridge University Press, 2012.

[7] Articles 289(murder), 293 (voluntary active euthanasia) and 294 (assisted suicide) of the Penal Code. Article 40 provides a defence to a criminal charge if the accused was forced by *overmacht* (see *fn.4 supra*) to commit an offence.

[8] Beginning with *Schoonheim, Nederlandse Jurisprudentie 1985 no 106*, where the defence of *'necessity'* was endorsed.

[9] Following the decisions in *Wertheim* (*Nederlandse Jurisprudentie 1982 no 63:233*) and *Admiraal* (*Nederlandse Jurisprudentie 1985, no 709*) the *Procurators General*, the highest Dutch prosecutorial authority, with the approval of the Ministry of Justice, began a review of prosecutorial policy with a view to establishing uniform guidelines in the matter of reported cases of euthanasia and assisted suicide. In *Wertheim* the district court opined that in certain circumstances, such as unbearable suffering, an enduring wish to die and in the absence of treatment alternatives, assistance with suicide might be justifiable. In *Admiraal t*he court held that the defendant, who had performed an act of euthanasia on a patient suffering from multiple sclerosis, had complied with the requirements of *"careful practice"*. In 1987, following the decision in *Schoonheim*, the Ministry of Justice gave an undertaking to the Royal Dutch Medical Association (*Koninklijke Nederlandse Maatschappij Ter Bevordering Der Geneeskunst, KNMG*) that in instances where euthanasia was performed by doctors no prosecutions would ensue if they complied with certain *"due care requirements"*.

profession[10] and the legislature[11] in the matter of third party assistance with death by doctors, in the period 1980 to 2002, is unique and merits dispassionate appraisal and evaluation.

While of value in its own right this appraisal and evaluation will also provide the basis for a comparative analysis of the approach adopted towards end-of-life matters in other jurisdictions, and especially of those principles which underpin judicial reasoning in specific cases – cases that epitomise the central role of traditional Western jurisprudential paradigms, and which, notwithstanding explicit acknowledgment of the right of the individual to refuse medical treatment, even in circumstances where death is the inevitable outcome, eschew the deliberate taking of human life, including voluntary death.

Likewise, it will allow for the contextualisation of both euthanasia and assisted suicide within the totality of Dutch medical behaviour which has the potential to shorten life, including the issue of passive euthanasia. It will enable, too, an understanding of the reasons why some medical practices which result in an earlier than natural death are subject to greater stricture, including possible criminal charges, than others, not only in the Netherlands but also in other jurisdictions.

The choice of the period 1980 to 2002 as the focus of attention is not an arbitrary one. Notwithstanding the fact that the termination of the life of one person by another, even at the victim's earnest and express request, has always been, ever since the codification of its criminal law in 1886,[12] a specific offence in the Netherlands, prosecutions were virtually non-

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[10] See fn.9 supra. In June, 2011 the KMNG published a new position paper on the role of physicians in termination of life at the patient's request: *'The Role of the Physician in the Voluntary Termination of Life', KNMG, June, 2011.* The KNMG considers this paper a response to the public debate that arose in 2011 on whether people who are *"finished with life"* should be enabled to die with dignity. The initiative group *Uit Vrije Wil ('Of one's own free will')* presented a proposal for legislation that would enable people aged 70 years and older who consider their life *"finished"* and who wish to die with dignity to request assistance in terminating their life. Providing this type of assistance when there is no unbearable suffering without prospect of improvement falls outside the scope of current Dutch legislation on euthanasia and is always a criminal offence. The initiative group holds the position that it should not be an offence when the individual making the request is elderly. See Sutorioius, Peters & Daniels, *'Proof of a Law',* The Hague, Nederlands*: Uit Vrije Wil* http://sparta.projectie.com/~uitvrije/index.php?id=1006 While it is unlikely that Uit Vrije Wil based their proposal on Anthony Trollope's 1881 science-fiction novel, *'The Fixed Period'*, nonetheless there are uncanny similarities. See fn.1, Chapter 1: Introduction supra.

[11] The Law on the Disposal of Corpses, *Wet op de Lijbezorging, Staatsblad, 1991:133*; *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002.*

[12] Article 293 of the Criminal Code, 1886. When the first draft of the proposed *Criminal Code* was presented to Parliament in 1879 this article was numbered *317* and was accompanied by the following explanatory note: *"He who complies with another person's explicit and serious wish to take his life is to be subjected to a punishment considerably lighter than he who has been found guilty of plain murder. The consent cannot remove the punishability of taking another person's life, but it does completely alter the character of the act – the law, so to speak, no longer punishes the assault against a certain*

existent,[13] despite an awareness by prosecutorial authorities, however anecdotal, that euthanasia and assisted suicide were a matter of common practice.

The term euthanasia itself only began to be used in the Netherlands in the late 1970s and early 1980s and uncertainty as to its scope was not finally dissipated until the publication of the Report of the State Commission on Euthanasia in 1985[14] where it was defined as *"intentionally terminating another person's life at the person's request"*.[15] This made the term congruent with the behaviour prohibited in Article 293 of the Criminal Code.

In reality, both *euthanasia* and *assistance with suicide* were regarded traditionally as discrete offences which did not attract criminal prosecution. However, in 1987, following a number of court decisions, particularly those in in *Postma,*[16] *Wertheim,*[17] *Admiraal* [18]and *Schoonheim,*[19] the process of formalising this position at law began.[20] The Procurators-General, the highest Dutch prosecutorial authority, with the approval of the Ministry of Justice, initiated a review of national prosecutorial policy with a view to the establishment of uniform guidelines in respect of reported cases of euthanasia and assisted suicide.[21]

As a starting point the prosecutors relied on extant judicial findings to delineate the boundaries within which the practice and performance of assisted death would be deemed legally permissible. In the event, it was decided that prosecutions would not be brought

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person's life, but the violation of the respect due to human life in general – no matter what the motive for the act may be. Crime against human life remains, crime against the person is absent".

[13] In the sixteen year period between 1981 and 1997 there were **20** prosecutions of doctors. In **9** cases the doctor was found guilty. No punishment was made in **3** and in the other **6** the doctor was given a conditional sentence without a custodial element. In a small number of cases a fine was imposed because the death had been incorrectly reported as a natural one. *See Chesterman, S, 'Last Rights: Euthanasia, the Sanctity of Life and the Law in the Netherlands and the Northern Territory of Australia',* International and Comparative Law Quarterly, Vol. 47 (April 1998), at 377/8.

[14] *Euthanasie: Rapport van de Ataats Commissie Euthanasia, Vol.1: Advies, The Hague, Staatsuitgeverijl, 1985.*

[15] A member of the *Staatscommissie*, Henk Leenen, a leading Dutch health-care lawyer, had suggested a similar definition in 1977. He is generally credited as the person who most influenced the definition of euthanasia in *Section 2* of the Belgian *Act Concerning Euthanasia, 2002*, viz. *"the intentional life-terminating action by someone other than the person concerned, at the request of the latter"*. See Chapter II on Belgium. There is a degree of subtlety attaching to this definition of euthanasia. Killing a person without a person's request does not fall within the definition in Dutch law. Rather, such an act is referred to as *"termination of life without an explicit request."* No distinction is drawn between euthanasia and assisted suicide. This was confirmed from the statement by the *Royal Dutch Medical Association (KNMG)* in its Report, *'Vision on Euthanasia' [Standpunt inzake euthanasia]* (1984) 39 Medisch Contact 990.

[16] *Nederlandse Jurisprudentie 1973, no 183.*

[17] *Nederlandse Jurisprudentie 1982 no 63:233.*

[18] *Nederlandse Jurisprudentie 1985 no 709.*

[19] *Nederlandse Jurisprudentie 1985 no 106.*

[20] *See fns.4&9 supra.*

[21] *See fn.9 supra.*

under *Articles 293* and *294* of the *Criminal Code* if the then, albeit inchoate, "*requirements of due care*" were met.

Determinations in particular criminal cases, together with recommendations of the National Health Council, of the State Commission on Euthanasia and of the Royal Dutch Medical Association (KNMG), beginning in the early 1980s, led to the development, refinement and statutory endorsement of these *requirements*.

In summary, the basis for the legitimisation of euthanasia, and the requirements for its licit practice, began to be formulated and was settled some two decades prior to the passage of the *Termination of Life on Request and Assisted Suicide (Review Provisions) Act, 2002*.

Hence, the selection of 1980 as the starting point of the period under examination

Notwithstanding the absence of formal legalisation of third party assistance with death its actual practice, by doctors, was legitimated as a result of authorisation by the courts, by the prosecutorial authorities and by the medical profession, of both substantive and procedural criteria.[22]

Central to the **substantive** element was the presence of a "*voluntary and well-considered request*".[23] Absent such a request, the behaviour was not considered a potentially justifiable case of *euthanasia* but one of either murder or manslaughter. The District Court held that there were circumstances in which termination of life without a request could take place.[24] This was endorsed by the Amsterdam Court of Appeal.[25] *Euthanasia* performed in the absence of *"unbearable and hopeless suffering"* was not regarded as justifiable. If performed by a person other than a doctor the act fell to be considered under *Articles 293* and *294* of the *Criminal Code*, but was not viewed as justifiable. The "*requirements of due care*" were enforceable through the criminal law.

The essential components of the **procedural** criteria for permissible *euthanasia* were that the doctor take adequate steps to satisfy himself that the substantive conditions had been

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[22] At the time under consideration the main sources for the law in respect of euthanasia were the decisions of the Supreme Court in the *Schoonheim (Nederlandse Jurisprudentie 1985, no.106)* and *Chabot (Nederlandse Jurisprudenmtioe 1994, no.656)* cases; the *'Points requiring attention'* included on the form to be used in reporting cases of euthanasia as specified in Article 1 (Appendix) of an Order in Council on 17 December 1993 (*Staatsblad 1993: 688*), effective 1 June 1994 (*Staatsblad 1994: 321*); and official euthanasia guidelines issued by the Royal Dutch Medical Association, KNMG.

[23] The general accepted criteria for establishing the validity of such a request were that it had to be (i) *specific, made directly and timely; (ii) well-informed; (iii) made with full capacity and free from external pressures or influences.*

[24] *Nederlandse Jurisprudentie 1995, no.602: 2878.*

[25] *Nederlandse Jurisprudentie 1996, no.113. See also Van Oijen, Nederlandse Jurisprudentie 2005, no. 217.*

observed, that he consult at least one other doctor as to the patient's symptoms and life-expectancy, that he consider available treatment alternatives, and that he adjudge whether the request was *"voluntary and well-considered"*.[26]

A death due to euthanasia was not to be reported as a natural death. The implication of this latter requirement was that a doctor, if he reported the death, would *prima facie* incriminate himself in the commission of a serious offence.

The procedural requirements of careful practice were generally enforced by way of medical disciplinary proceedings under the auspices of the Medical Inspectorate[27], although some cases were subject to court proceedings.[28]

In late 1990, the Justice Ministry announced a new reporting procedure for doctors who had performed acts of euthanasia. This was predicated on the observance of the law requiring a doctor who had performed euthanasia or provided assistance in a suicide not to file a certificate of natural death. A doctor participating in such an act was required to notify the coroner of his actions.

Simultaneously, the Procurators-General published instructions that police investigations of reported cases should be as discrete as possible.

In 1993, the *Law on the Disposal of Corpses*[29] was amended in order to place this new reporting procedure on a statutory footing. Doctors were now required to complete a special form when reporting cases of euthanasia and assistance with suicide. Significantly, however, this form included a section dealing with the *"termination of life without an explicit request."* In defence of this inclusion the Government invoked the findings of national research which had indicated that this particular practice was extensive. Consequently, it was recognised that some degree of control was required but not to the extent that the practice would be subject to criminal prosecution.

Therefore, despite the fact that the conditions under which *euthanasia* and *assisted suicide* could be performed without incurring criminal action had been determined previously, and

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[26] The doctor should also discuss the matter with the patient's immediate family and with the nursing personnel responsible for the patient's care; he should keep a full written record of the case; the termination should be carried out in a professionally responsible way and the doctor should attend on the patient continuously until death occurs.

[27] The *Medical Inspectorate* is responsible for the enforcement of legal provisions relating to public health, hospitals, health care workers, the provision of advice and information to the Minster for Health and for the initiation of medical disciplinary proceedings.

[28] In 1997 (District Court, Leeuwarden) [*Schat*] a doctor was accused of an inappropriate euthanaticum (insulin) and failure to remain with the patient until she died.

[29] *See fn.11 supra.*

the justificatory defence of necessity for doctors had already been established as a result of court findings[30] it was not until 2002, eighteen years later, that the requisite legislation was passed by the Dutch Parliament.

The *Termination of Life and Assisted Suicide (Review Provisions) Act 2002 "ratified judicial decisions, guidelines of medical professional associations, and prosecutorial practice that had already brought about legal change in the 1980s."*[31] The means employed to achieve this were relatively uncomplicated and did not entail detailed statutory provisions.[32] The specific prohibition of the termination of life on request and assisted suicide in the 1886 Criminal Code was simply amended to allow for an exception for doctors on the basis of the justification of *necessity*.

The inclusion in the Act of *specific substantive* and procedural *"due care requirements"*,[33] together with a provision for an advance written request for the termination of life on the

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[30] *Postma (Nederlandse Jurisprudentie 1973, no 183), Wertheim (Nederlandse Jurisprudentie 1982, no 63:233), Admiraal (Nederlandse Jurisprudentie 1985, no 709)* and *Schoonheim (Nederlandse Jurisprudentie 1985, no 106).*

[31] *Griffiths et al., op.cit., fn.1 supra, at 29.* It is interesting to note that during the debate on the *Euthanasia Bill* in the Dutch Parliament between February 2000 and April 2001 speakers in defence of its provisions, and particularly members of the Government, repeatedly averred that what was being proposed merely codified *"existing practice"*.

[32] By way of contrast the process which led to the legalisation of voluntary euthanasia in Belgium, which occurred almost simultaneously with the passage of the Dutch Act, because of the absence of an existing prohibition of termination of life on request an entire corpus of enabling legislation, including requisite definitions, had to be drafted resulting in the lengthy *Act Concerning Euthanasia* in 2002. See Chapter III on Belgium.

[33] The *"due care criteria"* are best explicated in the words of the Regional Review Committee Committees Annual Report, 2011:

"The committees assess whether the attending physician has acted in accordance with all statutory due care criteria. These criteria, as laid down in section 2 of the Act, are as follows*: Physicians must:*

a.be satisfied that the patient's request is voluntary and well-considered;

b. be satisfied that the patient's suffering is unbearable , with no prospect of improvement;

c. have informed the patient about his situation and his prospects;

d. have come to the conclusion together with the patient that there is no reasonable alternative in the patient's situation;

e. consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;

f. have terminated the patient's life or provided assistance with suicide with due medical care and attention."

The patient's request must be specific and made to the physician who will perform the procedure. Four elements are crucial: 1.The request for termination of life or assisted suicide must have been made by the patient himself.

2. The patient must be decisionally competent, that is he must have a clear understanding of relevant information about his situation and prognosis, be able to consider any possible alternatives and understand the consequences of his decision.

3. The request must be voluntary. There are two aspects to this: The request must be internally voluntary, i.e. the patient must have mental capacity to determine his own wishes freely, and externally voluntary, i.e. he must not have made his request under pressure or unacceptable influence from those around him.

part of an individual aged sixteen or older who is no longer capable of expressing his will,[34] and the recognition of the Regional Review Committees which had been established earlier by an Order in Council, provided statutory authority for existing procedures. The particular provisions in respect of an advance written request and the formal endorsement of the Regional Review Committees were, in fact, the only two novel elements of the legislation.

Hence, the selection of the year 2002 as the cut-off- date for the current appraisal.

Within this selected timeframe, therefore, it is intended, ***first***, to define precisely what is meant by the term *'euthanasia'* as it used by the Dutch.[35] In contrast to what euthanasia is understood to mean in other jurisdictions the Dutch definition, while admittedly narrow, is nonetheless devoid of opacity. Notwithstanding particular predispositions on the part of non-Dutch commentators as to the respective rights or wrongs of the approach to euthanasia *per se* in the Netherlands, the very fact that its actual practice is contingent on that country's own objectively ascertainable certitude makes it somewhat easier to conduct a clinical estimation of its application in practice.

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4. The request must be well-considered. In order to make a well-considered request, the patient must be fully informed and have a clear understanding of his disease."
www.euthanasiecommissie.nl/RTEJV2011.ENGELSDEF_tcm52-33587.pdf> accessed September, 2012.
Procedures for termination of life on request and assisted suicide are almost always carried out by the attending physician; in practice, this is often the patient's general practitioner. In some cases the procedures are performed by a locum because the patient's situation rapidly deteriorates or because the attending physician is absent or does not wish to carry out the procedure himself, for instance because of his religious or ethical views. *"In such situations it is important that the physician who carries out the procedure, and hence submits the notification, should obtain sound information in advance about the patient's situation and e personally satisfied that the due care criteria have been complied with."* Ibid.
The information provided by the attending physicians is of crucial importance to the committees' reviews. *"If the physician gives an account of the entire decision-making process in his notification, he may not be required to answer further questions at a later stage. The physician is expected to use the model notification form established in* ***2009****. The questions in it provide attending physicians with a guide as to how to make it clear to the committee that they have complied with the due care criteria."* Ibid.

[34] It should be pointed out that *Article 450(3)*of the *Law on Contracts for Medical Care, 1995* provided that where a person of sixteen or older is no longer competent a doctor or a representative of the patient is required to honour a refusal of treatment made in writing when the patient was still competent. In guidelines published by the Royal Dutch Medical Association in 2003 it is stated: *"The requirement of consent plays a key role in the legitimacy of a doctor's behaviour. One consequence of this is that if the patient refuses a treatment (hence does not consent to it) the doctor may not carry out that treatment. This applies also in the situation that the patient's refusal of the treatment will lead to the patient's death. A refusal of treatment must be respected by a doctor, subject to the condition that the patient is competent." Guidelines,(2003) 5 Medisch Contact.*

[35] John Keown has made the valid point that the euthanasia debate is riddled with confusion and misunderstanding. *'Much of the confusion which besets the contemporary euthanasia debate can be traced to an unfortunate imprecision in definition. Lack of clarity has hitherto helped to ensure that much of the debate has been frustrating and sterile.'* He also admits that it may be overly optimistic *'to expect the emergence of common definitions not least as the different definitions reflect different underlying moral presuppositions whose resolution is a prerequisite to definitional consensus.' See Keown,* op.cit., fn.4 supra, at 16/17.

Second, the objective is to provide a precise and detailed exposition of current Dutch law in respect of the legal performance of third party assistance with death. The fact that it is considered necessary to do so is indicative of the confusion and obfuscation that can occasionally accompany allegedly objective assessments of the existential legal reality in that jurisdiction.

Third, it is intended to contextualise the approach adopted by the Dutch authorities in their determination to make the practice of assisted death more transparent and to provide legal certainty for its performance by doctors. To do so, an examination of the consensual interaction between successive Governments, the Ministry of Justice, the political community generally, the national prosecutors, the courts, organisations such as the NVVE (the Dutch Association for Voluntary Euthanasia) and the Royal Dutch Medical Association (KNMG) is required. This interaction is emblematic of the disposition, despite societal segmentation, towards consensus and proportionality that mark the Dutch approach to all matters of national interest.

For completion, an analysis is also required of the judicial reasoning employed in a number of iconic cases – *Postma,*[36] *Wertheim,*[37] *Schoonheim,*[38] *Pols,*[39] *Stinissen,*[40] *Chabot,*[41] *Brongersma,*[42] *van Oijen,*[43] and *Vencken*[44] – which was responsible for the delineation of the specific contours within which acts of euthanasia and assisted suicide - contingent on a doctor's compliance with agreed "*due care requirements*"- could be performed without incurring a criminal penalty as might otherwise have been the case under the provisions of the Criminal Code.

As a result of this review it will become evident that notwithstanding the fact that judicial legalisation of third party assistance with death occurred as a result of the finding in *Schoonheim,* the essential features of what were to become statutory "*due care requirements*" in the 2002 *Act* can be traced to the judicial dicta in *Postma* and *Wertheim*. In

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[36] *Nederlandse Jurisprudentie 1973, no.183.*
[37] *Nederlandse Jurisprudentie 1982, no.63.*
[38] *Nederlandse Jurisprudentie 1985, no.106.*
[39] *Nederlandse Jurisprudentie 1987, no.607.*
[40] *Nederlandse Jurisprudentie 1989, no.909.*
[41] *Nederlandse Jurisprudentie 1994, no.656*
[42] *Nederlandse Jurisprudentie 2003, no.167.*
[43] *Nederlandse Jurisprudentie 2005, no.217.*
[44] *LJN: AUO 211, 20-000303-05.*

addition, the decision in *Stinssen* had established crucially that artificial feeding should be considered medical treatment.[45]

Fourth, it is intended to subject the Dutch statutory control mechanisms governing the practice and performance of euthanasia and assisted suicide to forensic analysis, in terms both of their substance and effectiveness.

Fifth, it is necessary to locate the Dutch practice of euthanasia within the totality of medical behaviour that has the potential to shorten life, including passive euthanasia.[46]

Sixth, it is intended to consider developments in respect of the practice of euthanasia "*without an explicit request*", and specifically in those instances where the patient is in an irreversible coma or in a persistent vegetative state. Similarly, an examination of the approach adopted in neonatology, together with appropriate references to the Groningen Protocol, including consideration of the important *Prins*[47] and *Kadijk*[48] cases, is required.

2. Definitions

In the Netherlands euthanasia is defined as "*the termination of life on request*", or what is now commonly referred to elsewhere as voluntary active euthanasia. The Dutch, however, eschew the word '*active*'. Despite officially recorded incidents to the contrary this definition, therefore, would appear to exclude cases of the intentional, active termination of life without a request as well as intentional killing by deliberate omission. "*Non-voluntary, or even involuntary, euthanasia is thus a contradiction in terms.*"[49]

The word euthanasia is not contained in the Dutch legal lexicon. It does not appear in the Dutch Penal Code. Neither does it appear, nor is it defined, in *The Termination of Life and Assisted Suicide (Review Provisions) Act, 2002.*[50]

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[45] Nederlandse Jurisprudentie 1989, no.909. This decision was of particular significance, albeit not specifically cited, in subsequent cases in which the withdrawal or withholding of artificial nutrition and hydration was in question. *See,* for example, the English case *Airedale NHS Trust v Bland* [1993] AC 789 (HL) and the Irish case, *In re a Ward of Court (withholding medical treatment)(No2)[1996] 2 IR 79.*

[46] A corollary of this analysis will be an evaluation of the often vehement, and occasionally virulent, criticism by respected international jurists, including a less than complimentary evaluation by the *United Nations' Human Rights Committee*, which the legislation and the accompanying regulatory controls have aroused.

[47] *Nederlandse Jurisprudentie 1995, no.602.*

[48] *Tijdschrift voor Gezondheidsrecht 1996, no.35.*

[49] Jurriaan de Haan, *'The New Dutch Law on Euthanasia',* Medical Law Review, 10, Spring 2002, at 57, fn. 5.

[50] This is a matter of some surprise given the importance normally required of statutory definitions. For further discussion see Borst-Eilers, E, *'Euthanasia in the Netherlands: Brief Historical Review and Present Situation'* in Misbin, R (ed), *'Euthanasia: The Good of the Patient, the Good of Society,*

Section 293(1) of the Penal Code provides that any person *"who takes the life of another person at that other person's express and earnest request"* shall be liable to a term of imprisonment not exceeding twelve years or a fifth category fine.[51] This provision is incorporated, with slight amendment, in Article 20 of the 2002 Act.

While euthanasia is not defined in the Act assisted suicide is.[52] However, little if any differentiation is made between euthanasia on request and assisted suicide in the Netherlands. This was confirmed by the *Report of the Health Council on Euthanasia* published in 2004.[53]

The implication arising from an absence of definition in the Act is that its meaning is encompassed by the phrase *"termination of life"* in both the Penal Code and in the title of the *Act* itself.[54] One jurist at least has no doubt as to what the Dutch understand euthanasia to mean:

"[...] in the Dutch and Belgian context, the only proper sense refers to the situation in which a doctor ends the life of a person who is suffering 'unbearably' and 'hopelessly' (without prospect of improvement) at the latter's explicit request (usually by administering a lethal injection)."[55]

This precise and narrow definition is one which is only thinly separated from related medical phenomena, usually described as normal medical practice, such as pain relief in doses known to be likely to hasten death, and the withholding or withdrawing of life-prolonging treatment. From a moral, ethical and criminal viewpoint these procedures are deemed unproblematic in jurisdictions within the Western jurisprudential tradition. In the Netherlands they are

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University Publishing Group, 1992, at 58; Keown, *op.cit, fn.4 supra; Griffiths Weyers & Adams,* op.cit., fn.1 supra.

[51] *That is a fine not exceeding NLG 100,000.*

[52] In the *Definition of Terms* in Chapter 1, Article 1 of the Act it is defined as *"intentionally assisting is a suicide of another person or procuring for that other person the means referred to in Article 294 second paragraph of the Penal Code."*

[53] Terminale Sedatie Signalering ethiek en gezondheid 2004 [Terminal Sedation, Current Issues in Ethics and Health, 2004] The Hague, Gezondheidraad. Available in English at http://www.gr.nl.pdfo4@12.02E.pdf See also *'Standpunt inzake euthanasia (Vision on Euthanasia)*(1984), 39 Medisch Contact 990', Koninklijke Nederlandse Maatschappij Ter Bevordering Der Geneeskunst (Royal Dutch Medical Association/KNMG).

[54] The absence of a definition in the legislation is in contrast to the situation obtaining in Belgium. *Section 2* of its *Act Concerning Euthanasia, 2002,* defines euthanasia as the *"intentional life-terminating action by someone other than the person concerned, at the request of the latter."* While the Dutch Act only refers to *"termination of life on request"*, without explicitly defining this concept, it is clear, based on the use of this phrase and arising from the *"due care requirements"* which a doctor must fulfil in order to legitimise an act of assisted death, the scope of the application of the Dutch and the Belgian Acts is identical. See Chapter III on Belgium.

[55] Griffiths et al, *op.cit., fn.1 supra, at 2.*

differentiated from the practice of voluntary active euthanasia solely by the acquiescence of a doctor in the voluntary wishes of a patient for an earlier death.

It would wrong to assume that because euthanasia on request when performed by a doctor, under specific conditions, is legal in the Netherlands that this entails the exclusion of the principle of double effect[56] in that jurisdiction or indeed of procedures such as those mentioned above. As is the case in other jurisdictions such procedures are regarded at Dutch medical law as normal medical practices which give rise to a death attributable to the patient's underlying condition. There are no specific controls in place for the regulation of such procedures other than those requirements that have evolved as a result judicial determinations in specific hard cases.

For completion, it should be noted that the term *"termination of life"* contained in the title of the 2002 Act, and as interpreted in Dutch law, encompasses not only euthanasia by a doctor on request and assistance by a doctor with the suicide of another, both of which are licit under defined circumstances, but also includes *"termination of life without an explicit request"*, the administration of drugs that are normally used for pain and symptom control in doses that are **not** medically indicated, and the withholding and withdrawing of life-prolonging treatment that a patient has refused and that is not medically futile, all of which are illicit.

In summary, therefore, euthanasia in the Netherlands is understood to be the termination of the life of a person who is suffering *"unbearably* and *without prospect of improvement"*, at his *"voluntary and well-considered request"*, by a *doctor* who fulfils those *"substantive and procedural requirements of due care"* enumerated in Article 2 of the *Termination of Life and Assisted Suicide (Review Provisions) Act, 2002.*

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[56] According to this ethical principle it is permissible to allow a bad consequence to result from one's actions, even if it is foreseen as certain to follow, provided certain conditions are satisfied. Therefore, it is permissible to produce a bad consequence if: (i) the act one is engaged in is not itself bad; (ii) the bad consequences is not a means to the good consequence; (iii) the bad consequence is foreseen but not intended; and (iv) there is a sufficiently serious reason for allowing the bad consequence to occur. See Gormally, *'Euthanasia, Clinical Practice and the Law',* The Linacre Centre, London,1994, at 45-50, *cited in Keown, op.cit., fn.4 supra, at 20.* See Kenny, AJP, *'The History of Intention in Ethics' in 'Anatomy of the Soul', Oxford,* Basil Blackwell, 1973; Mangan, JT, *'An Historical Analysis of the Principle of Double Effect',* Theological Studies, 1949, 10: 41-46; Quill, Dresser & Brock, *'The Rule of Double Effect',* New England Journal of Medicine, Vol. 337: 1768-1771. The principle was endorsed by the House of Lords *Select Committee on Medical Ethics* in 1994. It was also strongly defended by the *New York Task Force on Life and the Law,* also in 1994. In *Airedale NHS Trust v Bland [1993] AC 789, at 869,* Lord Goff alluded to the *"established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life."* He also stated: *"Such a decision may properly be made as part of the care of the living patient,* ***in his best interests****; and, on this basis, the treatment will be lawful."* Author's emphasis. See fn.11, Chapter VI on England.

Notwithstanding the central importance of the requirement for a voluntary and well-considered request the justification of euthanasia at Dutch law has never rested solely on the voluntary request of the patient. In a variety of cases the Dutch judiciary have referred to the norms of the medical profession as defining the boundaries of legal euthanasia. This position was ratified explicitly by the Supreme Court in *Schoonheim.*[57] The justificatory conditions for the performance of a legal act of euthanasia must include both respect for the autonomy of the patient and a situation of *necessity* where the doctor is faced with a conflict of duties arising from the patient's *"unbearable and hopeless suffering"*.

3. The Law

Prior to the enactment of the 2002 Act, Sections 293 and 294 of the Dutch Penal Code of 1886 unequivocally proscribed both voluntary euthanasia and assisted suicide. Both these sections were amended in order to provide the justificatory defence of necessity for doctors - and only for doctors - who perform either act.

The defence in mitigation is justificatory, not excusatory.

The distinction is important. A justificatory defence (such as self-defence) justifies the act; an excusatory defence (such as provocation) merely excuses the actor from punishment for a wrongful act.[58]

The Act consists of three parts. The first codifies the *"requirements of due care"*[59] and establishes the Regional Review Committees[60] as the principle bodies responsible for reviewing reported cases of euthanasia and assisted suicide and of deciding whether to refer the actions of the doctor involved to the prosecutorial authorities.[61]

The second amends Penal Code Articles 293 (in relation to the termination of life on request) and 294 (in respect of assisted suicide) in order to legalise euthanasia and *assisted suicide* when performed by a doctor who complies fully with the schedule of *"due care requirements"* listed in Chapter II of the Act, and who has reported his actions to the municipal pathologist.

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[57] *Nederlandse Jurisprudentie 1985, no.106. See fn.8 supra.*

[58] See Keown, op.cit., fn.4 supra, at 83.

[59] See fn.33 supra.

[60] See Section 5 below.

[61] An important distinction is necessary between cases reported and those that come to the attention of the Committees via other means. Cases held by the Review Committees to be outside their jurisdiction due to an absence of a valid request or because they consider the doctor's actions to be *'normal medical practice'*, as well as cases that come to their attention in some other way than via a report from a doctor (e.g. from another doctor, a nurse, the manager of an institution, etc.), are dealt with directly by the prosecutorial authorities themselves. See Griffiths et al, op.cit., fn.1 supra, at 82.

The *"due care requirements"* do not include a provision that the patient be in the terminal phase or that the illness be a terminal one. Neither is there any restriction to suffering of somatic origin. These are matters which were dealt with by the courts in a variety of cases including *Chabot*[62]and *Brogersma.*[63] Both these cases are reviewed below.

The third part amends the *Burial and Cremation Law 1991* in respect of those due care criteria which, if observed by a physician, will not be considered a criminal offence.[64]

Failure to observe these criteria will result in the geographically relevant Regional Review Committee deeming the actions of the doctor as *"not careful",* and a referral to the prosecutorial authorities for adjudication as to whether the matter is criminally actionable.

The role, composition, appointment, remuneration, duties and powers, and the requirement to issue annual reports of the Regional Review Committees are contained in Chapter III of the Act.[65]

The objective of *"legal certainty"* identified in the Preamble of the *Bill* placed before Parliament in February, 2000, was to formally de-criminalise an existing discrete offence, when performed by doctors, which, in effect, had already been judicially de-criminalised in practice. Whether the desired certainty has been achieved continues to be the subject of international jurisprudential investigation. Suffice it to say, however, that the authority charged with the responsibility of regulating the practice of third party assistance with death,

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[62] *Nederlandse Jurisprudentie 1994, no.656.*

[63] *Nederlandse Jurisprudentie 2003, no.167.*

[64] The Act added a new *section, 293(2),* to the *Penal Code* which reads: *"The act referred to in the first subsection" i.e. the termination by a person of another person's life at that other person's express and earnest request "shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in section 2 of the Burial and Cremation Act."* The criteria are lengthy but merit repetition:
"The requirements of due care, referred to in Article 293 second paragraph Penal Code, mean that the physician:(a) holds the conviction that the request by the patient was voluntary and well-considered;(b)holds the conviction that the patient's suffering was lasting and unbearable; (c) has informed the patient about the situation he was in and about his prospects; (d) and the patient holds the conviction that there was no other reasonable solution for the situation he was in; (e) has consulted at least one other, independent physician and (f) has terminated a life or assisted in a suicide with due care."
There are specific requirements in respect of patients aged sixteen or older who are no longer capable of expressing their will, those aged between sixteen and eighteen and are deemed to have a reasonable understanding of their interests, and those aged between twelve and sixteen who are deemed to have a similar understanding of their interests.
The new section to the Penal Code also requires the doctor not to issue a death certificate but to notify the municipal pathologist of his/her performance of an act of euthanasia *"in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act, 1991."*

[65] The Act provides that the Committees are the primary regulatory authority in respect of the practice of assisted death. They, rather than the courts, adjudicate on whether individual doctors have met the statutory *"due care requirements"*.

the Regional Review Committees, for their part, in their Annual Reports, the latest being that for 2011, continue to evince satisfaction as to both certainty and control.[66]

The focus of attention in the amendments to Article 293 and 294 of the Penal Code and in the *"due care criteria"* listed in the Act related largely to the role of the doctor and the requirement that he hold certain convictions as to the *"voluntariness"* of the request and that the patient's suffering was *"unbearable"*. In short, the main emphasis was on providing the doctor with the requisite justificatory defence of necessity.

There was no reference to the principle of self-determination *per se*. Successive Dutch Governments and the Royal Dutch Medical Association (KNMG), other than endorsing the requirement that the request for death be voluntary, have consistently set their faces against self-determination as an element in the legal performance of euthanasia.[67]

In summary, therefore, the Act provides that it is legally permissible for a doctor to perform an act of euthanasia, i.e. to terminate a patient's life at the patient's *"voluntary"* and *"well-considered request"*, provided that he fulfils certain *"due care requirements"* and reports himself, via the municipal pathologist, to the geographically appropriate Regional Review Committee. The patient euthanized must have been suffering *"unbearably"* and *"hopelessly"*.[68] On foot of this self-reportage, together with a detailed report as to his or her

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[66] www.euthanasiecommissie.nl/RTEJV2011.ENGELS.DEF_tcm52-33587.pdf accessed September, 2012. This Report was published in August, 2012. See also Legemaate. J, *'Twenty-five Years of Dutch Experience and Policy on Euthanasia and Assisted Suicide: An Overview'* in Thomasma, D (ed) , *'Asking to Die: Inside the Dutch Debate about Euthanasia'*, Kluwere Academic Publishers, 1998; McLean, S, *'Assisted Dying: Reflection on the Need for Law Reform'*, Routledge-Cavendish, 2007;Huxtable, R, *'Euthanasia, Ethics and the Law: From Conflict to Compromise'*, Routledge-Cavendish, 2007; Keown, *op.cit., fn.4 supra;* Griffiths, Weyer & Adams, *op.cit., fn.1 supra*. In his recent study, *'Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing', op. cit., fn.3 supra, Cohen-Almagor* found *"the high number of unreported cases of euthanasia"* alarming. *"The fact that some patients have been put to death without prior consent is extremely worrisome.....[and]the fact that many physicians do not wish to be bothered with the procedures is [also] alarming,"* at 179.

[67] This is a matter which continues to receive some attention among Dutch jurists arising from the operation of a nation-wide system of before-the-act consultation with specially trained consultants, known as **SCEN** (*Support and Consultation on Euthanasia in the Netherlands*). Under this process consultant doctors provide other doctors with information and advice in respect of euthanasia. They also assist in ascertaining whether the requirements of due practice and care are being met. For discussion on the use of **SCEN** consultants see *Regional Review Committee: Annual Report (2009) 8* http://www.euthanasiecommissie.nl/Images/JVeuthanasie%202009%20Engels%20DEF%20(EU16.01)_tem52-30367.pdf See also van der Weide, Onwuteaka-Philipsen & van der Wal, *'Implementation of the project Support and Consultation on Euthanasia in the Netherlands'*, (2004) 769 (3) Health Policy 365. The *Committee of the Procurators-General*, in appealing the decision of the District Court in *Brongersma (Nederlandse Jurisprudentie 2003, no.167)* stated that the acquittal of the doctor, Sutorious, would lead to an unqualified right of patient self-determination. The disavowal of self-determination in the Dutch legislation is to be contrasted with the attitude displayed by the Belgian *Act Concerning Euthanasia, 2002,*

[68] The implication being that there is no other reasonable solution. See fn.33 supra in respect of the due care criteria and their application by the Regional Review Committees.

own conduct, the committee will assess whether the doctor has met the *"requirements of careful practice"*. If he or she has, the prosecutorial authorities will not be alerted. If not, the prosecutor is informed. It is then becomes a matter for the Procurators-General to decide whether to prosecute.

"The Dutch Government simply now formally and unambiguously recognises that what has been going on for a decade, which is that euthanasia is practiced on a large scale in the Netherlands, that physicians have generally adopted certain rules of 'careful practice' and that they have often been open and frank about this."[69]

4. Overall contextualisation of the approach to euthanasia

The historical laissez-faire disposition of the Dutch prosecutorial authorities in the matter of assisted death is explicable, in part, by the high regard in which general medical practitioners have been traditionally held in that jurisdiction. Irrespective of their involvement in the death of a patient it was not thought appropriate to prosecute members of the medical profession. Added to this cultural and prosecutorial insouciance was the fact the Royal Dutch Medical Association (KNMG), notwithstanding its undoubted contribution to the formulation of the *"due care requirements"* for the licit performance of acts of euthanasia and assisted suicide, which were eventually incorporated into the *2002 Act,* had steadfastly ignored the legal requirement[70] to report *non-natural* deaths to the municipal prosecutor.

In the absence of actionable evidence, therefore, the prosecutorial authorities were powerless. Other than self-reportage by doctors themselves there was no facility available to enable an accurate record of the number of *non-natural* deaths occurring. However, the authorities were aware, albeit anecdotally, that euthanasia, including those instances in which a voluntary request had not been made,[71] and assisted suicide, were widely practiced. The very fact that the Procurators–General, with the imprimatur of the Justice Ministry, initiated legal proceedings, in carefully selected cases, in the early 1980s, against doctors suspected of having performed euthanasia, in order to achieve legal clarity as to the parameters within which third party assistance with death could be performed, together with the identification of requisite regulatory conditions for its manageable governance, was implicit testament of this awareness.

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[69] De Haan, *op.cit., fn.49 supra, at 67.*

[70] As per the *Burial and Cremation Act 1955.*

[71] The findings of the first national survey of euthanasia practices conducted in 1990/91 indicated that there was in the region of **1000** such acts per annum, a statistic which did enormous damage to the Dutch claim that the practice or assisted death was governed by clear and precise guidelines.

While doctors persisted resolutely in their refusal to report non-natural deaths - on the understandable grounds that they could incur a criminal penalty[72] - it became palpably evident that little if any progress in terms of transparency and legal certainty could be achieved. A new official strategy, therefore, was required.

To engender greater medical co-operation it was decided to change the reporting system. Doctors would no longer be required to report non-natural deaths to the municipal prosecutor. Instead, the Procurators-General themselves would decide whether a prosecution in a given instance was warranted.

This arrangement, together with the invocation of extant judicial findings, particularly in respect of the availability of the defence of necessity, beginning with *Postma*[73] and *Wertheim,*[74] led ultimately to the de-criminalisation by statute of euthanasia and assisted suicide when performed by doctors.

Irrespective, however, of the strength of the determination of the Government and the national prosecutors to effect greater transparency in the practice of assisted death, and legal certainty for those who performed it, their endeavours would have come to nought were it not for the concurrence and influence of the Royal Dutch Medical Association (KNMG) in the initiation, formulation and development of *"due care criteria"*, the observance of which would legitimate its performance by doctors. Prior to the finding in *Wertheim* the Association announced that the medical profession was prepared to take responsibility for acts of euthanasia. In reality, this announcement was the signal which the courts required to enable them to devise an appropriate defence in cases where members of the medical profession face charges of complicity in the deaths of patients.

In the absence of compliance by the medical profession, and by general practitioners in particular, with a regime involving reportage of non-natural deaths and the observance of specific *"due care requirements"*, euthanasia would never have been statutorily endorsed. The likelihood is that the traditionally discrete nature of the practice of assisted dying would have persisted unaltered and undiminished.

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[72] The first national survey of euthanasia practices indicated that regardless of whether they considered their actions to be either morally or ethically based, and notwithstanding the empirical fact that providing assistance with death was an offence under the *Penal Code*, doctors considered that a taint of criminality accompanied the requirement that they report such non-natural deaths to the municipal prosecutor who had the sole authority whether to prosecute.

[73] *Nederlandse Jurisprudentie 1973, no. 183.*

[74] *Nederlandse Jurisprudentie 1982, no.63.*

The endeavour to de-criminalise assisted death when performed by doctors was not exclusive to the Procurators-General, the Courts or the Royal Medical Association. They were not acting in isolation from other institutional elements of Dutch society.

J.H. van den Berg, in his *'Medical Power and Medical Ethics',*[75] questioned whether the shortening of life should be permissible and the Catholic ethicist Sporken argued that *"active intervention leading to the termination of life"* and *"non-intervention when a life-threatening complication occurs"*, from an ethical point of view, were not significantly different from one another.[76] Both, in his view, could be defended from a moral standpoint. A leading lawyer, Van Till, averred that medical actions necessary to assure the humane conclusion of a person's life could be justified from a medical-ethical and from a legal viewpoint.[77]

Meanwhile, a national debate as to what was or was not, or more accurately what should or should not, be included in the term euthanasia had begun. However, *"no consensus existed on which actions were covered by the term and which were not."* [78]

While distinctions were drawn between passive, active, voluntary and non-voluntary, direct and indirect euthanasia, ultimately the term became synonymous with the behaviour encompassed by the terms of *Article 293* of the Penal Code: *"the termination of life at the request of the person concerned".*

In 1972, the Committee on Medical Ethics of the Health Council had defined euthanasia as *"acting with the deliberate intention to shorten a patient's life or refraining from action with the deliberate intention not to prolong a patient's life, whenever this is in the patient's best interests and the patient's condition is incurable."*[79] In distinguishing between voluntary and

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[75] 1978, New York: W.W.Norton (this is a translation of *'Medische macht en medische ethiek, Nijkerk'*: Uitgeverij G.F.Callenbach, 1969).

[76] Sporken, P, *'Provisional Diagnosis. Introduction to Medical Ethics',* Utrecht: Ambo, 1969 *(This is a translation from Voorlopige diagnose. Inleiding tot een medische ethiek).*

[77] Till, d'Aulnis de Bourouill, H.A.H. van, *'Medico-Legal Aspects of the End of Human Life',* Deventer: Kluwer, 1970. Resonances of this suggestion by Till can be discerned in the controversial endorsement of *'help in dying'* by the Remmelink Commission Report in 1991.

[78] See Griffiths, Bood & Weyers, *op.cit.,* fn.4 supra, at 50.

[79] *Gezondheidstraad 1972: 12.* The Health Council has issued a series of recommendations in the matter of assisted death:
1975 *Adsvies inzake euthanasia bij pasgdeborenen* [Recommendation concerning Euthanasia in the case of new-borns], The Hague, Staassuitgeverij.
1994 *Patienten in een vegetatieve toestand* [Patients in a Vegetative State], The Hague, Gezondheidsraad.
2002 *Dementie: advise van een commissie van de Gezonbdheidsraad aan de Minister van Volksgezondheid, Welzijn en Sport* [Dementia: Advice of a Committee of the Health Council to the Minister of Health, Welfare and Sport], The Hague, Gezondheidsraad.

non-voluntary euthanasia the Committee stated that voluntary euthanasia is that which occurs at the express consent of a competent patient. It defined *passive* euthanasia as *"euthanasia this is performed by ceasing or not initiating life-prolonging measures and treatment"* and *active euthanasia* as *"euthanasia this is performed by the use of life-shortening measures and treatment"*. The Health Council averred that active euthanasia should not be permitted.[80]

In the same year passive euthanasia was endorsed as legitimate by the General Synod of the Dutch Reformed Church. It was interpreted as abstaining from life-prolonging measures for medical reasons. Likewise, it stated that the wish of a dying competent patient that further treatment be halted should be respected.[81]

In 1975 the Royal Dutch Medical Association (KNMG) published a report on euthanasia. It defined euthanasia as acts or omissions intended to cause a patient's death, in his or her interests, in circumstances where there was a *"voluntary request"* and the prognosis was *"hopeless"*. While the Association viewed passive euthanasia as the most appropriate method to fulfil a patient's wish for an early death it did state that *"under very exceptional circumstances it can be necessary purposely to administer palliative treatment in a dosage that is too high."*[82] Significantly, however, the Association did not then believe that the doctor-patient relationship allowed for assistance with suicide.

Three years later, in 1978, a Report by the Dutch Association for Voluntary Euthanasia (NVVE) stated that, in its view, *"direct, active euthanasia"* by a doctor was permissible when specific criteria were fulfilled.[83]

2004 *Terminake Sedatie Signalering ethiek en gezondheid 2004* [*Terminal Sedation. Current Issues in Ethics and Health, 2004*], The Hague, Gezondheidsraad. Available in English at http://www.gr.nl.pdf/04@12-02Epdf

2007 *Oveerwegingen bij het beeindigen van het level van pasgeborenen* [*Considerations in connection with the termination of life of new-borns*], The Hague, Centrum voor ethiek en gezondheid.

[80] During public hearings conducted by the *State Commission on Euthanasia* in the early 1980s it was clear that the distinction made by the *Health Council* between *'euthanasia'* and *'other medical behaviour that shortens life'* and the view that *'abstinence and pain relief'*, even when death is foreseen as the inevitable result, constitute *'normal medical practice'* was widely accepted.

[81] *Generale Synode 1972.*

[82] *Koninklijke Nederlandse Maaschappij Ter Bevordering Der Geneeskunst (KNMG) 1975: 10.*

[83] *These were: (i) a fully informed patient must have made it clear in a voluntary well-considered and unequivocal request that he/she wishes euthanasia; (ii) the patient's condition must be in the terminal phase, and (iii) the euthanasia should be performed by the doctor responsible for treatment.* It was argued that in such instances direct active euthanasia was not illegal because *"voluntary euthanasia under certain circumstances is to be considered normal medical practice."* See *Nederlandse Vereniging Voor Vrijwillige Euthanasie: 'Men moet ten slotte het recht hebben om al seen heer te sterven'* [*After All, One Should Have the Right to Die Like a Gentleman*], Amsterdam, NVVE.

In 1982, a State Commission on Euthanasia was established at the request of Parliament to provide advice as to the desirability or otherwise of amending the law on euthanasia.[84] In its Report in 1985 a majority[85] favoured legalisation under certain conditions.

When consulted by the Commission the Royal Dutch Medical Association (KNMG) thought it preferable not to adopt a specific position in respect of euthanasia *per se*. However, it did recommend that if an act of euthanasia were to be performed it should be carried out by a doctor, *"in the context of careful medical practice and sufficient procedural control must be guaranteed"*, there should be a *"voluntary and well-considered request"* by the patient, and what was described as *"unacceptable suffering"* should be present.[86]

The State Commission defined *euthanasia* as *"intentionally terminating another person's life at the person's request."*[87] The Commission proposed legislative revision of Article 293 so that euthanasia would be legal when performed by a doctor in a medically responsible way, at the request of a patient who was in a situation of *"hopeless necessity"*, and when certain requirements of *"careful medical practice"* had been met.

Both the Commission and the Health Council recognised the need for an effective system of control. In particular, the specific issue of whether a certificate of natural death could be issued by a doctor who had performed euthanasia required resolution. However, the majority view was unequivocal: euthanasia could not be considered a natural cause of death.[88]

One of the most significant acts of the State Commission was to distinguish between *"euthanasia per se"* and *"false forms of euthanasia"*. It stated that treatment that was *"medically futile"* or treatment that the patient refused (passive euthanasia), and death due

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[84] *Staatscommissie 1985: 12.* Advocates of euthanasia opposed the establishment of the *Commission.* They regarded the *Commission* as a ploy to delay legislative reform.

[85] The Report consisted of a majority report and a minority one. In the latter two members rejected any proposal for the legalisation of euthanasia.

[86] The word *"unacceptable"* was interpreted at the time as encompassing suffering that was *"unbearable and without prospect of improvement."* This is a matter which continues to enervate Dutch commentators in the context of the more nuanced approach evident in some judicial findings and in the *Annual Reports* of the Regional Review Committees which, almost imperceptibly, tends towards the provision of a *"dignified death"*, or the avoidance of an *"inhumane death."* The first indications of this can be traced to the decision in Schoonheim (*Nederlandse Jurisporudentie 1985, no.106).*

[87] *Staatscommissie 1985: 59.*

[88] In a criminal case in 1985 – the year the Commission issued its Report – a doctor who had terminated a patient's life at her explicit request filed a certificate of natural death. His defence of *necessity,* which had been deemed an applicable defence in *Schoonheim* a year earlier, was upheld. However, the invocation of the *'necessity'* defence in respect of the filing of a false certificate was not accepted. The Court held that such an action undermined legal control of the termination of life. See *Tijdschrift voor Gezondheidsrecht 1985, no.44.* This was upheld by the Court of Appeal and the Supreme Court affirmed the finding in 1987. See *Tijdschrift voor Gezondheidschrift 1988, no.13.*

to pain relief (indirect euthanasia), should no longer be considered euthanasia. These practices were *"normal medical behaviour".* Likewise, it held that the difference between pain relief that is legitimate and that which is homicidal lay not in differences in the doctor's subjective intention but in whether the pain relief, including the dosage and the method used in administering the relief, conformed to the standards of proper medical behaviour which define the limits of the rubric of medical exception.

This latter finding impacted in particular on the *Euthanasia Guidelines* issued by the Royal Dutch Medical Association in 2003 which stated that if life-shortening pain relief is not justified in terms of the patient's pain or symptoms it crosses the line between pain relief and termination of life.[89] Similarly, in 2004, the Health Council, in its report on terminal sedation, argued that it is not the doctor's intention but the medical standard that defines terminal sedation. [90]

The *"requirements of careful medical practice"* which the Commission identified as necessary for the legal performance of an act of euthanasia by a doctor contained virtually all of what would eventually be listed in Chapter II of the *Termination of Life on Request and Assisted Suicide (Review Provisions) ACT, 2002.*

In addition, the findings in *Postma*[91] and *Wertheim*[92] had established that *"when a patient who is suffering unbearably and hopelessly makes a voluntary and well-considered request, a doctor who accedes to the request, if he conforms to the requirements of careful practice and make his behaviour controllable by not filing a certificate of natural death is not guilty of a crime".*[93]

In essence, therefore, the practice of voluntary active euthanasia became legally acceptable long before its statutory endorsement two decades later. In the years intervening between the decision in *Schoonheim* and the enactment of the 2002 law, the authorities were not unduly concerned with the legality of euthanasia. There was no reason to be. Its practice had

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[89] *Koninklijke Nederlandse Maaschappij Ter Bevordering Der Geneeskunst (KNMG) 2003: 6.*

[90] The Council was also of the view that there was no significant difference between killing on request and certain forms of assistance with suicide. In circumstances where a doctor gave lethal medication to a patient, and it is self-administered, such a case should be treated in the same way as killing on request.

[91] *Nederlandse Jurisprudentie 1973, no.183.*

[92] *Nederlandse Jurisprudentie 1982, no.63.*

[93] Griffiths, Bood & Weyers, *op.cit., fn.4 supra, at 73.*

been legitimated by the established *"due care requirements"*. Rather, the focus of attention was on appropriate methods for the control of its practice.[94]

Prior to *Schoonheim* various doctrinal approaches to the possible legitimisation of acts which contravened *Articles 293* and *294* of the Penal Code had been widely discussed. Some of these resonated with specific elements of the earlier debate - between 1965 and 1982 - on the question of the legalisation of abortion.[95] However, the *"medical exception"* argument, propounded by Enschede in respect of abortion, failed to gain traction in the matter of assisted death.[96]

Another defence centred on the notion of *"absence of substantial violation of the law"* or *"material illegality"*. The contention was that behaviour which violated the letter, not the purpose, of the law, should not be considered an offence. This defence had been invoked in the *Wertheim*[97] case but it was rejected by the District Court.

The defence of overmacht (circumstances beyond one's control) contained in *Article 40* of the Criminal Code was also propounded. This received jurisprudential recognition by the Supreme Court in *Schoonheim.* In Dutch law there are two aspects to this defence: the excuse of *duress*[98] and the justification of necessity.[99]

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[94] It is significant that the *Commission's* guidelines and recommendations were published immediately prior to the landmark *Schoonheim* finding in which the Supreme Court held that a doctor who ends the life of a patient may, in certain circumstances, successfully invoke the defence of necessity which is contained in *Section 40* of the Penal Code. Section 40 reads: *"A person who commits an offence as the result of force he could not be expected to resist is not criminally liable."*

[95] It was argued by Enschede, who subsequently became a member of the Dutch Supreme Court, that *Articles 295 to 298*, and *Article 251b* of the *Criminal Code*, which criminalised abortion, did not apply to doctors. He claimed that a doctor who terminated a pregnancy on the basis of *"medical indication"* fell within an implicit *'medical exception'* to the abortion prohibition and would not be guilty of a criminal offence. This view carried considerable weight and in the absence of amending legislation abortion, to all intents and purposes, was decriminalised contingent on its being performed in a medically responsible manner. See Enschede, C, *'Abortion on medical indication and the criminal law'*, Nederlands Tijschrift voor Geneeskunst 110: 1349-1354.
Abortion remained illegal but it was freely practiced and became an accepted fact of life. Enforcement of the ban on abortion was no longer a feasible proposition after the *Royal Dutch Medical Association*, in 1971, stated that *"the doctor's duty to give medical assistance can entail the decision to perform an abortion when he is asked in an unwanted pregnancy."* In effect abortion was decriminalised by the early 1970s. It was not until 1982, however, that the appropriate legislative provision was enacted.

[96] Enschede, C, *'The Doctor and Death: Dying and the Law'*, Deventer: Kluwer, 1985.

[97] *Nederlandse Jurisprudentie 1982, no.63.* Counsel for the defence argued that even though the defendant's conduct had violated the letter of the law, she could not be convicted because she had not violated the purpose of the law – protection of life – given that the deceased wanted to be released from life.

[98] In *Postma* (*Nederlandse Jurisprudentie 1973, no. 183*) the defendant invoked the defence of *'duress'*. This was rejected on the grounds that a doctor can be expected, and should be able to, withstand pressure from patients in respect of desired treatment.

In 1984 the D66 left-liberal party in Parliament tabled a bill, known as the *Wessel-Tuinstra Bill,* proposing the legalisation of euthanasia and assisted suicide provided the patient's condition was *terminal* or whose physical or mental suffering was *unbearable.* The bill garnered majority support among parties in Parliament but because the Christian Democrats opposed its introduction further progress was halted. It was decided to postpone consideration of its contents until after the State Commission had reported.[100]

In 1985, after the decision in the *Admiraal* case,[101] the Minister for Justice, with the agreement of the Royal Dutch Medical Association (KNMG) and the National Prosecutors, guaranteed that doctors who complied with the *"requirements of due care"* that had been identified in *Schoonheim* and other cases, would not be prosecuted. This was a clear recognition by the Government that the defence of necessity was one which accorded with the prosecuting authorities' objective of achieving legal certainty in respect of the conditions governing the licit performance of euthanasia and assisted suicide by doctors. In effect, this decision was official notification that the process of incorporation into law of an exceptional defence for doctors who perform euthanasia was well underway.

In 1989, the then Chairperson of the Dutch Health Council, Dr Els Borst, who later became Minister for Health, listed the conditions necessary for the defence of *necessity* to be availed of by doctors. They included *"an entirely free and voluntary"* request; the request must be *"well considered, durable and persistent"*; the patient must be experiencing *"intolerable (not necessarily physical) suffering, with no prospect of improvement"*; euthanasia must be *"a last resort"*; it must be performed by a *"physician"* and the physician must *"consult with an independent physician colleague"* who has experience in this field. The seeds of what were to

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[99] The justification of *'necessity'*, according to the Supreme Court, can be invoked in circumstances where the defendant finds him/herself in a situation of conflicting duties. It is a matter of some interest to note that in his valedictory lecture as Procurator General of the Supreme Court of the Netherlands, entitled *'Tension between Law and the Criminal Code'*, delivered to an extraordinary session of the Court on 29 April 1992 [The Hague: Ministry of Justice], Professor Remmelink, who as Advocate General had submitted the brief to the Supreme Court arguing that the Court should reject Schoonheim's appeal, stated that the explanation for the delay of six months between the hearing and the delivery of the judgment lay in the fact that in the interim the Executive Board of the Royal Dutch Medical Association had adopted a new policy which, for the first time, recognised the legitimacy of euthanasia performed by a doctor.

[100] The Christian Democrats were participants in the Coalition Government of the day. Continued participation in government by the Christian Democrats throughout most of the 20th century effectively inhibited any change in the law on euthanasia. It was not until 1993 when a government was formed in which no confessional parties were represented that the issue became a viable political option. Even then the issue was postponed until a second coalition government without the Christian Democrats was formed in 1998.

[101] *Nederlandse Jurisprudentie, 1985, no.709.* See fn.9 supra.

be the eventual *"due care requirements"* established by statute can be clearly identified in this list.

In January, 1990 the first of four[102] national surveys of medical behaviour at the end of life was undertaken. It was supervised on behalf of the Government by a Commission chaired by the Attorney General Professor Remmelink. The remit of the Commission was admirably succinct. It was to report on the practice by physicians of *"performing an act or omission....to terminate [the] life of a patient, with or without and explicit and serious request of the patient to this end".*[103] The Commission asked P.J. van der Maas, Professor of Public Health and Social Medicine at Erasmus University to undertake the task of collecting the necessary data.

In order to ensure that euthanasia could be appropriately contextualised within the totality of medical practices resulting in earlier than natural death it was mutually agreed that the survey should include **all** medical decisions affecting the end of life. The umbrella term devised for this purpose, and one which gained popular usage subsequently,[104] was *'Medical Decisions concerning the End of Life.'* It included *"all decisions by physicians concerning courses of action aimed at hastening the end of life of the patient or courses of action for which the physician takes into account the probability that the end of life of the patient is hastened."*[105] Such decisions encompassed the administration, supply or prescription of a drug, the withdrawal or withholding of a treatment (including resuscitation and tube-feeding), and the refusal of a request for euthanasia.

The findings[106]in respect of the incidence of lethal drugs being administered with the express purpose of accelerating the dying process of patients in circumstance where the patient had not explicitly requested assistance with death shocked not only the international jurisprudential community but also the Dutch themselves.

Controversially, the *Remmelink Committee* referred to this practice – of accelerating death in the absence of an explicit request - as *"help in dying"* (*stervenshulp*) and opined that it was

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[102] Surveys were conducted in 1990, 1995, 2001 and 2005.

[103] *Medische beslissingen rond het levenseinde. Het onderzoek voor de Commissie onderzoek medische praktijk inzake euthanasia (1991) 3.*

[104] Griffiths et al, *op.cit., fn.1 supra, at 52* refers to *'Medical Behaviour that Potentially Shortens Life'.*

[105] See *fn. 103 supra.*

[106] Ibid. The Report has not been translated. An English summary was published by the Justice Ministry: *'Outlines Report Commission Inquiry into Medical Practices with Regard to Euthanasia'.* A concise summary of the Report is contained in Dr.Richard Fenigsen's *'The Report of the Dutch Governmental Committee on Euthanasia,'* (1991) 7 Issues Law Med 339.

part of *"normal medical practice."*[107] While it is evident from the survey's findings that such *'help'* was regarded by many doctors as part of their normal duty to dying patients, nonetheless its categorisation by the Committee as *"normal medical practice"* aroused both political and legal concerns. In response, the Government made it clear that such behaviour was not normal medical practice. Rather it was *"termination of life"* and the cause of death was *"non-natural"*. As provided for under the *Burial and Cremation Act* such a death had to be reported to the prosecutorial authorities.

The findings also showed that only **18%** of euthanasia cases were being reported as such by doctors. While this was an appreciable improvement on previous numbers – there were only **4** officially reported cases of euthanasia in 1982 and **84** in 1986[108]- the authorities considered this level of reportage to be woefully inadequate if the desired transparency and proper legal control was to be established.

When the second national survey was conducted in 1995 it was found that the rate of reporting of euthanasia cases had increased to **38%**, a statistic which, while an appreciable indication of greater co-operation by doctors, also confirmed what had already been suspected by the authorities namely, that it was the putatively criminal character of the earlier reporting procedure that had previously inhibited compliance by medical personnel. These statistics impelled the authorities to establish, by an order in Council, Regional Review Committees whose remit was to act as a buffer between doctors and prosecutors. While the principle function of these Committees was to assess notification by doctors of acts of euthanasia, they also had the objective of making the process of review more acceptable to doctors, in the hope that they would be more inclined to self-report.[109] The Committees were operational for four years prior to being placed on a statutory footing by the 2002 Act. Their role and influence in the management and control of euthanasia and assisted suicide cannot be understated.[110]

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[107] The phrase *"help in dying"* has been memorably described as *"a tendentious euphemism"* by John Keown. See his *'Euthanasia, Ethics & Public Policy: An Argument against Legalisation'*, op.cit, fn.4 supra, at 117.

[108] Between 1991 and 2006 the numbers had risen from **861** to **1923**. See 1982-85: Second Chamber of Parliament, 1986-87, no 19 700, Ch.VI, No 3:68; 10986-2002: Van der Wal et al 2003:154; 2003-2006: Annual Reports of the Regional Review Committees.

[109] See *Regeling regionale toetsingscommissies euthanasia, 27 May 1998, Staatscourant 1998, no. 101 (*included as an appendix to the Annual Reports of the Regional Review Committees*).*The Committees began work at the end of 1998. Their annual reports are replete with details of the incidence of euthanasia, together with evidence of a nuanced approach in particular cases tangible indications of future accommodation or procedures allowing for what is referred to as a *"dignified death."*

[110] See Section 5 below.

In 1997, the Royal Dutch Medical Association (KNMG), supported by the Ministry of Health, established an experimental programme in Amsterdam to provide a corps of consultants trained in all aspects of euthanasia who would advise family doctors as to the proper course of conduct to be followed prior to carrying out a patient's request for euthanasia. Initially called ***SCEA***[111] it was established as a permanent fixture in 1999 and extended to the entire country. It is now known as ***SCEN***.[112] From the outset the Regional Review Committees endorsed and supported this programme. In their 2002 Annual Report they advocated its continuance and expanded *"because it makes an important contribution to the quality of due care in connection with euthanasia."*[113] The operations of **SCEN,** however, appear to approximate to a before-the-fact control of euthanasia, something which the Government and the medical profession had resisted resolutely previously.[114] After-the-fact control had always been preferred. Nonetheless, the Regional Review Committees *"are increasingly inclined to regard a report of euthanasia that is accompanied by a* ***SCEN*** *consultant's report as requiring less attention than other cases."* [115]

Case Law

In addition to these developments there were a number of important judicial findings in respect of the legal contours within which acts of euthanasia could be performed in particular circumstances. Between 1970 and 1982, there had been cases in which violation of Articles 293 and 294 of the Criminal Code was in issue. Chief among these were *Postma* [116]and *Wertheim*.[117] However, the case which was to become most closely associated with the

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[111] *Steun en Consultatie Euthanasie Amsterdam (Support and Consultation Euthanasia Amsterdam).*

[112] When the programme was extended nationwide the 'N' for Netherlands replaced the 'A' for Amsterdam.

[113] *Regional Review Committees Report 2002: 31.* An evaluation of the **SCEN** programme came to the same conclusion. See Jansen-van der Weide, *'Handling Requests for Euthanasia and Physician-Assisted Suicide'*, dissertation, VU Amsterdam, 2005: 68ff.

[114] See Kimsma, G, *'Euthanasia Consultants: Professional Assessment before euthanasia and physician-assisted suicide in the Netherlands', in Younger, S & Kimsma, G, 'Physician Assisted Death in Perspective'*, Cambridge University Press, 2012, at 181.

[115] *Griffiths, op.cit., fn.1 supra, at 140.* In its 2011 Report the Committees state: *"The committees are pleased to note that specialists these days almost always call in a SCEN physician when euthanasia is performed in a hospital...The committees also note that some SCEN physicians offer to advise the attending physician on the performance of the procedure – an excellent example of the support component of the SCEN programme." www.euthanasiecommissie.nl?RTEVV2011.ENGELSDEF_tcm52-3358.pdf> accessed September, 2012.*

[116] *Nederlandse Jurisprudentie 1973, no.185.See fn.4 supra.*

[117] *Nederlandse Jurisprudentie 1982, no.63. See fn.9 supra.*
The first occasion on which the Dutch public was confronted with euthanasia-related issues was in 1967 when an anaesthetist, treating a comatose 21 year-old patient, Mia Versluis, who required artificial respiration, proposed that her feeding tube be removed. Her father lodged a complaint with the Medical Disciplinary Tribunal. The Amsterdam Court of Appeals held that when termination of life-support was being considered a doctor must consult with medical colleagues and the situation must be discussed with the patient's family. The anaesthetist was found guilty of behaviour that undermined

judicial endorsement of third party assisted death, both euthanasia per se and assistance with suicide, was that of *Schoonheim*.[118]

In *Postma,* the defendant doctor, in the presence of her husband, also a doctor, had terminated her 78 year old mother's life via an injection of morphine. The woman, on several occasions, had asked her daughter to end her life. The defendant was tried for violating Article 293 of the Criminal Code. In evidence the Medical Inspector testified that the average doctor in the Netherlands no longer considered it necessary to prolong a patient's life endlessly. He averred that it had become widely accepted in medical circles that when a patient is given pain relief the risk of the patient dying sooner because of this treatment could, under certain circumstances, be acceptable.[119]

While the District Court accepted these requirements - with the exception of the condition relating to the *"terminal phase"* - it nonetheless found that the method used by the defendant was not a reasonable means of achieving the goal of ending her mother's life. She was given a conditional custodial sentence of one week with one year's probation.[120]

The significance of this case lay in the jurisprudential confirmation that the administration of pain relief in dosages known to be likely to cause death did not constitute a violation of *Article 293* of the Criminal Code.[121]

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confidence in the medical profession. He was fined 1000 guilders and the court ordered that the ruling be published in the Official Gazette. *See Nederlandse Staatscourant 1969, no.57:7.* Prior to 1967 there had been a case, in 1952, where a doctor, who was found guilty of *"killing on request"*, in violation of Article 293, was sentenced to one year's probation *"because, as far as the Court is aware, this is the first time that a case of euthanasia has been subject to the ruling of a Dutch judge." See Nederlandse Jurisprudentie, 1952, no. 275.* In 1908 a man had been convicted for the attempted murder of his girlfriend. He claimed that she requested him to do so. In 1910 a man who claimed that he had shot his girlfriend at her request was convicted of murder. In 1944, the Supreme Court unified the ruling of the Court of Appeals, Amsterdam, in a case of a man who strangled his girlfriend. In the opinion of the Supreme Court the Court of Appeals had not paid sufficient attention to the explicit request of the woman involved. *See Nederlandse Jurisprudentie 1844, no. 314.*

[118] *Nederlandse Jurisprudentie 1985, no 106.* See fns.8&9 supra. A translation, with explanatory notes, is available in Griffiths, Bood and Weyers, *op.cit., fn.4 supra, at 322-328.*

[119] Among the conditions alluded to were (i) *the patient must be incurably ill; (ii) he/she finds the suffering mentally or physically unbearable; (iii) he/she has expressed a wish to die; (iv) he/she is medically speaking in the terminal phase of illness and (v) the person who accedes to the request is a doctor, or preferably the doctor responsible for treatment.* See *Nederlandse Jurisprudentie, 1973, no. 183, at 558.*

[120] See McKhann, C.F, *'A Time to Die: The Place for Physician Assistance',* New Haven, Connecticut, Yale University Press, 1999, p.122. The *Postma* case was the best known prosecution in this period of a person who killed another at the latter's request but it was not the only one. There were at least three other prosecutions for violations of Articles 293 and 294. *See Gomez, C.F, 'Regulating Death',* New York, The Free Press, 1991, pp.28-32; Griffiths, Bood & Weyers, op.cit., fn.4 supra, at 53.

[121] Immediately after the court's finding the Royal Dutch Medical Association (KNMG) issued a statement affirming its view that the administration of pain relieving drugs and the withholding and withdrawal of futile treatment could be justified even if it resulted in death.

In *Wertheim*[122] the District Court held that assistance with suicide could only be justifiable if the following specific requirements were fulfilled:

- (i) enduring and unbearable suffering;
- (ii) the desire to die was also enduring;
- (iii) the decision was voluntary;
- (iv) the person seeking assistance was well-informed as to his condition;
- (v) was fully aware of the available alternatives;
- (vi) was capable of weighing all the relevant considerations and had done so;
- (vii) there were no alternative means of improving his/her situation, and
- (viii) the person's death did not cause any unnecessary suffering to others.

The Court also found that a decision to provide assistance with suicide may not be made by one person alone. A doctor must be involved who must determine the method used, and the utmost care must be taken in arriving at the actual decision to assist and with the assistance itself, including consultation with other doctors. The Court found that the 76 year old defendant[123]had not met these requirements. She was found guilty of the offence of assisting in the suicide of another as prohibited by Article 294 of the Criminal Code.[124]

The finding in *Schoonheim*[125] endorsed the availability of the defence of necessity for doctors, contingent on the fulfilment of certain criteria. In reality, *Schoonheim* legalised euthanasia and assisted suicide almost two decades prior to their formal legislative approval in 2002.

It is impossible to attain any appreciation or understanding of the history of permissible euthanasia in the Netherlands without an acknowledgement of the influence on the progression of the *de facto* legalisation of acts which remained criminal offences other than when performed by members of the medical profession, arising from this, and the *Pols*

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[122] *Nederlandse Jurisprudentie 1982, no.63.*

[123] A volunteer euthanasia activist who had been recommended by the patient's GP. The GP had refused a request to provide assistance with the suicide of the patient.

[124] In addition to *Postma* and *Wertheim* there had been cases between 1979 and 1980 which had attracted both prosecutorial and public attention. In 1969 a man strangled his incurably ill wife at her request. He was sentenced to seven months in jail. In 1978 a foster son was prosecuted for strangling his step-mother after she had attempted suicide, without success, on several occasions. He was imprisoned for eighteen months. In 1980 the husband of a psychiatric patient who did not want to be institutionalised again was prosecuted for having constructed a device that enabled her to take her own life. On appeal he was sentenced to six months in jail. In none of these cases was it doubted that the defendants had acted at the request of the person killed. Neither was it doubted that their intentions had been anything but honest. In two of the cases the Court found that it was wrong of the defendants not to have sought the assistance of a doctor.

[125] *Nederlandse Jurisprudentie 1985, no.106.*

case.[126] While the defence of *necessity* was identified as applicable in *Schoonheim* it was denied in *Pols.* However, the findings in both *"brought much clarity with regard to the legality of euthanasia."*[127]

A general practitioner, Schoonheim had administered euthanasia to a 95 year-old woman who, although her illness was not terminal, was in a less than desirable medical condition. She had explicitly and repeatedly requested that she be given assistance to die. Convicted in the District Court Schoonheim's conviction was upheld by the Court of Appeals. In the Supreme Court, however, it was held that the doctor may have acted as a result of a conflict of duties[128] – identified as that between not killing and relieving pain and suffering. The justification of necessity – available under Section 40 of the Penal Code - was affirmed. Schoonheim was acquitted.

In summary, the Supreme Court held that where there is a dilemma between law and medical ethics euthanasia is justifiable.

Likewise, it held that *"unbearable and hopeless"* suffering included *"increasing loss of personal dignity"* and *"the prospect of an undignified death"*.

The significance[129] of these findings was demonstrated subsequently in *Chabot*[130] and *Brongersma*[131] and is of on-going relevance in the context of the discernibly nuanced interpretation of *"unbearable suffering"* to include a *"dignified death"*, or one that is not *"inhumane"*, evident latterly in Dutch jurisprudence generally and particularly in the Annual Reports of the Regional Review Committees.[132]

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[126] *Nederlandse Jurispridentie 1987, no.607.*

[127] Griffiths Bood & Weyers, op.cit., fn.4 at 65.

[128] Following *Schoonheim* euthanasia was regarded as a legitimate option for a doctor who was faced with a conflict of duties – the duty to respect life and the duty to relieve suffering. In effect, it is the doctor's conflict of duties that establishes the justifiable invocation of the defence of necessity. See Griffiths, Weyers & Adams, op.cit., fn. 1 supra.

[129] The judicial reasoning in *Schoonheim* has been subjected to sustained criticism by jurists, not least by John Keown. He has stated that the decision was remarkable because *"first, the necessity defence has traditionally been understood as justifying an ostensible breach of law in order to save life, not to take it. Second, the judgment failed to explain why the doctor's duty to alleviate suffering overrode his duty not to kill. Doctors in other countries see no conflict at all between their duty not to kill and their duty to alleviate suffering. Finally, the court appeared to abdicate to doctors the power to determine the circumstances in which voluntary active euthanasia attracted the necessity defence. What qualifies doctors to decide when it is right to kill patients?"* See Keown, J, *op.cit., fn.4 supra.*

[130] *Nederlandse Jurisprudentie 1994, no.656.*

[131] *Nederlandse Jurisprudentie 2003, no 106.*

[132] See fn.66 supra.

While undoubtedly the most significant, nonetheless the decision in *Schoonheim* was not the only judicial finding which had an impact on specific aspects of the practice and performance of euthanasia.

As earlier outlined the Royal Dutch Medical Association (KNMG)[133], in 1984, had expressed the view that euthanasia was acceptable when carried out by a doctor who fulfilled specific *"requirements of careful practice"*. The following year an anaesthetist, *Admiraal,*[134] stood trial for ending the life of a multiple sclerosis patient. *Admiraal* claimed he had fulfilled the *"due care requirements"* which had been identified in previous court findings and which had also been endorsed by his own professional association. In mitigation he pleaded necessity. He was acquitted.

As a consequence it became clear that a doctor who complied with the *"requirements of careful practice"* would not be convicted for performing an act of euthanasia. This was confirmed by the Minister for Justice who notified the Royal Dutch Medical Association (KNMG) in late 1985 that doctors who comply with the *"requirements of careful practice"* published by the Board of the Association in *Medisch Contact*, the *Association's* official publication, would not be prosecuted.[135] Over time the *"requirements of careful practice"* eventually morphed into the *due care requirements* listed in the 2002 Act.

In *Chabot*[136] it was held that assistance with suicide is legally justifiable in the case of a patient whose suffering does not have a somatic basis, and who is not in the terminal phase. Likewise, it was decided that an expressed wish to die by a person suffering from a psychiatric illness or disorder can be deemed the result of an autonomous (i.e. a competent and voluntary) judgment. The Court found, however, that the suffering of such a person cannot legally be considered to lack any prospect of improvement if the patient has refused a realistic therapeutic alternative. The Supreme Court held that the patient need have no physical illness and he or she need not been in the terminal phase. The suffering which was considered sufficient was purely mental, resulting from a *"depression in a particular sense*

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[133] *Standpunt inzake euthanasia* [*Position on Euthanasia*] *Medische Contact 39.*

[134] *Nederlandse Jurisprudentie 1985, no.709.* See fn.9 supra.

[135] That a doctor who met the requirements of careful practice would not be prosecuted was confirmed in a case taken in 1987. Similarly, failure to consult another doctor, of itself, was deemed insufficient grounds for a criminal prosecution. The prosecuted doctor had administered lethal injections to a patient at her explicit request. When criminal charges were laid, the doctor requested the Court of Appeals, Arnhem, to quash the indictment. The Court did so. In its view the indisputable facts required the conclusion that prosecution of the doctor for euthanasia could not succeed since it would become evident at trial that the defendant had acted in a situation if necessity. The Supreme Court rejected the prosecution's appeal on the grounds that the arguments given by the Court of Appeals formed a sufficient basis for its conclusions. *See Nederlandse Jurisprudentie 1988, no.157.*

[136] *Nederlandse Jurisprudentie1994, no. 656.*

without psychotic characteristics in the context of a complicated grieving process."[137] The Court reaffirmed its earlier findings that euthanasia and assistance with suicide can be justified if *"the defendant acted in a situation of necessity."*[138]

Chabot, a psychiatrist, had assisted in the suicide of one of his patients, a 50 year-old woman, because of her persistent grief at the death of her two sons, one of whom had died as the result of cancer and the other had committed suicide. His patient had no history of psychiatric disorder. She wanted to die because she felt her life had lost its meaning as a result of the deaths of her children. In his interviews with her Chabot did not diagnose any psychiatric illness, clinical depression, trace of psychosis or personality disorder.[139] He accepted that suicide was the only option to end her misery and was convinced that she

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[137] Ibid. The Supreme Court rejected the prosecution's submissions that necessity required somatic pain and that a psychotic patient could not make a genuine request for death. The Court held, however, that in cases where the suffering was not somatic a proper factual basis for the necessity defence could be laid only where the patient had been examined by an independent doctor who had assessed the gravity of the suffering and other possibilities for its alleviation.

[138] *"That is to say...that confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight. In particular, a doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care." Nederlandse Jurisprudentie, 1994, no.656: 3154.* The 2011 Report of the Regional Review Committees dealt with mental illness or disorder and depression: *"In general, requests for termination of life or assisted suicide because of unbearable suffering arising from a mental illness or disorder, with no prospect of improvement, should be treated with great caution. If such a request is made by a psychiatric patient, even greater consideration must be given to the question of whether the request is voluntary and well-considered. Mental illness or disorder may make it impossible for the patient to determine his own wishes freely. The attending physician must ascertain whether the patient appears capable of grasping relevant information, understanding his condition and advancing consistent arguments. In such cases it is important to consult not only an independent physician but also ne one more experts, including a psychiatrist. It is important that their findings are also made known to the committee." www.euthanasiecommissie.nl?RTEJV2011.ENGELS.DEF_tcm52-33587.pdf access September, 2012.*
In 2011 the committees received **13** notifications of euthanasia or assisted suicide involving patients with psychiatric problems. All **13** notifications were found to have been handled with due care. **Two** of the cases (**Nos.12 & 13**) were discussed at length in the 2011 Report.
In the matter of depression the Report stated: *"In the year under review, there were again notifications in which the patient was suffering from depression in addition to one or more somatic conditions. Depression often adds to the patient's suffering. The possibility that it will also adversely affect his decisional competence cannot be ruled out. If there is any doubt about whether the patient is depressed, a psychiatrist will in practice often be consulted in addition to the independent physician. If other medical practitioners have been consulted, it is important to make this known to the committee. It should also be noted that it is normal for patients to be in low spirits in the circumstances in which they make a request for euthanasia, and that this is not in itself a sign of depression."*

[139] The patient, Mrs. Bosscher, had stated that *"the only sense life has got for me now is to find my way to Peter and Robbie"* (her two deceased sons) *"through a dignified death." See 'Arlene Judith Klotzko and Dr Boudewijn Chabot discuss Assisted Suicide in the absence of Somatic Illness',* Cambridge Quarterly Journal of Healthcare and Ethics, Vol.4 (995), at 241.*; also* Cohen-Almagor, *R, 'Euthanasia in the Netherlands: The Policy and the Practice of Mercy Killing',* Kleuwer Academic Publishers, 2010, at 46.

would kill herself in any event, with or without his help. Although convicted, he was not punished. He was later admonished by a Medical Disciplinary Court.[140]

In *Van Oijen*[141]the Supreme Court held that the justification of necessity, in principle, could be available in a case of ending the life of a dying patient without the patient's request, but only in extraordinary cases. However, this defence was not available to Van Oijen and he was found guilty both of murder and of filing a false certificate of natural death. There is some doubt as to whether the decision in this case definitively closed the door on the possibility of legal *"help in dying"* as envisaged by the Remmelink Committee, alluded to earlier.[142] Both the Court of Appeal and the Supreme Court emphasised that *Van Oijen's* behaviour might, in other circumstances, have been justifiable.

In 2005, the *Vencken*[143]case addressed the issue of terminal sedation which, in the late 1990s, offered the possibility of relieving the symptoms of a terminally ill patient by deep and continuous sedation until death occurs. When accompanied by the withholding of artificial nutrition and hydration – because this is seen as medically futile – the combination of the act (sedation) and an omission (not administering artificial nutrition and hydration) could be considered as hastening the patient's death. It appears that some doctors in the Netherlands preferred terminal sedation because it did not entail reportage as a non-natural death.[144] The prosecutorial authorities expressed concern that there were no control mechanisms in place for *terminal sedation* and decided to prosecute Vencken who gave a dying patient morphine and a sedative, *Dormicum.* The prosecutors took the view that it was not the doctor's subjective intention (*"to relieve suffering versus to hasten death"*) but the consequences of his behaviour that determined whether what he did was termination of life. The patient had

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[140] The Disciplinary Court ruling was based on three findings: (i) Chabot was faulted for not insisting on therapy as an alternative to assisted suicide; (ii) he failed to arrange for Mrs Bosscher (the patient) to be personally examined by another consultant; this was considered to be an ethical breach of duty, and (iii) he had not adequately preserved his professional distance, particularly in light of the frequency and length of his sessions with the patient and the fact that these took place at her home. See Griffiths, J, *'Assisted Suicide in the Netherlands: The Chabot case',* Modern Law Review, Vol. 58 (March 1995), p.239.

[141] *Nederlandse Jurisprudentis 2005, no.217. Van Oijen* was a general practitioner. He had previously prescribed palliative drugs but they had not been administered. Having consulted with the woman's daughters he administered a relaxant and the patient died shortly afterwards. He filed a certificate of natural death. The incident was reported to the Medical Inspectorate who in turn informed the relevant prosecutors. He was found guilty in the District Court and fined 5000 guilders. On appeal the guilty verdict was upheld. On appeal to the Supreme Court it was found that there were no mitigatory circumstances present in the case. *Van Oijen's* patient was not suffering *"unbearably"* and her pitiful situation was not decisive because death was about to occur of its own accord.

[142] See *fn.107 supra.*

[143] *LJN: AUO211, 20-000303-05.*

[144] The results of the 2001 national survey had indicated that *'terminal sedation'* was used in circa **10%** of all deaths by euthanasia.

died within minutes of the drugs being administered. The doctor was charged with murder.[145] His eventual acquittal, however, did not obviate a disciplinary tribunal under the aegis of the Medical Inspectorate.[146]In the event his actions were deemed to be normal medical behaviour.

It is thought that this decision was taken in the knowledge that a committee of the Royal Dutch Medical Association (KNMG) was in the process of formulating guidelines, at the instigation of the Minister for Health, in respect of terminal sedation. The committee, however, favoured the term *"palliative sedation"* which, in its view, refers to inducing a deep and continuous coma in a patient in the last stage of life. They deemed artificial nutrition and hydration in such cases to be futile.[147] The Committee averred that it is the patient's medical condition and not the doctor's subjective intentions that are determinative of the legitimacy of *"palliative sedation"* - a view which approximates to the principle of double effect.[148]

The committee also formulated a number of specific *"due care requirements"* for the administration of such sedation. Following publication of the committee's report the national prosecutors announced that if doctors met these requirements no criminal proceedings would follow. They concurred with the committee's view that palliative sedation was *"normal medical practice"* and not a form of *"termination of life"*. However, the situation in which *"terminal sedation"* is administered and where artificial nutrition and hydration is withheld for long enough that the death of the patient is probably hastened, has not been resolved finally in the Netherlands.

In 2000, a court in Haarlem acquitted a Dr. Sutorious for assisting 86 year old Edward Brongersma, a lawyer and former Senator, to commit suicide. Brongersam had asked Sutorious, who was a **SCEN**[149] doctor, for assistance with death on at least eight occasions since 1986. Apparently, Brongersma, who had led a very active life, had problems of incontinence and balance. Sutorious requested two independent consultants to examine and

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[145] The doctor reported the death as one due to natural causes. He believed that terminal sedation fell within the parameters of the *'medical exception'*. He was acquitted in the District Court because it found that the quantum of drugs used was medically indicated. Therefore an intention to kill could not be proven. On appeal it was ground that it had not been proved that the patient had died as a result of the drugs administered. The doctor was acquitted yet again. There was no appeal by the prosecutor to the Supreme Court.

[146] On the basis that doubt existed as to the *"carefulness"* of the doctor's behaviour.

[147] The Committee proposed that *'palliative sedation'* be administered only to those patients with a life expectancy of less than two weeks, so that the death of the patient occurs as a result of the underlying disease and not from the withholding of artificial nutrition and hydration. KNMG - *Richtlijn Palliatieve Sedatie [KNMG – Guidelines on Palliative Sedation], Utrecht, 2005*

[148] See *fn.56 supra*

[149] See *fn.67 supra*.

interview Brongersma. Both confirmed that the patient was suffering and that his request for death was a voluntary and well-considered one. Having assisted with the suicide Sutorious reported the case and characterised the reasons for Brongersma's request as *"lonely, feelings of senselessness, physical deterioration and a long-standing wish to die not associated with depression."* In response to a question as to the precise nature of the patient's suffering Sutorious replied: *"The person in question experienced life as unbearable."* When asked if there were treatment alternatives he stated: *"No, the person in question [had]weighed the pros and cons, and there was no disease to treat."*

The prosecutor claimed that *"aging, deterioration and fear of losing control over the end of life"* do not justify a doctor assisting with suicide. However, the Court accepted the appeal to necessity.[150] On appeal the Procurators-General stated that the District Court's decision would lead to an unqualified right of patient self-determination. Likewise, they expressed doubts as to whether the suffering in the case had been *"hopeless and unbearable"* and contended that the case differed to *Chabot*[151] because Brongersma did not have a psychiatric disorder, was *"a very gifted man who saw no further opportunity to exercise his capacities, and also apparently wanted to exercise control over his suffering."*

The Court of Appeal reversed the District Court finding. It ruled that relieving suffering that does not have a medical cause is not part of the professional duty of a doctor. The appeal to the justification of necessity was rejected. Sutorious was found guilty but the court exercised its discretion not to impose punishment. Sutorious appealed to the Supreme Court.

In December 2002, nine months after the *Termination of Life and Assisted Suicide (Review Provisions) Act* came into effect the Supreme Court upheld the decision of the Court of Appeal and found that a doctor who assists in suicide in a case in which the patient's suffering is not predominantly due to *"medically classified disease or disorder"*, but stems from the fact that *"life has become meaningless"*, acts outside the scope of his professional competence.[152]

Brongersma is significant in that it was heard simultaneously with debates in Parliament on the *Termination of Life and Assisted Suicide Bill.* Questions were raised as to whether the *Bill* before the House covered situations comparable to those in *Brongersma.* The Minister for Justice specifically stated that the *Bill's* provisions were not intended to cover such a case. This assurance, however, together with the court's finding did not end the uncertainty

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[150] District Court Haarlem, 30 October 2001, *no 15/035127-99; Tijdschrift voor Gezondheidsrecht 2001/21.*

[151] *Nederlandse Jurisprudentie 1994, no. 656.*

[152] *Nederlandse Jurisprudentie 2003, no 167.*

surrounding the concept of *disease.* It was obvious during the hearings, both at District Court level and in the Supreme Court that disease *per se* is open to more than one interpretation.[153]

The *Van der Wal* report[154] in 2003 defined the concept of *"tired of life"* as the situation in which the patient asks for assisted suicide in the absence of a serious physical or psychiatric disorder.[155] The survey found that while doctors frequently receive requests from patients claiming to be *"tired of life"* they rarely regard them as sufficient reason to provide the assistance requested.[156] This, however, would appear to be in stark contrast with the views of the public generally. The same survey indicated that **45%** of Dutch people thought that if elderly people so request they should be able to receive drugs to end their lives.[157]

In 2004, the Dijhuis Committee of the Royal Dutch Medical Association (KNMG) published a report on norms for doctors who are confronted with requests from patients for assistance with suicide on the basis that they are *"tired of life."*[158] The Report stressed the importance of the issue arising from the fact that, in its view, it was highly likely that such requests would increase with time.

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[153] *"The indistinctness of the criterion will mean....that doctors will have to make decisions not knowing exactly where the legal boundary lies, which may have an adverse influence on their willingness to report." Griffiths et al,* op.cit., fn.1, at 38. The Uit Vrije Wil group has launched a campaign to have access to assisted death on demand for people who have reached the age of 70 or over who feel that they are finished with life legalised. See Sutorious, Peters & Daniels *'Proof of Law', The Hague, Netherlands: Uit Vrije Wil http://sparta.projectie.com/~uitvrije/index.php?id=1006 accessed December, 2012; 'Tired of Life Group calls for assisted suicide',* Dutch News, 31 January, 2011.

[154] *Medische besluitvorning aan het einde van het leven: de praktijk en de toesings procedure euthanasia en het Verslag van de begeleidingcommissie van het evaluatieonalerzoek naar de medische besluiting aan het einde van het leven* [*Medical Decision Making at the End of Life: Medical Practice and the Assessment Procedure for Euthanasia*], *Utrecht, de Tijdstroom, 2003.*

[155] GPs were asked to describe the situation of one such patient. The characteristics were: *"high age (78) and lack of a partner. Three-quarters of the patients suffered from one or more diagnosed disorders arising from cancer or heart problems, visual impairment, hardness of hearing, arthrosis and depression", at 104. Brongersma* was not the first occasion on which the issue of *'tired of life'* had been addressed in public. The former Supreme Court Judge Drion had argued, in an article published extra-curially in 1991, that very old single people who are *"finished with life"* should have the right to receive lethal drugs from their physician. See Drion, H, *'Het zelfgewilde einde van oude mensen',* NRC-Handelsblad (19 October, 1991). A request by the Dutch Association for Voluntary Euthanasia to carry out an experiment to establish whether making a *"last-will-pill"* available to elderly people seeking an early death could be done safely was rejected by the inter-party agreement on which the 2007 Coalition Government was formed. This stated categorically that no permission for such an experiment would be forthcoming during its term in office. See *Coalition Agreement, 7 February, 2007, at 42.*

[156] Ibid., *at 107.*

[157] Ibid.

[158] *Norms for the behaviour of Doctors in the case of Requests for Assistance in Suicide due to Suffering from Continued Life: Report of the Dijhuis Committee, Utrecht, KNMG, 2004. http://srtsennet.nl/Publicaties/KNMGPublicatie/Op-zoek-naar-normen-joor-het-leven-rapport-Commissie-Dijhuis-2004.htm*

In summary, the Dijhuis Committee's opinion was that such assistance should be deemed lawful because of *"the unbearable and hopeless suffering involved."* The source of such suffering, however, was not deemed to be decisive: *"people without classifiable diseases can suffer unbearably and hopelessly."* The demarcation identified by the Supreme Court in *Brongersma* did not assist in the solution to the practical problem faced by a doctor given *"the possibility of suffering without disease and of diseases without suffering."*[159]

The Committee also expressed the view that doctors, especially GPs and nursing home doctors, can be experts with respect to existential suffering at the end of life.[160]

The Board of the Royal Dutch Medical Association has not as yet expressed a view either way as to the recommendations of the Dijhuis Committee other than to state that the issue is a complex one and requires a careful approach. The Minister for Justice promised to follow *"closely"*[161] the discussion which the Medical Association hoped to engender among doctors generally on the subject. However, given the influence of the Royal Dutch Medical Association (KNMG) in the past and the role which it played in the identification and endorsement of *"due care requirements"* which, when observed by doctors, to the satisfaction of Regional Review Committees, obviate criminal proceedings, it would not be surprising if the Dijhuis recommendations were to be incorporated eventually into the existing schedule of condoned practices of euthanasia.

In conclusion, therefore, it is clear that in the Netherlands the defence of *'necessity'* is available to doctors faced with a *"conflict of duties" (Schoonheim)*; that *"help in dying"* is, in principle, available to patients, albeit in extraordinary circumstances (*Van Oijen*); that *"palliative sedation"* is considered to be *"normal medical practice"* and not a form of *"termination of life"* (*Vencken*); that assistance with suicide is legally justifiable in the absence of *"somatic"* indices and that mental distress can amount to *"unbearable suffering"* (*Chabot*) and that while the condition of being *"tired of life"* does not justify assistance by a doctor with suicide (*Brongersma*), nonetheless the jury is out on the issue given the views expressed by the Royal Dutch Medical Association (KNMG).

The developments prior to the formal legalisation of euthanasia and assisted suicide in the 2002 Act demonstrate clearly that far from being matters which were decided upon within a short timeframe - the fourteen month window between February 2000 and April 2001 when

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[159] Ibid, at 21.

[160] The Committee described such suffering as *"suffering from the prospect of having to go on living in a situation of no or very little quality of life, which results in a persistent desire to die, while the absence of quality of life is not or not preponderantly caused by a physical or mental disorder."* Ibid., at 15

[161] Second Chamber of Parliament 2004-2005, Appendix, no 909.

the matter was debated in Parliament – the process, in reality, was more the culmination of an orchestrated series of separate undertakings by official national entities and representative bodies which, when combined, eventuated in a consensual approach which led to the statutory provisions now governing the legal practice and performance by a doctor of acts which, in all other circumstances, continue to be criminal offences.

Public Opinion Surveys:

The results of various public opinion surveys conducted in the Netherlands over some 50 years merit brief mention. Any evaluation of the findings of these surveys must necessarily be accompanied by a health warning arising from the varying definitions of *euthanasia* on which they are based. The underlying concept of euthanasia contained in the questions is either inadequately defined or is poorly distinguished from other medical behaviour that has the potential to shorten life. Notwithstanding such difficulties, however, it is evident that, since 1950, when the first recorded surveys were conducted, particularly those undertaken by the *Social and Cultural Planning Bureau (SCP)*[162], there has been a gradual but clearly discernible increase in the number of people in favour of euthanasia, understood as euthanasia voluntarily requested.

In response to the question *"Should a doctor give a lethal injection at the request of a patient to put an end to his suffering?"* asked in regular SCP surveys between 1966 and 2004, the range was **40%** to **51%**.[163] Younger people were slightly more positive than older people. There did not appear to be a difference of any consequence between the opinions of men and women. Supporters of the non-confessional (social-democratic and liberal) parties were strongly positive, whereas a majority among Christian Democrats only emerged in the mid-1980s. A majority of persons who claimed no religious affiliation were already supportive in 1966 and remained the most supportive grouping. A majority of Catholics were opposed in 1966 but by 1991 they were essentially indistinguishable from the rest of the population.

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[162] Sociaal en Cultureel Planbureau [Social and Cultural Planning Bureau]:
1992 Sociaal en cultureel rapport 1992 [Social and Cultural Report 1992], The Hague, VUGA.
1996 Sociaal en cultureel rapport 2000. Nederland in Europa [Social and Cultural Report 1996.The Netherlands in Europe], The Hague, Staatssuitgeverij
2000 Sociaal en cultureel rapport 2000. Nederland in Europa [Social and Cultural Report 2000. The Netherlands in Europe], The Hague, Sociaal en Cultureel Planbureau.
2002 Sociaal en cultureel rapport 2002 De kwaliteit van de quartaire sector [Social and Cultural Report 2002. The Quality of Public Service], The Hague, Sociaal en Cultureel Planbureau.
2004 Sociaal en cultureel rapport 2004. In het zicht van de toekonst [Social and Cultural Report 2004. In sight of the Future], The Hague, Sociaal en Cultureel Planbureau.

[163] See Van der Wal, *'Medical Decision Making at the End of Life: Medical Practice and the Assessment Procedure for Euthanasia'*, Utrecht, de Tijdstroom, 2003.

Members of the Dutch Reformed religion were slightly less supportive than the general population and the stricter Calvinists were least supportive of all.[164]

The SCP has contextualised public opinion surveys within the process of cultural diffusion that took place in Dutch society between the 1960s and the 1990s.[165] Up until the middle to late 1960s values throughout the country were *"traditional"* in respect of issues such as marriage, sexuality, womens' rights, homosexuality, abortion, euthanasia and political protest. In 1970, legislation was enacted legalising the free sale of contraceptives; the crime of adultery was repealed in 1971, as was a restrictive provision on homosexuality. The *volte-face* in 1971 by the Royal Dutch Medical Association's opposition to abortion – by the invocation of the medical exception rubric - meant, for all practical purposes, that enforcement of the ban on abortion was no longer feasible.[166]

In the *Bureau's* opinion any difference of view *vis-a-vis* euthanasia between urban and rural areas had dissipated by the beginning of the 1990s and it appears that there is now little, if any, remaining difference between these populations on the matter.[167]

In 1996, the results of a new and comprehensive study of Dutch public opinion was published which, in general, confirmed the findings of earlier polls.[168] It found that in 1995 about **10%** of the public were of the opinion that euthanasia should *"always be forbidden"*, whereas **64%** considered that it should *"always be allowed"*, if requested by the patient. Some **80%** of those who answered this question said that the doctor in the case described in the

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[164] See van der Maas et al, *'Changes in Dutch Opinions on Active Euthanasia, 1966 through 1991'*, Journal of the American Medical Association 273: 1411-14.

[165] Social and Cultural Planning Report 1996: 516-25. Griffiths Boon & Weyers have described this cultural diffusion well: *"Two kinds of change played an important role in getting euthanasia on to the agenda for public debate: a cultural change and a change in medical technology. The Cultural change can be characterised with the words secularisation, individualisation, and democratisation. The medical-technological change greatly increased the doctor's ability to postpone death and had as a consequence that the medical imperatives 'do whatever is possible' and 'relieve suffering' no longer always went hand in hand. The ethical questions to which this technological development gave rise on the one hand, and the greater cultural emphasis on personal autonomy on the other hand, helped create the space on the public agenda within which debate on the patient's role in determining the time and manner of his death could take place."* Op.cit., fn.4 supra, at 49.

[166] Not all doctors in the Netherlands agreed with this. A group of doctors who opposed the Association's views founded the Dutch Association of Physicians (NAV), a *'pro-life'* organisation, in 1973.

[167] Social and Cultural Planning Report 1996: 516-25. See fn.162 supra.

[168] Van Holsteyn & Trappenburg, *'The Last Judgement: Public Opinion concerning New Forms of Euthanasia'*, Baarn, Ambo, 1996. A summary of this study is available in English in Van Holsteyn & Trappenburg, *'Citizens' Opinions on New Forms of Euthanasia. A Report from the Netherlands'*, Patient Education and Counselling 35: 63-74.

questionnaire (based on the TV documentary film *'Death on Request'* broadcast in October, 1994) had done the right thing. The film had recorded an actual case of euthanasia.[169]

One of the particularly valuable attributes of this study is its analysis of the reasons provided by the respondents for their opinions. These tended to correlate most strongly with a person's attitude toward personal autonomy. In general, those who believe autonomy is important were much more likely to support the various medical behaviours with the potential to shorten life, even in a case where the patient's autonomy had to be exercised by a family member or a parent. Attitudes toward the principle of beneficence were of some, but not major, importance. Weekly church attendance was associated with opposition to the various medical behaviours that potentially shorten life outlined in the questionnaire but it was also very strongly associated with a person's attitude towards autonomy (**4%** of those who never had a religious affiliation rejected the notion of personal autonomy, compared the **66%** of those who regularly attended church). The authors stated that the autonomy effect remained even when religious affiliation was held constant.[170]

5. Regulation & Control Mechanisms

Of crucial importance to the Dutch system of control of the practice and performance of euthanasia is the self-reporting procedure by doctors. Following the enactment of the 2002 *Act* a new subsection was added to Article 293 which provides that the termination of the life of another person by a doctor, at that person's express and earnest request *"shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Provisions) Act,* ***and if the physician notifies the municipal pathologist of*** **this** ***act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act."*** [171]

Beginning at a local level in 1985, and at a national level from 1990, and in consultation with the Royal Dutch Medical Association (KNMG) from 1998 inwards, the Procurators General had established a special procedure for investigating cases in which a doctor reports a non-natural death. This system was meant to encourage doctors to report their performance of

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[169] A 1998 poll indicated that **92%** support the practice of euthanasia in general. *See 'Dutch Might Legalise Euthanasia',* Associated Press, 12 July, 1999.

[170] Van Holsteyn & Trappenburg's research indicates that, in general, Dutch public opinion is quite close to Dutch law, except with regard to the legal right of parents to request withholding of life-prolonging treatment from a baby with Downs syndrome (public opinion seems to be against this) and the *'right'* of elderly persons who are *'tired of life'* to receive pills from their doctor with which they can commit suicide at a time of their own choosing (public opinion would support such a *'right'*).

[171] Author's emphasis.

euthanasia, thus enabling the authorities to assess both the incidence of, and the circumstances in which, euthanasia took place.

Central to this system of control were the Regional Review Committees.[172] Following their establishment doctors were no longer compelled to report directly to the prosecutorial authorities. The Committees acted as an intermediate contact – a buffer - between the doctors and the prosecutors. Initially, this new procedure entailed all cases of euthanasia being reported to the appropriate geographic prosecutor by the Committees. However, this has now been changed. The Committees, on their own authority, are empowered to assess whether a doctor has fulfilled the *"requirements of due care"*[173] and unless he has been found not to have done so the case will not be referred to a prosecutor.[174]

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[172] There are five Regional Committees: 1. Groningen, Friesland and Drenthe. 2. Overijssel, Gelderland, Utrecht and Flevoland. 3. North Holland. 4. South Holland and Zeeland. 5. North Brabant and Limburg. At the request of the Ministry of Health, Welfare and Sport, a third evaluation of the *Evaluation of Termination of Life on Request and Assisted Suicide [Review Procedures] Act* covering the years 2007 to 2011 was scheduled for 2011 and 2012. The evaluation will include a critical examination and analysis of the Committees' findings and interviews with Committee members and secretariat staff. The results of this evaluation have not yet been published.

[173] The approach adopted by the Review Committees to an evaluation as to whether the *"requirements of due"* care have been complied with is exemplified in the statement contained in the *2011 Annual Report*: "*In assessing compliance with the due medical care criterion, the committees carefully consider the current standard in medical and pharmaceutical research and practice, normally taking their guide the method, substance and dosage recommended by the Pharmacy Research Institute (WINAP) of the Royal Dutch Medical Association for the Advancement of Pharmacy (KNMP). The Institute's Standaard Euthanatica, tocpassing en bereiding 2007 (Standaard Euthanatica 2007) also states which substances – and dosages – the KNMP does or does not recommend for use in cases of termination of life on request or assisted suicide. In 2008, the Committees drew attention to Standaard Euthanatica 2007 and announce that they would continue to take it as their guide in the journal Medisch Contact (Medisch Contact no 47, 20 November 2008).*

The Committees note that, while the vast majority of attending physicians followed Standaard Euthanatica 2007 in 2011, they were also confronted with poor availability of thiopental, the recommended first-choice coma-inducing substance. In December, 2010, the KNMP and the KNMG therefore published a supplement to Standaard Euthanatica 2007, listing alternatives for thiopental, additional to the second-choice substances on page 26 of Standaard Euthanatica 2007.

Nevertheless the committees in 2011 again came across the use of substances not recommended in Standaard Euthanatica 2007 (or its supplement), and notifications in which the dosage was not specified or was not in accordance with the recommendations in Standaard Euthanatica 2007 or it supplement. In these cases the committees asked the physician to explain why the recommendations were not followed. Unfortunately, they note that not all physicians were able to give adequate reasons. In ***three*** *cases this year, the committee found that the attending physician had not complied with the due medical care criterion. In two cases (cases 18 & 19) the dosage of coma-inducing drug adminiustered to the patient was only half that recommended in the Standaard Euthanatica 2007. In all three cases, the attending physicians failed to check whether the patient was in a sufficiently deep coma before administering the muscle relaxant. The physicians concerned thus took the risk that their patients would experience a feeling of asphyxiation shortly before death, a possibility that must be avoided at all time.*" www.euthanasiecommissie.nl/RTEJV2011.ENGELS.DEF_tcm52-33587.PDF accessed September, 2012.

[174] If, in the judgement of the relevant Committee, a reported case of euthanasia meets the statutory requirements laid down in Chapter II, Article 2 of the 2002 Act, that is conclusive.

In summary, therefore, the 2002 Act, not alone codified the legalisation of *euthanasia,* but it also statutorily established the Regional Review Committees as the final arbiter of *"careful euthanasia"* practice by doctors. In cases where it is found that the doctor was *"not careful"* the matter is brought to the attention of both the prosecutorial authorities and the Medical Inspectorate. The prosecutorial authorities decide whether further action is required and the Medical Inspectorate makes a judgment as to whether there is a need for disciplinary measures.[175]

In 2003, the Committee of the Procurators-General issued guidelines in respect of prosecutorial decision-making in the light of the 2002 Act.[176] A revised set of guidelines was issued in 2007.[177] The prosecutorial authorities will become involved only in circumstances where the Regional Review Committees decide that they do not have jurisdiction in a particular case or where they find that the doctor was *"not careful."* In assessing whether the doctor was *"not careful"* the Review Committees distinguish between the **substantive** requirements (*"unbearable suffering and voluntary request")* and the **procedural** requirements.[178] Prosecution in principle would be indicated if a Committee found that the suffering was not *"unbearable"* and that there was a possibility of improvement, or if it was unable to determine that either was the case because of the doctor's failure to consult another doctor or to keep proper records. Similarly, prosecution in principle would be

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[175] While some **3500** or more cases of euthanasia are reported by doctors to the Regional Review Committees each year (there were **3,695** notifications of terminations of life in **2011**, of which **3446** were cases of euthanasia and **196** of assisted suicide) prosecutions are extremely rare. The actions of the doctors are usually deemed to have been *'careful'.* The miniscule number of prosecutions that have occurred since the establishment of the *Committees* are of *non-reported* cases that come to the attention of the prosecutors other than through official channels. This situation is in stark contrast to that which obtained in the fifteen years between 1981 and 1995, for example, when criminal charges were brought against some **30** individuals out of some **7000** cases that came to the attention of the prosecutors. These cases included euthanasia and termination of life **without** an explicit request. In the period 1981 to 1995 prosecutors dealt with over **6000** cases, **120** of which were given full consideration by the Committee of Procurators General, resulting in **11** indictments involving **13** doctors.

[176] *Aanwijzing vervolgingsbeslissing inzake actieve levensbeendiging op verzoek (euthanasia en hulp bij zelfdoding): Staatscourant 2003, no. 248, p.19 (23 December 2003).*

[177] *Staatscourant 2007, no. 46, p.14 (6 March 2007).* The differences between the 2003 guidelines and those of 2007 are marginal.

[178] In principle the justification of '*necessity*' is applicable in cases where only procedural requirements are in issue. Articles 293 and 294 as amended by the 2002 Act provide that the behaviour otherwise prohibited does not constitute an offence *"if it is committed by a physician."* It does not specify that the doctor be the doctor responsible for treatment. Prior to the Act it was generally supposed that euthanasia must be carried out by the doctor responsible for the patient's treatment. In their 2005 Annual Report the Regional Review Committees adopted the view that what is decisive is whether *"the doctor had such a relationship with the patient as to permit him to form a judgment concerning the requirements of due care".*

indicated if the doctor was found to be *not careful* because the patient's request was not *"voluntary and well-considered."*[179]

Permission for a funeral or a cremation is contingent on the doctor responsible filing a death certificate in which it is stated that the death occurred as a result a natural cause. If the doctor reports the case as a non-natural one, in other words a case of *euthanasia*, the municipal pathologist sends the file to the appropriate Regional Review Committee. Filing a certificate of natural death in circumstances where an act of euthanasia has been performed is a distinct criminal offence.[180]

The role of the Regional Review Committees, therefore, is of fundamental importance in the regulation and control of euthanasia. Of the five sections contained in the *Termination of Life on Request and Assisted Suicide (Review Provisions) Act, 2002,* two are devoted entirely to the establishment, composition and appointment of the Committees, and their powers.[181]

There are indications in their Annual Reports that the Committees have begun to adopt a flexible approach when determining whether a doctor's behaviour has totally conformed with the legal requirements. Even in circumstances where there is evidence that not all the relevant criteria have been observed there can be a finding, on balance, of *"careful"* practice.

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[179] However, in circumstances where the doctor was found *"not careful"* because of a failure to consult another independent doctor but the act of euthanasia was otherwise carried out properly, prosecution would not be indicated. Where a doctor fails to report but can show that he/she fulfilled the legal requirements, prosecution may be considered for such failure (which is a distinct offence under the *Criminal Code*), or for a minor offence under the *Law on Burial and Cremation*. The failure to report gives rise to a presumption of guilt and it behoves the doctor to show that he/she fulfilled the statutory requirements or was in a situation of necessity.

[180] Article 228(1) of the Criminal Code. While there have been a number of prosecutions under this article they are rare. In 1987 the Supreme Court rejected a submission that the justification of necessity applied to a violation of this article, *see Tijdschrift voor Gezondheidsrecht 1988, no. 13.*

[181] In the 2011 Report www.euthanasiecommissie.nl/RTREJV2011.ENGELS.DEF_tcm52-33587.PDF accessed September, 2012, the Committees state, **first**, that they have adopted a new procedure, within the framework of the 2002 Act, for processing notifications of acts of assisted death. An experienced member of the secretariat of the Commission will, henceforth, decide whether the due care criteria have been complied with. *"This assessment will be based on the Committees' long experience in reviewing notifications of euthanasia."* The Committees estimate that some **80%** of all notifications will be processed in this way in the future. The Committees have decided that documentation concerning straightforward notifications will be sent electronically to three Committee members (a lawyer, a doctor and an ethicist) for assessment. If all three confirm that the notification is a straightforward case, which means that they have no further questions and the due care criteria have been complied with, the findings on the notification can be finalised. However, even if just one committee member has questions with regard to the notification, the file will be sent to all committee members for plenary discussion at a monthly meeting. **Second,** in an effort to reduce the backlog of work – an indication of the rapid increase in the number of reported cases of euthanasia over the past ten years –an extra three alternate members will be appointed in 2012 to each regional committee, bring the total membership to nine.

Only a very small number of cases are found to be *"not careful"*.[182] While all *'not careful'* cases are automatically referred to the Procurators-General and to the Medical Inspectorate the latter body does not take any disciplinary proceedings against a doctor, or the institution in which the act of euthanasia was performed, unless the case is referred to it directly by the Procurators-General.

It is unquestionable that the Regional Review Committees have proved to be of enormous importance not only as a mechanism of legal control, but also from the point of view of legal information. Dispassionately appraised there is no evidence of a *Potemkin village* syndrome[183] in their operations. In fact, quite the contrary would appear to be the case. Their Annual Reports indicate a willingness to provide the maximum information in respect of each case investigated and notwithstanding their liberal interpretation of the *"requirements of due care"* in specific instances, and their current nuanced approach to the interpretation of *"unbearable suffering"* which may yet eventuate in a more benign official attitude towards the concept of a *"dignified death"*, to a great extent they have disarmed critics of the control regimen of the practice of euthanasia in the Netherlands.[184]

The range of sanctions available to the Committees extends beyond the bland language employed in the 2002 Act. In a situation in which it is found that a doctor has been less than diligent with regard to the reporting requirements he can be asked for further information and/or called for interview by the relevant Committee. There have been recorded instances where a Committee, while finding the doctor's behaviour *"careful"* nonetheless point to deficiencies in the actual performance of the act of euthanasia itself. There have been instances also where a Committee refers such cases to the Medical Inspector. Similarly, and more seriously, a doctor, found to be acting *"in good conscience"* can be found *"not careful"* as a result of a purely technical violation. Committees have been known to instigate a review of procedures at particular institutions where euthanasia has taken place and where the

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[182] In the period 1999-2006 there were **25** cases, representing **2** instances out of every **1000** cases reported. Of the **15,832** cases reported in the same period, **32** were deemed not to fall within the purview of the responsible for treatment. Prior to the *Act* it was generally supposed that euthanasia must be carried out by the doctor responsible for the patient's treatment. In their *2005 Annual Report* the *Regional Review Committees* adopted the view that what is decisive is whether *"the doctor had such a relationship with the patient as to permit him to form a judgment concerning the requirements of due care".*

[183] See quotation from Callahan, D, at beginning of this chapter.

[184] See Haverkate, Onwuteaka-Philipsen , van der Heide et al, *'Refused and Granted Requests for Euthanasia and Assisted Suicide in the Netherlands: Interview Study with Structured Questionnaire', (2000)* 321 British Medical Journal 856; van der Weide, Onwuteaka-Philipsen, & van der Wal, *'Granted, Undecided, Withdrawn and Refused Requests for Euthanasia and Physician-Assisted Suicide',* (2005) 165 (15) Archives of Internal Medicine 1698-1704.

Committees consider that improvements are required.[185] Their Annual Reports indicate that the two aspects of reported cases which most often give rise to difficulties relate first, to the nature and timing of the consultation with another doctor and *second,* whether the patient's suffering was *"unbearable".* The latter issue arises most often in situations involving comatose patients. In cases where special attention is deemed necessary a conclusion that the doctor was *"careful"* is invariably found.[186]

There is a strong view in the Netherlands that the requirement for doctors to report participation in non-natural deaths is of itself a form of prospective control. That this is the case is evidenced in the greatly increased incidence of reporting by doctors and the infrequency of *"not careful"* findings by the Regional Review Committees. Similarly, the growing use of **SCEN**[187] consultants appears to be not only a form of control in advance but also functions as an institutional means of transmitting relevant information to doctors, adding to a variety of other institutionalised (e.g. hospital protocols) and non-institutionalised (e.g. professional journals) ways in which they are kept informed.

However, even the most ardent supporter of the practice of euthanasia in the Netherlands cannot discount the empirical findings of the national surveys conducted between **1990** and **2005** in respect of both the incidence and the types of euthanasia practised. Before these surveys were undertaken the available information on euthanasia was fragmented, often impressionistic and anecdotal, and of unclear general validity.

The Remmelink Commission had reported that in **1990** there were some **130,000** deaths resulting from all causes. Of these **49,000** involved *'a medical decision concerning the end of life'* - the term devised by the Commission to include *"all decisions by physicians concerning courses of action aimed at hastening the end of life of the patient or courses* of *action for which the physician takes into account the probability that the end of life of the patient is hastened."* Voluntary active euthanasia occurred in about **1.8%** of all deaths, or about **2,300**

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[185] In their 2004 Annual Report the Committees referred to a particular case, *Case 15*, where there was a frequent use of morphine. This was brought to the attention of the Medical Inspectorate. The prosecutors decided not to prosecute but a Medical Disciplinary Tribunal reprimanded the doctor involved. In their 2005 Report they drew attention to an inadequate euthanasia protocol in a specific hospital. No prosecutions followed but the Medical Inspector requested the hospital to change its protocol. Again in *2005* there was a finding of *'careful'* practice despite the use of inappropriate drugs. The particular *Committee* requested the hospital to revise internal guidelines in respect of the use of morphine. Inappropriate administration of drugs continues to be a problem. See 2011 Regional Review Committee Report http://www.euthanasiwecommissie.nl/RTEJV2011.ENGELS.DEF_cm52-33587 accessed 29 September, 2012. See fn.173 supra

[186] Of the **15** *"not careful"* judgments in the period 2003-2005, **11** related to acts of euthanasia and **4** to assistance in suicide. In **2** of the **4** cases of assisted suicide the reason for the *'not careful'* judgment was that the doctor had not been present at the time of the suicide.

[187] See p.68 supra. See also fn.67 supra.

cases, and there were about **400** cases of physician assisted suicide, about **0.3%** of **all** deaths.[188]

More than half of the physicians who were regularly involved with terminal patients had performed either voluntary active euthanasia or had provided assistance with suicide. Only **12%** of doctors said that they would never do so.

The Commission also found that intentional hastening of death, either by act or by omission, with or without a request by the patient, occurred in some **1000** cases, or **0.8%** of **all** deaths. Significantly, these deaths were additional to those found in respect of voluntary active euthanasia. [189]

6. Medical behaviour contextualisation

The Dutch understanding of euthanasia requires contextualisation within the totality of medical behaviour in that jurisdiction which has the potential to bring about earlier than natural death. Medical behaviour that potentially shortens life in the Netherlands consists of a variety of legal procedures encompassed in the general descriptions *'normal medical behaviour'* and *'termination of life'*.

- *Normal medical behaviour* includes the following procedures:

(i) a doctor acceding to a patient's refusal of treatment. The legitimating principle underpinning this particular action is that of patient autonomy and the judicially endorsed right of a person, even where death is the foreseen outcome, to refuse either the commencement of a specific treatment or its discontinuance. To ensure the legality of such

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[188] Op.cit., fn.103 supra, at 179.

[189] It is interesting to note that in the Regional Review Committees Annual Report **2011** <http://www.euthanasiecommissie.nl/RTEJV2011.ENGELS.DEF_cm52-33587> accessed 29 September, 2012, there were **3695** reported cases of assisted death (compared to **3136** in 2010). There had been **2636** cases in **2009.** Of the **3695** cases reported in **2011**, **3446** were of euthanasia, **196** were physician-assisted suicide and **53** were a combination of both. **2797** of the cases involved cancer. Other conditions included cardiovascular disease (**114**); neurological disorders (**205**); other conditions (**394**); and a combination of conditions (**185**).In the majority of cases (**2975**), patients died at home. The remainder died either in hospital (**189**), nursing homes (**111**), care home (**172**), or elsewhere (e.g., a relative's home or a hospice, **248**). In **3329** cases the attending doctor was a general practitioner, in **212** cases a specialist working in a hospital, in **139** cases a geriatrician and in **15** cases a registrar. In all cases the Committee deemed itself competent to deal with the notification. There were **4** cases in which the physician was found not to have acted in accordance with due care. The average time that elapsed between the notification being received and the committee's findings being sent to the doctor was **111** days. See **Appendix 1.**

action by a doctor the person's consent, either competently given at the time of the recommended treatment or by way of a prior directive, is required.[190]

(ii) the withholding or the withdrawal of life-prolonging treatment which is considered futile; and the administration of pain-relief that has a life-shortening effect. The legitimating principle in the first of these is non-maleficence and beneficence in the latter. Both of these actions are legally endorsed as *'medical exceptions'.*

In short, normal medical practice is the behaviour of doctors that falls within the medical exception rubric. This allows the death which results from such behaviour to be reported as a natural one. No criminal law consequences attach to procedures considered to be *normal medical practice*.

- *Termination of life* includes two kinds - voluntary and non-voluntary.

The specific categories encompassed by the voluntary termination of life include euthanasia and physician-assisted suicide. The legitimating principles in both are beneficence and autonomy, and both are deemed legal based on the justificatory principle of *'necessity'*.

Non-voluntary termination of life refers solely to the termination of life without an explicit request. In those circumstances where it is deemed legitimate it is based on the principle of beneficence and is justified by *'necessity'*.[191]

The term *'termination of life'* refers to behaviour that

- (i) causes the death of a patient;
- (ii) is intentional, that is done with knowledge and acceptance of the foreseeable lethal effect;
- (iii) involves the administration of a drug in a dosage which is not medically indicated to relieve the patient's suffering or symptoms, or for which there is a medically responsible alternative, or
- (iv) involves withholding or withdrawing treatment that is not medically futile and has not been refused by the patient or his representative.

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[190] Article 450(i) of the *Law on Contracts for Medical Care* specifically requires informed consent

[191] *Prins,Nederlandse Jurisprudentie 1995, no.602; Kadijk, Tijdschrift voor Gezondheidsrecht 1996; Van Oijen, Nederlandse Jurisprudentie 2005, no.217.*

In summary, therefore,

- (i) A doctor is obliged to comply with the wishes of a patient who refuses life-prolonging treatment; in a situation where the patient is non-competent at the time the treatment is due to be administered but who, when competent, completed an advance care directive in which he expressed his refusal of such treatment, the doctor is also obliged to comply;
- (ii) the withholding or withdrawing of futile medical treatment and the administration of doses of pain relief despite the fact that this may hasten the death of the patient are both considered to be normal medical practice. They fall within the category known as the medical exception. This latter allows doctors to perform acts which if performed by others would be criminal offences;
- *(iii)* when performed by a doctor, and at the explicit request of the patient, termination of life is legal. In all other instances such action is either murder or manslaughter. Termination of life without an explicit request does not fall under the medical exception criterion; neither is it covered by Article 293 of the Criminal Code.

In *Prins,*[192] and Kadijk,[193] cases involving severely defective new-borns, the District Court rejected the defences of absence of substantial violation of the law and of necessity but nonetheless held that active termination of life without an explicit request can be justifiable if certain *"requirements"* are fulfilled. These decisions were upheld by the Amsterdam Court of Appeals. The *"requirements"* specified were:

- *"(i) unbearable and hopeless suffering on the part of the baby,*
- *(ii) the decision to terminate and the method used satisfied the requirements of careful practice;*
- *(iii) the doctor's behaviour was consistent with scientifically sound medical judgment and the norms of medical ethics and the termination had taken place at the express, and*
- *(iv) repeated request of the parents as the legal representatives of the new-born baby."* [194]

The later decision by the Dutch Supreme Court in *Van Oijen* case[195]also found that termination of life in the absence of a request can be legally justifiable albeit in narrowly-defined circumstances. In that case however the doctor was convicted of murder.

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[192] *Nederlands Jurisprudentie 1995, No.602; 1996. No.113.*
[193] *Tijdschrift voor Gezondheidsrecht 1996, No.35.*
[194] *Nederlandse Jurisprudentie 1995, no. 602: 2878.*
[195] *Nederlandse Jurisprudentie 2005, no.217.*

In the national surveys which were conducted into the practice of euthanasia in the years **1990, 1995, 2001** and **2005** it was found that normal medical practice that is expected to shorten a patient's life consists almost entirely either of withholding or withdrawing life-prolonging treatment or of the administration of life-shortening doses of pain relief.[196] In Dutch law it is a violation of the professional standard for a doctor to administer treatment that is medically futile.[197] Treatment is considered medically futile at Dutch law if it has no chance of success[198] or if it cannot succeed in restoring the patient to a *"minimum level [of functioning]."*[199]

When medically indicated for the relief of pain or other symptoms a doctor in the Netherlands, as elsewhere, may administer drugs even in circumstances where such treatment is expected to shorten the life of the patient. In the Netherlands, however, the legitimation of such behaviour is contingent on the fact that pain relief is medically indicated and not, as is the case in other jurisdictions, on the distinction, required by the doctrine of double effect,[200] between primary and secondary subjective intentions of the doctor.

This was the position adopted by the State Commission on Euthanasia in its Report[201] in 1985, implying that such behaviour falls within the *'medical exception'*. In its guidelines published in 2003 the Royal Dutch Medical Association (KNMG)highlighted that *"the nature and amount of the doses given be justifiable in terms of necessary pain or symptom relief...If doses are knowingly given that cannot be [so justified]...then the purpose of the behaviour is apparently....to hasten death. A critical line is thereby crossed and the behaviour must be considered euthanasia, with all resulting consequences."*[202]

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[196] A summary in English of the data from the 1990, 1995 and 2001 surveys is available in Onwuteaka-Philipsen, B et al, *'Euthanasia and other End-of-Life Decisions in the Netherlands in 1990, 1995 and 2001'*, The Lancet 362: 395-9. A summary of the 2005 survey findings is available in van der Heide et al, *'End-of-life Practices in the Netherlands under the Euthanasia Act'*, New England Journal of Medicine 356: 1957-65.

[197] In guidelines published by the Royal Dutch Medical Association in 2003 refraining from *"futile"* treatment was described as a *"professional duty"*.

[198] The direct translation of *"kansloos medisch handelen"* is that it cannot *"contribute to solving the medical problem"*.

[199] A translation of *"zinloos medisch handelen"*.

[200] See fn.56 supra. See also fn.11, Chapter VI on England.

[201] See fn. 14 supra.

[202] Royal Dutch Medical Association Guidelines, 2003: 6: *Standpunt Feredatiebestuur KNMG inzake euthanasie 2003* http://lnmg.artsennet.nl access September 2012

In the Annual Report of the Regional Review Committees 2006 it was stated that *"death as a by-product of treatment that was necessary to relieve serious suffering"* falls within the *'medical exception'*.[203]

In conclusion, therefore, the duty to report a non-natural termination of life in the Netherlands is now contingent on an **objective** criterion, that is, whether there was a medical indication for the doctor's actions, such as the administration of pain relief, rather than on the doctor's **subjective** intention.[204]

7. The practical import of the 2002 legislation and issues in neonatology

There have been discernible indications of a significant change in both the interpretation, and the application, of the *"requirements of due care"* following the enactment of the 2002 legislation, and particularly since the establishment of the Regional Review Committees. The **subjective** intention of the doctor has been displaced by an **objective** medically indicated standard.

A number of nuanced indications merit specific attention in the context of fears of a further slide down the slippery slope.

One of the requisite *"due care requirements"* for a licit act of euthanasia listed in the 2002 *Act* was that the patient's suffering be *"unbearable"* and *"hopeless"*, in the sense that there was no reasonable alternative treatment possible in the particular circumstances.

From the outset, however, *"unbearable suffering"* was not interpreted solely in terms of physical pain.

As outlined earlier, the Supreme Court in *Schoonheim*[205] referred to an *"increasing loss of personal dignity"* and to the fear of not being able to die *"in a dignified manner"* as being legally justifiable grounds for euthanasia. After the decision in *Brongersma*[206] the Royal Dutch Medical Association (KNMG) responded by saying that the definition of *"unbearable suffering"* had been stretched too far and that *"what is new is that it goes beyond physical or*

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[203] Regional Review Committees Annual Report 2006: 9: available at http://www.toetsingcommissieeuthanasie.nl accessed September, 2012

[204] See Griffiths, Weyers & Adams, op.cit., fn.1 supra, at 140/141: *"The legal and ethical requirements applicable to a given case of end-of-life medical behaviour are....determined by 'objective' factors and the medical standard and not by a doctor's self-reported 'intentions'."*

[205] *Nederlandse Jurisprudentie 1985, no.106.*

[206] *Nederlandse Jurisprudentie 2003, no.167.*

psychiatric illness to include social decline".[207] The Justice Minister at the time said that being *"tired of life"* was not a sufficient reason for euthanasia.[208]

In their 2002 Annual Report the Regional Review Committees emphasised that a patient's suffering must be both *"unbearable"* **and** *"without prospect of improvement".*[209] Suffering that is *"unbearable"* is subjective. Suffering *"without prospect of improvement"* is a matter of medical expertise.[210] Naturally the *"unbearable"* character of the suffering will differ from patient to patient but it must be such as to be understandable to a doctor,[211] and it must be conscious.

The Committees adopt the view, however, that the requirement of *"unbearable* suffering" cannot be fulfilled if the patient is comatose and is therefore assumed not to experience suffering. Even though the patient may be comatose the *Committees* appear to accept physical indications of suffering such as groaning, blinking and difficulties with breathing. In a situation in which the patient's comatose state is considered to be potentially reversible the Committees have taken the view that since it would be inhumane to allow the patient to be wakened this can fulfil the requirement of *"unbearable suffering"* also.

It would seem, therefore, that the interpretation by the Committees of the notion of *"unbearable suffering"* is both flexible and generous even to the degree that the justification of *'necessity'* might be extended to include not only ***subjective*** suffering on the part of the patient but also an ***objective*** assessment by a doctor of the possibility of an *"undignified death".*

In *Van Oijen*[212] the Supreme Court affirmed a lower court's finding that since the patient was in a coma her suffering could not be considered *unbearable* and that she was so close to death that hastening it further was not necessary in order to put an end to appalling *"inhuman deterioration".* However, the Court did state that *"inhuman deterioration"* could be

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[207] *Standpunt Fereratiebestuur KNMG euthanasie2003 [Position of the Federal Board of KNMG concerning euthanasia 2003]*, Utrecht, KNMG available at http://knmg.artsennet.nl access September, 2012.

[208] See Sheldon,T, *"Dutch GP cleared after Helping to end man's 'Hopeless Existence'"*, British Medical Journal, Vol. 321 (November 11, 2000), at 1174.

[209] See Annual Report 2002: 23.

[210] *"Improvement"* refers to the patient's suffering, not to the underlying medical condition.

[211] There have been a number of cases in which this issue has been addressed by the Regional Review Committees' Annual Reports. In 2005 there were **21** cases where multiple forms of both somatic and non-somatic suffering were in evidence. The relevant *Review Committees* accepted the judgment of the doctor in each case that the patient's experience of unbearable suffering was understandable. In 2000, in the case of the suffering of a 97-year-old woman who had had a stroke which resulted in dependence on others and fear of re-occurrence, the Committee held that the suffering was not *"unbearable"*; however the prosecutors disagreed and no prosecution followed.

[212] See fn.141 supra

assessed **objectively** by a doctor. In other words, such deterioration is not dependent on the patient's awareness.

The significance of this finding can be appreciated in practical circumstances where, for example, the legitimate withholding or withdrawal of treatment does not result in the anticipated early and easy death of the patient. Does the doctor in such an instance make an objective assessment of the *"inhuman deterioration"* and act accordingly? This is an issue that has particular resonance in neonatology.[213]

This entire matter is one which is fraught with danger and provides oxygen for the argument that the Dutch experience is an existential example of an empirically certified and probative decline in both State and medical approaches to end-of-life matters notwithstanding the presence of apparently stringent regulatory control mechanisms.

In summary, suffering has never been narrowly interpreted in the approach to or the control of euthanasia in the Netherlands. The decisions in both *Schoonheim* and *Van Oijen* support the contention that the courts include the prospect of "*inhuman deterioration*", by which is meant, presumably, deterioration in the human condition which, by **objective** standards, is considered to be inhuman, albeit in circumstances where the patient himself is **subjectively** incapable of experiencing such suffering.

What is described as suffering in such circumstances is in fact inhuman and unbearable in the eyes of those who witness it, and because the requirements of due care specify *"unbearable suffering"* on the part of the patient to legitimise the act of euthanasia, this objective assessment meets the relevant criteria.

The fact that the Regional Review Committees have adopted this approach in their assessment of individual cases might indicate that the argument that a *slippery slope* has commenced in the Netherlands has greater traction than previously thought. Based on indications to date, *"it does not seem irresponsibly speculative to suggest that Dutch law is slowly but steadily moving in the direction of explicit recognition of a doctor's duty to ensure that his patient dies a 'humane' or 'dignified' (menswaaring) death as a distinct ground for the conflict of duties that lies at the basis of the justification of necessity."*[214]

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[213] See section on neonatology below.

[214] Griffiths, Weyers & Adams, op.cit., fn.1 supra, at fn. 418, p. 143. Griffiths relates that, in personal correspondence with him, G den Hartogh, who has written extensively on the issue of sedated death, *"argues that allowing 'help in dying' in such cases poses a real risk of a 'slippery slope'* (an argument about which he is generally sceptical) *because the criteria are rather vague, and there is no request from the patient (which would indicate that he himself regards as a 'loss of personal dignity' and a*

Neonatology

Under narrowly defined circumstances it is legal in the Netherlands to terminate the life of a severely defective new-born baby. Shortly after *Schoonheim* the Royal Dutch Medical Association (KNMG) appointed a Commission on the Acceptability of Medical Behaviour that Shortens Life (CAL) specifically to report and advise on the legitimacy of the termination of life in various categories in which the patient was either *"not competent"* or was *"not entirely competent"*.[215]

The Commission issued four interim reports in the period 1990-93. The first of these, in 1990,[216] was devoted specifically to severely defective new-born babies and, together with a report by the *Dutch Association for Paediatrics (NVK),*[217] published in 1992, formed the basis of subsequent legal developments in *statu nascendi*.

Because of technical advancements there were ever-increasing possibilities of keeping alive babies who might in other circumstances die. The *CAL* and *NVK* reports found that there was an increasing tendency on the part of paediatricians to depart from the principle *'in dubio abstine'* and to apply the contrary principle *'in dubio fac'*. If there was a chance that the baby might survive action was taken to keep him alive. If the baby did not die but the resulting condition was such that, on reflection, the intervention may not have been justified in the first instance, the doctor was then confronted with a choice between a continuation of the treatment begun or the application of the principle of *'in dubio abstine'* at that point.[218]

Crucial to the legitimacy of the termination of life in a situation in which the withdrawal of life-prolonging treatment has not resulted in the speedy death of the child and has left it is a situation of unacceptable suffering is what *CAL* refers to as the *"priority principle"*: termination of life takes place after – or as an extension of – a decision to let the baby die by

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'dignified death'. He seems thereby to overlook the possibility of drawing clear lines (other than a complete taboo) *that lend themselves to reasonably consistent and reviewable application, as well as of a degree of 'intersubjective' decision-making to reduce the risk of arbitrariness."*

[215] *Commissie Aanvaardbaarheid Levenbeeindingend Handelen [Commission on the Acceptability of Termination of Life of the Royal Dutch Medical Association].*

[216] *CAL 1 Zwaar-defecte pasgeborenen* [Severely Defective New-born babies], 1990.

[217] *Nederlande Vereniging voor Kindergeneeskund* [Dutch Association for Paediatrics]: *Doen of later? Grenzen van het handelen in de neonatologie [To act or to abstain? The limits of medical practice in Neonatology],* Utrecht, 1992.

[218] *"Only on the condition that an intervention with which one has begun (without the patient's consent) can later be stopped, is it possible to assure that it is not medical technology, but medical-ethical norms that have proved their value over the years ('in dubio abstine' and 'primum non nocere'), that define the character of medicine and....guarantee the well-being of the individual patient", see CAL Report 1991: 27[Landurig comatenze patienten].*

withholding or withdrawing treatment.[219] The guiding principle, according to the Dutch Health Council, is the *'future quality of life of the child,* ***as that will be experienced by the child itself'.***[220] The *CAL Report* refers to a decision being taken in such circumstances as being one *"primarily based on the expected physical and/or mental handicaps of the new-born baby and the limits that these should not exceed."*[221]

The discussion in neonatology, in essence, concerns the basic question as to whether and when a life-prolonging treatment may be discontinued. Refraining from treatment in the beginning is rare – notwithstanding the principle of *'in dubio abstine'*. Normally, all available technical possibilities are availed of in order to save the life of the baby. The reports recognised two reasons for abstaining from or discontinuing life-prolonging treatment: the prognosis that the baby *"has no real chance of survival"* and the prognosis that the baby has a *"limited chance of life worth living."* The concept of a life worth living is contextualised within specific categories of the child's ultimate level of functioning such as the possibility of communication (verbal and non-verbal); suffering *(*physical or otherwise*);* dependency on others; autonomy*;* and personal development.[222]

Both reports found that Dutch paediatricians were virtually unanimous in the view that refraining from further prolongation of life is legitimate if the baby's prospects of *"a liveable life"* are grim. There are some doubts, however, as to whether medical behaviour based on such a premise is legal. The preponderance of current opinion is that it is not.[223]

The role of parents in arriving at decisions where the prolongation or otherwise of the life of a child is in issue is one which is accorded significant respect but if circumstances arise, for example, where a parent's refusal of medical care is not in the best interest of the child Dutch law, as in other jurisdictions, allows for temporary assignment of custody to a guardian.

In 1995, murder charges were brought against two doctors who had terminated the lives of new-born babies they were treating.[224] They reported what they had done. In each case the baby was not expected to live long. After consultation with the parents in both instances *euthanatica* was administered to prevent the baby dying in an inhumane way. While the

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[219] When dealing with the issue of long-term coma CAL stated that since *"the death has already been accepted [when the decision to abstain from further life-prolonging treatment is made]....administration of drugs in a fatal dosage can be indicated ...as a form of help in dying."* See CAL 1 1990: 35. See fn. 215 supra.

[220] *Gezondheidsraad 2007, at 9. Author's emphasis.*

[221] CAL 1 Report 1990, at 17. See fn. 216 supra.

[222] CAL 1990: 15: See fn. 216 supra; VK: 31-32: see fn. 217 supra.

[223] For further discussion on this matter see Griffiths et al, op.cit., fn.1 at 226 et seq.

[224] The Prins and the Kadijk cases respectively. *Prins: Nederlandse Juruisorudentie 1995, no.602; 1996, no.113. Kadijk: Tijdschrift voor Gezondheidsrecht 1996, No. 35.*

prosecutorial authorities recommended against prosecution the Minister for Justice ordered that the two doctors be prosecuted for murder. It is thought that the underlying reason for this decision was to avail of the opportunity to achieve legal clarity. The doctors were acquitted by the District Court and the Courts of Appeals.

Decisions whether to prosecute in instances where the termination of the life of a new-born baby occurs are now taken as a result of the judicial reasoning adopted and followed in both these cases. While there has been no legislation in respect of the termination of life of a new-born baby, and in the absence of Supreme Court determinations, the law appears nonetheless to be clear:

"if the parents agree, termination of life can be justified if necessary to put an end to further suffering in the case of a severely defective new-born baby, where the decision has legitimately been taken to withdraw or not to administer essential life-prolonging treatment in order to let the baby die, but death (while inevitable) does not (or foreseeably will not) take place immediately. The doctor must conform to the applicable requirements of due care and report what he has done to the prosecutorial authorities."[225]

In 2004, a group of neonatologists and neurologists based at the University Medical Centre in Groningen produced a Protocol intended to guide the behaviour of doctors in cases of the termination of life of new-born babies.[226] Essentially, there was little that was new in this Protocol. Its novelty lay in the fact that a group of doctors had formulated specific requirements applicable to the circumstances obtaining in neonatology. Because it was the first occasion on which such specific requirements had been published, albeit for the guidance of doctors only, it gained a certain critical notoriety among commentators and the media. The truth, however, is that by and large, it followed the approach taken by both the *CAL* and *NVK* reports: termination of life is legitimate if, after *"a well-founded decision to withhold or withdraw treatment"*, the baby remains alive, is suffering severely and hopelessly, and there is nothing *"medically responsible"* that can be done. The Protocol advises that such deaths be reported as *"non-natural"* ones.

In 2005, the Dutch Association of Paediatrics (NVK) adopted the protocol for use throughout the country and the Government announced that it would take account of it when

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[225] *See Griffiths et al, op.cit., fn.1, at 228.*

[226] Beatrix Kinderkliniek, Academic Hospital Groningen: *'Protocol for Termination of Life in the case of New-borns with a Serious Disorder'*, 4th. Draft 29 September, 2004. English translation available in Verhagen & Sauer, *'The Groningen Protocol: Euthanasia in Severely Ill New-borns'*, New England Journal of Medicine 352: 959-62.

formulating a proposal for a special review procedure for cases of termination of life without a request.

In summary, therefore, termination of life (that is, administering drugs of a type or in amounts appropriate only for effecting the earlier death of the baby, including not only euthanatica but also drugs used for pain relief in doses higher than indicated for the relief of pain), is in principle murder, but in the case of a doctor can be justified under the following circumstances:

- (i) there must be a high level of certainty concerning the diagnosis and prognosis;
- (ii) a decision to withdraw or withhold treatment on which the baby is or will be dependent for continued life must have been arrived at legitimately;
- (iii) both parents, being fully informed, must agree;
- (iv) the baby's suffering must be unbearable and hopeless in the sense that it cannot be alleviated in some other, medically responsible, way;
- (v) the requirements of due care must be observed, including full discussion with the medical team, consultation with at least one independent doctor (or a sufficiently independent judgment of the members of the treatment team), and proper record-keeping, and
- (vi) the baby's death must be reported as a non-natural one.

Irreversible Coma and Persistent Vegetative State:

The second report of the Commission on the Acceptability of Medical Behaviour that Shortens Life (CAL), published in 1991, dealt with patients in long-term coma or persistent vegetative state (PVS). The persistent vegetative state was defined as a severe and irreversible form of loss of consciousness in which all communication and normal movement are impossible.[227] As early as 1985 the *State Commission on Euthanasia* had proposed that long-term coma should be an exception to what it described as the *"central principle"*, namely that *"intentional termination of life without a request thereof from the person concerned cannot be allowed."*[228] At the core of the 1991 CAL Report findings was the contention that it was the prolongation, and not the cessation, of treatment that required legitimation. In its view the legitimacy of the termination of life was dependent on the

[227] CAL1 Report 1991 5-7: see fn.216 supra.
[228] *See Staatscommissie Euthanasie 1985, at 44-6. See fn.14 supra.*

"priority principle" – the use of *euthanasia* to terminate life should only be considered once it has been decided to discontinue the existing treatment, including artificial feeding.[229]

8. Conclusion

Notwithstanding the historical consensual approach adopted by the courts, the prosecutorial authorities and the medical profession in identifying *"due care requirements"* for the legitimate performance of euthanasia and assisted suicide, both on request and, in certain defined circumstances, there is no unanimity, either at international jurisprudential levels or among some medical practitioners in the Netherlands, as to the appropriateness of the legitimisation of the practice of third party assistance with death.

That there is disagreement among international jurists as to the validity of the defence of necessity, and of the effectiveness of the control mechanisms established by the 2002 *Act,* is evident from the vast array of published material on the issue. It is not likely that the different opinions expressed will ever be reconciled. As long as third party assistance with death in the Netherlands is legally permitted contrary views as to its legitimacy will continue.[230]

Of greater interest, however, are the views of Dutch jurists and medical practitioners. Notwithstanding criticisms of flaws in the practice of euthanasia the vast majority of both categories defend it legitimisation and the mechanisms established for its control. Accommodations may be required but, in the main, the policy and practice of third party assistance with death is deemed to be functioning well.

Nonetheless, a small, but clearly identifiable group, among them the noted jurist John Griffiths, who, while supporting the practice of euthanasia in principle, would like to see changes introduced. Changes of any substance, however, are unlikely.

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[229] See Griffiths et al, op.cit., fn.1 supra, at 254/55.

[230] *"...euthanasia is allowed in cases where guidelines are severely breached and killing is condoned when patients did not ask to end their lives. The culture around euthanasia makes the practice accessible within the confines of what is permissible...This culture has a chilling effect upon open, critical debate...In other parts of the world, under similar circumstances....euthanasia would not be considered an option",* Cohen Almagor, op.cit., fn.3 supra

Appendix

Number of notifications of euthanasia and assisted suicide to the Dutch Regional Review Committees 2006-2011:

1. Total number of notifications of euthanasia and assisted suicide:

2006.....1923

2007.....2120

2008.....2331

2009.....2636

2010.....3163

2011.....3695

2. Notifications by Region:

Region 1 Groningen, Friesland and Drenthe:

2006.....229

2007.....234

2008.....280

2009.....326

2010.....337

2011.....373

Region 2 Overijssel, Gelderland, Utrecht and Flevoland:

2006.....468

2007.....532

2008.....568

2009.....802

2011.....948

Region 3 North Holland:

2006.....485

2007.....533

2008.....607

2009.....649

2010.....819

2011.....873

Region 4 South Holland and Zeeland:

2006.....400

2007.....473

2008.....461

2009.....548

2010.....637

2011.....804

Region 5 North Brabant and Limburg:

2006.....341

2007.....348

2008.....415

2009.....469

2010.....551

2011.....697

Chapter III - Death and Political Expedience in Belgium

1. Introduction

In 2002 the Belgian Parliament enacted legislation - *Act Concerning Euthanasia*[1] - which legalised the practice of euthanasia by doctors, but not that of assistance with suicide,[2] in that jurisdiction, contingent on the fulfilment of detailed substantive and procedural requirements. In doing so it became only the second country in the world, after the Netherlands, where the termination of the life of a person by a doctor can be effected licitly at that person's voluntary and repeated request.

Apart from a recommendation by the Government appointed Advisory Committee on Bioethics[3], which had been established in 1993,[4] the segmented socio-political structure of

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[1] Wet van 28 mei 2002 betreffende de euthanasia. Belgisch Staatsblad [Law concerning Euthanasia 28, May 2002] 22, June 2002 <www.health.belgium.be/internet2Prd/groups/public/@public@dg1/@> accessed 12 October, 2012. The Belgian House of Representatives approved the Bill on 16 May, 2002. It was signed by the King on 28 May, 2002. It was published in the Belgish Staatsblad on 22 June, 2002 and came into force on 22 September, 2002. For an English translation see *http://www.kuleuven.ac.be/cbmer/viewpic.php?LAN=E&TABLE&ID=23 accessed 13 October, 2012.* See also, 10 European Journal of Health law, 2003, at 329.

[2] Unlike its Dutch counterpart the Belgian Law on Euthanasia does not expressly apply to assisted suicide. In March, 2003, however, the Belgian Order of Physicians decided that assisted suicide is equivalent to euthanasia so long as the provisions of the Law on Euthanasia have been followed. *See Ordre des Medecins, Bulletins du Conseil National No.100 (2003).* Likewise, the Federal Control and Evaluation Committee, which was established by the *Euthanasia Act, 2002*, and which reviews reported cases of euthanasia biennially, considers assisted suicide to fall within the statutory definition of '*euthanasia*' and disposes of cases accordingly. See Commission Federale de Controle et d'evaluation de l'euthanasie [Federal Control and Evaluation Commission], *Premier Rapport aux Chambres Legislatives, 22, Septembre-31 Decembre 2003 (2004) 23 www.health.belgium.be/eportal/healthcare/consutativebodies/commissions.euthanasia/publications/index.htm accessed 13, October, 2012.*

Life shortening medical practices by physicians, such as withholding or withdrawing life prolonging treatment on the basis of futility, proportionality or at the patient's direction and the administration of appropriate pain relief with life-shortening effect are considered to be within the realm of "*normal medical practice*" and not subject to criminal sanction. See Advice of the Council of State, Parliamentary Proceedings (Senate 2000-01, 2-244/21:1D). See also Article 97 of the Deontological Code (Code of Medical Ethics) of the Belgian Order of Physicians and the avoidance of "*therapeutic obstinacy*", Conseil Nationale de L'Ordre de Medicin, 'Code of Deontologie medicale' (Part II, Chapter 1, Relations avec le patient, 2000) <*http://www.ordomedic.be/fr/code/contenu/> access 19, October, 2012.*

[3] The Advisory Committee was established following agreement between the federal Government and the Dutch, French and German-speaking Communities and the *Joint Commission for Community Matters.* It comprised 35 members from various disciplines, such as doctors, academics sociologists, philosophers, jurists, etc). <*www.health.belgium.be/eprotal/Healthcare/Consultative bodies/Committees/Bioethics/index.htm> accessed 15 October, 2012.* Political disagreement over the management of the affairs of the Advisory Committee resulted in a delay in the commencement of its work until 1996, despite its having been established in 1993.

[4] According to Article 1 of its Founding Statute the Committee was established "*to inform and advise the Government and the public on problems arising from research and its implementation in the area of biology and heath care, and to explore the ethical, social and legal aspects of the issues involved, and in particular the right of the individual.*" See '*Co-Operation Agreement between the State, the Dutch and French and German Communities, and the Joint Commission of the Communities*', Belgian State Gazette, 3 May, 1993.

Belgium[5] in which ideological divisions were deeply institutionalised at both national and local levels and where religion was a dominant and influential consideration with regard to ethical matters, had provided minimal indications, at least to non-Belgians, prior to 1997 - when the Advisory Committee issued its report[6] - of the existence of even a nascent predisposition for the legalisation of euthanasia.

That Belgium enacted legislation, therefore, to provide for medicalised euthanasia came as something of an international jurisprudential surprise. The normative principles which were understood to underpin the traditionally prohibitive approach to third party assistance with death appeared to be summarily eschewed in favour of an imitative jurisprudence, and one more in accord with the derivative approach to assisted death in the neighbouring jurisdiction, the Netherlands, than based on any deep-seated national desire to have third party assistance with death legalised.

2. Historical Background

Two small Right-to-Die Associations, one Dutch-speaking,[7] the other French-speaking,[8] had been founded in 1980 but their influence was not thought to be in any sense determinative. Political support for the agendas of both these bodies was miniscule.[9]

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[5] Belgium is a monarchical parliamentary and proportional representative democracy. A federal state, it comprises of three regions: Flemish, Walloon and the Brussels Capital Region. Their competencies are mainly economic. There are also three Communities, Dutch, French and German. The competencies of the Communities relate, in the main, to each one's particular cultural concerns. They also have jurisdiction in certain aspects of health care, family policy and education. The Federal Government alone has competency in respect of euthanasia. See Lijphart, A *'Conflict and Co-Existence in Belgium: The Dynamics of a Cultural Divided Society',* Berkeley University Press, 1981, for discussion on segmentation and *'pillarisation'*. *'Pillarisation'* entails a society being divided in segments or *'pillars'* according to different religions or ideologies, with each having its own social institutions. Nys has stated that *"destabilising tendencies are neutralised by a pragmatic ruling political elite that seeks to solve societal and political problems in such a way that all parties concerned can more or less accept the outcome."* See Nys, chapters 7, 8, 9 and 10 in Griffiths, Weyers & Adams, *'Euthanasia and Law in Europe',* Hart Publishing, Oxford and Portland, Oregon, 2008, p.260.

[6] *'The Desirability of a Legal Regulation of Euthanasia' (1997) (Advisory Committee Opinion no.1)* <www.health.belgium.be/filestore/13080481/opinion%201%20web_13080481_en.pdf> accessed 16 October, 2012. See Vermeersch, E, *'The Historical and Ethical Background: The Belgian Law on Euthanasia',* (2002) 192 Acta chir belg 394. The Advisory Committee, in its *Opinion No.1,* was concerned solely with euthanasia proper which it defined as *"the intentional life-terminating action by someone other than the person concerned, at the request of the latter."* For an English translation of the Advisory Committee's Opinion No.1 see Nys, H, *'Advice of the Federal Advisory Committee on Bioethics concerning the legalisation of Euthanasia'*, European Journal of Health Care Law 4: 389-93, 1997.

[7] Vereniging voor het Recht op Waardig Sterven.

[8] Association pour le Droit de Mourir dans le Dignite.

[9] There was no broad social support for their ideas in a culture where social Catholicism was politically dominant. See Griffiths, Weyers & Adams, op.cit, fn. 5 supra, p.276: *"Even in liberal circles, there was no unqualified support for legislation concerning euthanasia. The most dominant faction in the Government from the 1950s, the Christian Democrats, was strongly opposed [and].... as a matter of principle, rejected or*

In 1983, the French-speaking and dominant force in Belgian politics, the Christian Democrats, had established a commission, the remit of which was to study the ethical dimensions of euthanasia. This commission, which reported in 1985 (the same year that the *State Commission on Euthanasia* reported in the Netherlands), distinguished between active and passive euthanasia – the former should be ruled out whereas the latter could be permissible as long as it was accompanied by palliative care and intensive counselling.[10]

Throughout the 1980s and the early 1990s there had been a number of attempts - the genesis of which, in all probability, was influenced by jurisprudential, prosecutorial and medical developments in the neighbouring jurisdiction, the Netherlands - by individual politicians to have a range of disparate, but nonetheless tangentially related end-of-life issues debated in Parliament.[11] Included among these were:

- *futile treatment for or the reanimation of a patient;*
- *the doctor-patient therapeutic relationship;*
- *the reservation of euthanasia for those in the last phase of a terminal illness or suffering from a disease leading to death;*
- *the proposition that medical hopelessness be the sole medical requirement for euthanasia and*
- *the permissible performance of euthanasia on foot of a written request but only in circumstances where the medical condition was incurable and there was persistent and unbearable suffering or distress which could not be relieved or controlled by a doctor on the legislative agenda.*[12]

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blocked the regulation of euthanasia." From the middle of the 1980s, however, both the French and Dutch speaking Christian Democratic parties modified their strict stance on the issue. In 1986, for example, the Dutch-speaking Christian Democrat Minister for Health and the Handicapped announced a national colloquium entitled *'Bioethics in the 1990s'*. One of the colloquium's working groups which dealt with *'Ending Life'* recommended altering the Penal Code on behalf of doctors who carried out acts of euthanasia. This colloquium provided the stimulus for the establishment in 1993 by the Government of the Advisory Committee on Bioethics. The idea for such a body had been put forward in 1984 in the Senate, and in in the Chamber of Representatives in 1996, both by way of a draft bill. Interestingly, the impetus in each case came from Christian Democrat members. See Demeester-De Meyer, W (ed.), *'Bio-ethica in de jaren '90 [Bioethics in the 90s]*, Vols I & 2, Gent, Omega Editions.

[10] CEPESS (Centro de Investigaciones Sociologicas/Centre for Sociological Research): *'Problemmes de bioethiques [Problems of Bioethics, First Report]'* Cahiers du CEPESS no 4, 1985: 1-2. See also Delfosse, M, *'Ethische problemen [Ethical Problems]'*, pp. 498-518 in Dewachter & de Gryse (eds.) *'Tussen staat en maatschappij: 1945-1995 Christen-democratie in Belgie [Between State and Society: 1945-1995 Christian-Democracy in Belgium]'*, Tielt, Lannoo, 1995, at 516.

[11] See Vermeersch, op.cit., fn.6 supra.

[12] In 1984 a bill was proposed by the French speaking Liberal Party which contained a provision whereby an amendment to the Penal Code would obviate the continuation of treatment or re-animation of a patient, with or without his request (*Proposal of Law, Senate, 1984-85, no 738/1)*. This bill was re-submitted in 1986 (*Proposal of Law, Senate, 1986-87, no 19/1*. Also in 1986 a draft bill was proposed which specified the rules governing the relationship between a doctor and a terminally ill patient. In 1993 a draft bill was submitted which recommended the reservation of euthanasia for patients in the last phase of "*a terminal illness or suffering from a disease leading to death*" (*Proposal of Law, Chamber of Representatives, 1993-94,*

All these endeavours ended in failure, due largely, although not entirely, to the influence of the Christian Democratic Party on the management of Government affairs, including the parliamentary programme, together with its exercise of an effective veto on ethical issues following the divisive passage of an abortion law in 1990.[13] Attempts at prioritising the issue of third party assistance with death were not enhanced either by the precedence accorded to other policy matters by the more secularist Liberal, Socialist and Green parties, notwithstanding their overt advocation of a pluralist agenda which would allow for a more liberal approach to ethical matters, particularly those of abortion and euthanasia.

The stance adopted by the main professional medical representative organisation, the Belgian Order of Physicians, was also of some significance.[14] It did not appear to be unduly discommoded by the putative absence of legal certainty for those of its members who did perform - albeit covertly - acts of euthanasia.[15]

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*no.1205/1).*The Green Party also submitted a draft bill in 1993. It proposed *"medical hopelessness"* as the only medical requirement for euthanasia. In 1995 a draft bill addressed euthanasia in the narrow sense only rejecting any form of medical treatment that would result in ending life without an explicit request from the patient. The draft bill submitted by the Socialists, also in 1995, would have made euthanasia legal in circumstances where there was *"patient consent and the condition was incurable".*

[13] An *ad hoc* committee on abortion had reported in the mid-1980s. The resulting abortion law in 1990 was passed via an *'alternative majority'* of Liberals and Socialists – a majority that did not include the Christian Democrats, albeit they formed part of the Government at the time. As a result of the passage of the abortion legislation the Christian Democrats insisted, successfully, on the inclusion of an explicit ban on *'alternative majorities'* on ethical matters in any subsequent coalition agreements. In effect, the Christian Democrats thereafter had a veto on all such legislation.

[14] Prior to the enactment of the *Law Concerning Euthanasia, 2002*, a doctor could not intentionally cause the death of a patient or help him/her to take their own lives (Articles 95 & 96 Deontological Code). The Deontological Code was amended after the Act was passed. Articles 95-98 of the current *Code* states that when a physician receives a question regarding the end of life, the physician has to inform the patient of all possible options and provide any medical and moral assistance required. See Bosshard, G, in Griffith, Weyers & Adams, op.cit. fn. 5 supra. During parliamentary hearings prior to the passage of the *Law Concerning Euthanasia, 2002,* the Vice President of the Order of Physicians stated that doctors were uneasy about their new role as the "*bringers of death*". See Parliamentary Proceedings (Senate 2000-2001), 2-244/24:108). In the matter of the lack of support for euthanasia in Belgium see Deliens & van der Wal, *'The Euthanasia Law in Belgium and the Netherlands',* (2003) 362 (9391) The Lancet 1239.

[15] The Belgian Order of Physicians, in contrast to its counterpart in the Netherlands, the Royal Dutch Medical Association (KNMG), considered legal regulation of euthanasia undesirable and believed that the matter was best left to individual doctors. However, euthanasia was a part of medical end-of-life practice for many physicians in Belgium. That this was so was shown in the results of studies in 1996, 1998, and 2001, which had been carried out in Flanders, the Dutch-speaking part of Belgium, where some **60%** of the population of Belgium lives. While the 1996 pilot study concentrated on the city of Hasselt the 1998 and 2001 studies encompassed the whole of Flanders. See Mortier, Delkiens, Bilsen et al, *'End-of-Life decisions of physicians in the city of Hasselt (Flanders, Belgium)',* (2000) 14(3) Bioethics, at 254; Deliens, L et al, *'End-of-Life Decisions in Medical Practice in Flanders, Belgium: a Nationwide Survey'* (2000) 356 (9244) The Lancet 1806 and Van der Heide, Deliens, Faisst et al, The Lancet 345 (the EURELD Study). See also Lewy G, *'Assisted Death in Europe and America'*, Oxford University Press, 2011.The main objective of the Deliens 2002 study was to estimate the frequency of euthanasia, physician-assisted suicide and other end-of-life decisions. The study confirmed that both euthanasia and physician-assisted suicide accounted for **1.1%** and **.2%** respectively of the total deaths examined. It also showed that other medical practices, such as pain relief in dosages with the potential for life-shortening and the withholding and withdrawing of treatment were much more

During the hearings on the proposed bill in the Senate[16] its spokesperson had averred that "*....the National Council [of the order of Physicians] does not wish to pass judgment either for or against any legislative initiatives in this matter....Nevertheless, a pressing question in our minds is whether a legislative initiative will bring us greater legal certainty. Of course it will, some say, because everything will be established in an Act. We, the physicians and lawyers of the National Council, are however not so certain that legal certainty will thereby be assured...There is also the question of whether the doctor-patient relationship, to which we attach supreme importance, will not be undermined by the new connotation introduced of the doctor as the bringer of death. As physicians, we feel very uncomfortable is such a role, perhaps because we are not yet used to such a role, but that does nothing to diminish our unease.*"[17]

Similarly, the official Belgian prosecutorial attitude of non-engagement – in contrast with the active role played by the Dutch prosecutorial authorities - was symptomatic of a pervasive disinclination first, to acknowledge that euthanasia was being practiced and second, to formulate normative criteria for its management and control.

While the original impetus for a change in the law did undoubtedly emanate from a consensual agreement between the country's political parties in the Senate that a bill providing for the licit practice or euthanasia be drafted based on the recommendations of the 1997 Advisory Committee on Bioethics Report[18], nonetheless the uncompromising stance adopted two years later by the Government parties towards the implementation of their agreed policy programme on euthanasia evidenced a reversion to previously entrenched political positions.[19]

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common than previously thought. Withholding or withdrawing of medical treatment accounted for **39%** of all deaths examined. Equally surprising was the revelation that the termination of life without a request was three times more common than euthanasia and physician-assisted suicide combined – **3.2%** of all deaths examined. For further discussion in the matter of the high rate of the termination of life without a request see Bilsen, Vander Stichele, Mortier et al., *'The Incidence and Characteristics of End-of-Life Decisions by GPs in Belgium',* (2004) 21 Family Practice 282. See also Otlowski, M, *'The effectiveness of legal control of euthanasia. Lessons from Comparative Law',* in Klijn, Otlowski & Trappenburg (eds) *'Regulating Physician-negotiated Death',* Elsevier, 2001, at 137.

[16] In the aftermath of the constitutional reforms of 1994 the Belgian Senate came to be regarded as a *Chambre de Reflection* where fundamental legislative issues, such as those pertaining to medical ethics, are discussed. However, both chambers of the Belgian Parliament, the House of Representatives and the Senate, have the power to initiate legislation on ethical matters. 41 members of the Senate belong to the Dutch language group, 29 to the French and 1 to the German. Children of the reigning monarch are ex officio, but politically non-aligned, members of the Senate.

[17] Parliamentary Proceedings, Senate, 2000-01, no 2-244/24: 108.

[18] See fn.6 supra.

[19] The Coalition Agreement (Regeerakkoord) can be found on the Federal Government's website http://www.belgium.be/eportal/index.jsp In a section entitled 'Ethical Questions' paragraph 11 of the agreement stated: "*In recent years biological and bio-medical science has made significant advances. Fundamental interference has become possible in human life. However, our country has not yet succeeded in working out a legislative framework appropriate to this development and suitable for a modern and*

Any contention, therefore, that the legalisation of euthanasia in Belgium was anything other than a convenient exercise in political opportunism on the part of a Government in which the Christian Democrats were no longer participants is wholly meretricious.

3. Political Developments

Between 1997 and 1999, the issue of euthanasia attracted increased political attention and irrespective of ideological differences it became apparent that some type of legislative initiative would eventuate, sooner rather than later. The policy programme agreed by the parties participating in the Government which was formed as a result of the General Election in 1999 between the Liberals, the Socialists and the Greens, of itself, was tangible evidence of a determination to introduce regulatory measures, of whatever type.[20]

The '*The Desirability of a Legal Regulation of Euthanasia*' Report of the Advisory Committee on Bioethics had defined euthanasia as '*the intentional ending of life by someone other than the person concerned, at the request of the latter*'.[21] On enactment, section 2 of the *Euthanasia Law* adopted this definition almost verbatim: the '*intentional life-terminating action by someone other than the person concerned, at the request of the latter*'.

Given the pluralistic composition of the Committee[22] – necessary in the context of the diverse cultural, ideological and linguistic character of Belgian society - the achievement of its members in establishing this definitional accord was of crucial importance in avoiding, however temporarily, a repeat of previous factional disagreements on ethical issues.[23] The willingness on the part of a majority of politicians to avoid entrenched polarised attitudes was exemplified by the debate on the Committee's proposals which took place in the Senate in 1997. This included the hearing of

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democratic society. Parliament must be enabled to fulfil its responsibility on such matters, including euthanasia, and must do this on the basis of each individual's convictions."

[20] The Coalition Government was led by the Liberals.

[21] See fn.6 supra. The Committee's recommendation contained four different proposals for legislation on euthanasia. These proposals reflected the views of the four groups within the Committee:

1. To change the Penal Code to legalise euthanasia, with a procedure for after-the-fact control. This proposal would have created a legal situation similar to that in the Netherlands after the statutory legalisation of euthanasia in 2002;

2. This also included a procedure for after-the-fact control. However, unlike in Proposal 1 was that the existing restrictions in the Penal Code were to be retained. Nonetheless, it would be possible for a doctor to invoke a so-called 'situation of necessity'. This proposal was inspired by the Dutch experience between 1994 and 2001.

3. This provided for a procedure for before-the-fact control not only of euthanasia, but also of other medical behaviour that potentially shortens life. Like proposal 2, this retained the existing provisions of the Penal Code but set out the grounds on which a doctor could invoke a 'situation of necessity'.

4. This proposed to retain the existing legal situation. In short, euthanasia would not be allowed under any conditions.

[22] See fn.3 supra.

[23] Specifically, the issue of abortion. See fn. 13 supra.

submissions from a wide spectrum of interested parties and was characterised by a degree of dispassion which, previously, might not have been thought possible. [24] In truth, had the Advisory Committee not achieved definitional agreement the likelihood of a legislative proposal on end-of-life matters succeeding would have been remote, if not completely impossible.[25]

Euthanasia legislation, therefore, appeared to be firmly in prospect as far as the main political parties were concerned. Likewise it appeared, on its face at least, and contingent on the continuance of the consensual disposition displayed during the deliberations of both the Advisory Committee and the Senate, that it was an issue on which the political establishment, including the leadership of the Christian Democratic Party,[26] notwithstanding unresolved principled policy differences between that party, the Liberals, the Socialists and the Greens, and an amalgam of smaller political entities could, in effect, agree to disagree, while simultaneously providing the necessary accommodation, by way of compromise, to achieve a measure of legislative accord.

That such was the case was evidenced by the fact that there was cross-party agreement that two committees of the Senate, those of *Justice* and Social *Affairs*, would be given the necessary authority to draft a Bill based, in large part, on the recommendations of the Advisory Committee.

This cross-party unity did not persist, however, beyond the Christian Democrats' exclusion from Government for the first time in forty years.[27] The new Government published a Bill in December,

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[24] Only one party declared itself against any form of regulation of euthanasia. This was the extreme right Flemish Block, Vlaams Blok. The declared the debate in the Senate a pointless exercise, and even went so far as to suggest that it was dangerous. See Parliamentary Proceedings, Senate, 1997, no 1-149, at 3940.

[25] In the debate in the Senate (9/10 December, 1997) the French and Dutch speaking Christian Democrats were comfortable with *Proposal 3* (see fn. 21 supra). They stated that the explicit attention had to be given to the development of palliative care in order to limit the demand for euthanasia. The two Socialist parties favoured *Proposal 2*. The Dutch-speaking Liberal also opted for *Proposal 2.* The Dutch-speaking Greens defended the right to life but nonetheless averred that they could support *Proposal 3.* The Dutch-speaking nationalists (known then as *Volksunie*) wanted more attention to be given to the development of palliative care, with secondary consideration to the regulation of euthanasia.

[26] The Christian Democrats had not been totally averse to legislative regulation of euthanasia. Unlike those of other parties, however, their proposals were based not on *'self-determination'* but on the concept of *'mercy'* and placed strong emphasis on euthanasia as a last resort, only to be considered for those who were terminally ill and beyond palliative care. They rejected any possibility of euthanasia for incompetent patients.

[27] As a result of the general election held in June, 1999. In March of the previous year, however, the Dutch-speaking Socialists had declared that any legislation that dealt only with euthanasia would be too limited. They also wanted legislation to cover comatose patients, handicapped new-borns and those suffering from serious dementia. This was not acceptable to the Christian Democrats. An impasse developed which was not resolved by the publication of a recommendation, in February, 1999, by the Advisory Committee – *Raadgevende Comite voor Bio-ethiek,* 1999 - concerning ending of life of incompetent patients. Unlike the pluralistic approach adopted in the matter of euthanasia *per se* this recommendation consisted of three directly opposite positions. The first rejected any form of euthanasia, and thus also any form of ending life without consent. The second would have allowed treatment to end life without current consent but only on condition that there was an advance written request and consent from an impartial representative. The third position was that treatment to end life, under certain conditions, should be possible in cases where

1999, whose stated aim *"was to embrace the four proposals of the governing parties that had been introduced at the beginning of the Senate hearings."* However, this Bill was virtually identical to one which had been proposed previously by the Dutch and French-speaking Socialists, neither of whom was willing to continue with the consensual approach. They opted for an independent position.[28]

4. Definitional precision

The precise statutory definition of euthanasia contained in the *Euthanasia Law*,[29] is in stark contrast to the complete absence of a definition in the Dutch *Termination of Life on Request and Assisted Suicide (Review Provisions) Act,* which was also enacted in 2002.[30] In fact, the word euthanasia does not appear anywhere in the Dutch Act. Instead it relies implicitly on the terms of Article 293 of the Dutch Penal Code which prohibits the termination by a person of the life of another even at that other's express and earnest request.[31]

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there was no prior or current consent. This brought to an end the political consensus that had been reached as a result of the Committee's first recommendation on euthanasia.

[28] The most important substantive differences between the governing parties and the Christian Democratic opposition can be summarised as follows:

(a) the governing parties considered that if a patient suffered from (i) persistent and unbearable pain or distress that could not be relieved, which (ii) was the consequence of a severe and incurable illness, this, in principle, together with the patient's request, was sufficient to justify euthanasia. The French and Dutch-language Christian Democrats took the position that the patient must be in a terminal state.

(b) the governing parties were in favour of legalising euthanasia. Both Christian Democratic parties wanted a construction in which euthanasia remained in principle forbidden but would be justifiable in the case of a legally-defined 'state of necessity'.

(c) the governing parties proposed to accept, in place of a current request, one made in a prior written request by a patient who (i) was no longer conscious, and for whom (II) there is no means of restoring consciousness, and who (iii) suffered from an incurable disease. The Christian Democrats rejected any form of advance request for euthanasia.

(d) The Christian Democrats proposed a requirement of ethical consultation beforehand, and stressed that the purpose was to give support to doctors and patients and not to create an 'ethical tribunal'. The governing parties regarded ethical consultation as unworkable and feared that it would, in fact, result in an 'ethical tribunal'.

(e) The Christian Democrats thought palliative care should always be tried before euthanasia was even considered. The majority parties saw palliative care as an option parallel to euthanasia. See Griffiths et al, op.cit. fn 5 supra, at p.286.

[29] *"The intentional life-terminating action by someone other than the person concerned, at the request of the latter."* s.2, Euthanasia Act, 2002.

[30] Ironically, however, and on its own admission, the Advisory Committee on Bioethics had been influenced not alone by legislative developments in the Netherlands but also by the writings of a leading Dutch health-care lawyer, Henk Leenen. See *'Euthanasie in het gezondheidsrecht [Euthanasia in Health Law]'*, in Muntendam, P, et al, *'Euthanasie [Euthanasia], Stafleu, Leiden, 1977, pp 72-147; 'Handboek gezondheidsrecht. Deel 1: Rechten van mensen in de gezondheidszorg [Handbook of Health Law.* Vol 1: Individual Rights in the Context of Medical Care]', 3rd ed. Alphen a/d Rijn, Samson HD Tjeenk Willink; *'Handboek gezondheidsrecht. Deel 1: Rechten van mensen in de gezondheidszorg [Handbook of Health Law,* Vol 1: Individual Rights in the Context of Medical Care]', 4th ed., Houten/Diegem, Bohn Stafleu Van Loghum.

[31] See Chapter II on The Netherlands.

It is to be noted that euthanasia as defined in Belgian law is not normal medical behaviour[32] such as the refusal of treatment either by way of advance directive or in the form of a current request; the withholding or withdrawing of treatment which is deemed to be medically futile; pain relief with life-shortening effects (usually on the application of the principle of double effect albeit there are conflicting views as to the compatibility of this principle with Belgian law)[33]or palliative and terminal sedation.[34]

While it would seem unnecessary to restate this legal fact, nonetheless there appears to be a continuing body of opinion among some doctors in Belgium which holds that because the performance of an act of euthanasia is specifically restricted by the *Euthanasia Act* to doctors it logically falls within the parameters of normal medical behaviour.[35]

The reasoning appears to be that regardless of the character of the medical actions taken, once performed by a doctor they should be deemed as normal and that the concept of normal medical behaviour encompasses all such behaviour irrespective of any potential criminal consequences were such actions to be carried out by non-doctors.

This, however, is not correct. A Royal Decree Concerning the Practice of Health Care Professionals, issued in 1967, governs those practices which fall within the general description *'normal medical*

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[32] A debate on this matter has flourished in recent times. It has been argued that, increasingly, doctors in Belgium regard the practice of euthanasia as normal medical practice and part of palliative care. That there is some substance to this view is attested by Article 2 of the Association of General Practitioners' *'Policy Statement on End of Life Decisions and Euthanasia'* (2003): *"Euthanasia is one of the possible choices in terminal care and must be framed by and embedded in total palliative care that transcends individual care"<www2.domusmedica.be/files/PB_euthanasie.htm>* accessed 12 January, 2013.There are indications, however, that there is a growing preference for palliative or terminal sedation as an alternative to euthanasia. See Bilsen, Cohen, Chambaere & Pousset, *'Medical End-of-Life Practices under the Euthanasia Law in Belgium', (*2009) New England Journal of Medicine 1119. See also Smets, Cohen, Bilsen et al, *'The Labelling and Reporting of Euthanasia by Belgian Physicians: a Study of Hypothetical Cases',* (2012) 22 (1) European Journal of Public 19. John Griffiths argues that normal medical practice cannot include euthanasia. See op.cit., fn.5 supra, at 313-4. The argument is that under Art. 2§1 of the *Euthanasia Act, 2002*, the doctor is obliged to discuss all options with the patient, including that of palliative care. Art. 2 of the *Palliative Care Act, 2002*, states that *"every patient has a right to palliative care at the end of life."* If, therefore, euthanasia was part of palliative care, it would, logically, create a right to euthanasia. It would also entail a positive obligation on doctors to perform euthanasia. However, under Art.14 of the *Euthanasia Law*, a doctor cannot be compelled to perform either euthanasia or physician-assisted suicide. The Law only provides the opportunity to request euthanasia. It does not create a positive right to euthanasia. Consequently, euthanasia cannot be considered to be normal medical practice. In 2003/4 proposals were introduced into the Belgian Parliament to amend the law whereby euthanasia would be regarded as *"normal"* medical behaviour. See *Proposal of law (Senate 2003-04) no. 3-804/1:8) (7 July, 2004).* This proposal was unsuccessful.

[33] See previous footnote.

[34] See' *Advice of the Council of State, Parliamentary Proceedings (Senate 2000-01, 2-244/21: ID)'*. See also Article 97 of the Deontological Code (Code of Medical Ethics) of the Belgian Order of Physicians and the avoidance of *"therapeutic obstinacy". Conseil Nationale de L'Ordre de Medecin (Part II, Chapter I, Relations avec le patient, 2000) http://www.ordomedic.be/fr/code/contenu/ accessed 15 October, 2012.*

[35] See fn.32 supra.

behaviour', including palliative care. On foot of a valid informed consent by the patient – but only as a result of such a consent - the Decree legally endorses the infringement by doctors of the physical integrity of the patient by means of surgery or other medically indicated interventions.

The *Euthanasia Act*, 2002, creates a specific legal justification for the performance of euthanasia by a doctor, similar to the justificatory defence of necessity provided in the Dutch Act for a doctor when confronted by a conflict of duties - the duty to save life on the one hand and the duty to relieve suffering on the other. When the Bill proposing legalisation was being debated in the Belgian Parliament the Council of State affirmed that its provisions would not be applicable to normal medical practice such as (i) *not starting or ending medical treatment that is useless or disproportionate and* (ii) *medically indicated pain relief that may result in shortening the life of the patient.*[36]

In summary, therefore, what the *Belgian Euthanasia Law* recognises is a right to request euthanasia. It does not recognise a right to euthanasia *per se.* The right to request euthanasia is in furtherance of the principle of self-determination on which the new law is based. Section 14 of the Act is unambiguous: current requests for euthanasia and those contained in advance directives, *"are not compulsory in nature"*. No doctor can be compelled to perform euthanasia; nor can other persons be compelled to assist in the performance of it.

The criteria for a valid acceptance of a voluntary request for euthanasia, both by way of an advance directive and as a result of a well-considered and repeated request at a time when it is concluded that there is no reasonable alternative treatment for the patient's condition - a belief to be arrived at jointly by the patient and the doctor - together with the protocols governing the role of the doctor who acquiesces in such a request, including consultation with an independent physician, and the mechanisms for review and control, form by far the greater portion of the provisions of the Act.

While the *Act on Palliative Care*,[37] which was also enacted in 2002, specifies that every patient has the right to palliative care the *Euthanasia Act* at no stage provides for an untrammelled right to euthanasia for a patient regardless of symptoms or prognosis. This right to palliative care has led to the use of what is referred to as the *"palliative filter"* procedure by Catholic hospitals in Flanders who, notwithstanding their concurrence in the availability of euthanasia for *"competent*

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[36] *See fn.30 supra.* There are contrary views on the accuracy of this reasoning. *See Dijon, X, 'Le sujet de droit en son corps: une mise a l'epreuve du droit subjectif', 'The Embodied Legal Subject: A Challenge to the Law of the Person', Brussels, Ferdinand Larcier, 1982; Nys, N, 'Medicine: Law and Medical Behaviour', Mechelen, Story-Scientia, 2005, 360-61.*

[37] *Loi du 22 aout 2002 relative aux droits du patient.*

terminally ill patients", implement a policy whereby care for a patient who has requested euthanasia includes an obligatory consultation with a specialised palliative care team which considers his/her real needs. The Euthanasia Act, however, makes no reference to this *"palliative filter'.*[38]

5. Dutch Influence

While the contemporaneous passage of legislation in Belgium and the Netherlands was coincidental it would not be unreasonable to suggest that the uncharacteristically speedy orchestration of matters in the former jurisdiction, on such a potentially divisive political and ethical issue, had not been influenced, however minimally, by the existing legislative template in the latter. The formal legislative endorsement of euthanasia in the Netherlands represented the culmination of a lengthy jurisprudential, prosecutorial and medical co-operative engagement. No comparable engagement occurred in Belgium.

The contrasting lengths of the respective Belgian and Dutch Acts are emblematic of the radically different approaches adopted in both jurisdictions. The genesis of the relatively brief Dutch Act is traceable to a pragmatic combination of an established justificatory defence for a doctor who performs euthanasia on request – achieved through an amendment of Article 293 of its Penal Code – and a listing of the requisite *"due care"* criteria underpinning the legality of such action, these latter having been agreed previously by the prosecutorial authorities, the courts and the medical profession. The truth of the matter is that there was little by way of novel substance in the Dutch Act other than the provision of statutory authority for the Regional Review Committees[39] which had begun operating some two years beforehand on the authority of an Order in Council.

The Belgian legislation on the other hand began *de novo* and from a jurisprudential *tabula rasa.*

First, it did not set out to amend its Penal Code. Unlike the Dutch Penal Code a specific prohibition of an offence akin to euthanasia was absent from the Belgian Code. This absence, together with the belief – but one which had never been authenticated - that assisted suicide was not deemed a criminal act, meant that the option of a justificatory defence by way of an amendment to the Penal Code was impossible. It also led ultimately to serious criminal law questions as to the nature of the offence committed by a doctor who does not fulfil the criteria for the licit performance of euthanasia as laid down in the Act.

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[38] See fn. 82 below. See also Nys, H, in Griffiths, Weyers & Adams, op.cit., fn.5 supra, at 310.
[39] See Chapter II on the Netherlands.

Second, there was no extant jurisprudential accord as to the applicability of the defence of *'necessity'* as there was in the Netherlands.

Third, there was no co-operative engagement by either the prosecutorial authorities or the chief medical representative body in an endeavour to establish clearly defined permissible parameters for the performance and practice of euthanasia by doctors.

In contrast to the terse, formulaic provisions of the Dutch *Act* which, in effect, merely replicated existing norms, the Belgian legislation contains very detailed definitional, substantive and procedural provisions.

The legislation in the Netherlands, notwithstanding its absolute requirement for a voluntary and well-considered request, was predicated more on the achievement of legal certainty for doctors who performed euthanasia than on any overarching desire to enhance further the already enshrined principles of *self-determination* and individual autonomy in law. The Dutch Government and the medical profession had traditionally opposed the reification of the concept of self-determination. Its acceptance would have entailed a degree of individual autonomy which, notwithstanding the unequivocal right of a patient to refuse medical treatment even in circumstances where death was the inevitable outcome, would have run counter to the professional integrity of doctors in recommending appropriate medical treatment in particular circumstances and in any decisions they might make with regard to the futility of a specific treatment requested by a patient.[40]

The Belgian legislation on the other hand placed greater emphasis on the rights of the individual, especially that of self-determination. The terms of reference of the Advisory Committee on Bioethics specifically alluded to such rights. While the right of the patient to request euthanasia is central to the provisions of the *Euthanasia Act,* nonetheless it does differentiate between the requisite conditions for a current request and those applicable to the situation in which an advance directive requests that euthanasia be employed in specific circumstances. In the debates which took place in advance of the enactment of the legislation there appeared to be little by way

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[40]There has been a suggestion that the actual application of the Dutch law on euthanasia provides evidence of a slippery slope into *"unbridled"* patient autonomy. *See* Burt, R, Book Review of *'Dying Justice: A Case of Decriminalising Euthanasia and Assisted Suicide in Canada'* by Jocelyn Downie, University of Toronto Press, 2004, in New England Journal of medicine 352: 1501-2. However, the Annual Reports of the Regional Review Committees would appear to indicate the contrary. Dutch law in both its formal provisions and its practical application is not based solely on patient autonomy. An essential additional requirement to a voluntary request for euthanasia is the existence of suffering that cannot be alleviated by means of acceptable alternative medical procedures.

of fundamental difference between proponents and opponents of the new law - with exception of the Christian Democrats[41] - as to the underpinning justification of self-determination.[42]

A purist interpretative approach to the criteria governing the patient's *"medically hopeless situation"*, which requires that there be *"persistent and unbearable physical or mental suffering that cannot be alleviated"* (section 3.1), might conclude that the predominant factor is one of beneficence rather than self-determination. Nonetheless, it is clear from the provisions of the Act that while the doctor and the patient must together conclude that there is no alternative to the situation in which the patient finds himself (section 3.2.1), it is the patient who, to a large extent, determines whether he is in such a condition.

Dutch and Belgian societies, to a large degree, share the same socio-political characteristics of pillarisation and segmentation.[43] It could not be credibly contended that these were not determinative in the approach adopted by the authorities in the Netherlands to the issue of euthanasia. That they did so is amply evidenced in the results of the various opinion surveys conducted over many years, most particularly those conducted by the Social and Cultural and Planning Bureau and by Van Holsteyn and Trappenburg.[44] However, a cultural diffusion had taken place in the Netherlands from the 1960s onwards which led to a change in traditional attitudes, not only to euthanasia but also to issues such as marriage, abortion, homosexuality and the emancipation of women.[45] In 1995, for example, about **10%** of the Dutch public were of the opinion that euthanasia should always be forbidden, whereas **64%** considered that it should always be allowed if requested by the patient. Some **80%** of those who replied to a question as to the propriety of the actions of a doctor who was portrayed in a TV programme performing an act of euthanasia stated that he had done the right thing.[46]

However, there was no contemporaneous or comparable cultural diffusion in Belgium and while ideological segmentation no longer appeared to possess the power it once did, nonetheless it is abundantly clear that the parties that formed the Government after the General Election of 1999 were motivated, in large part, to proceed with their proposed legislation in the expeditious and

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[41] See fn.26 supra.

[42] The perceptible greater disposition towards self-determination in Belgium, above that displayed in the Netherlands, was further evidenced in the enactment of the *Law on Palliative Care* and the *Law on Patients' Rights,* both of which took effect on 2002, and both of which have relevance in the context of the legal performance of an act of euthanasia.

[43] See fn. 5 supra.

[44] See Holsteyn, J van & Trappenburg, M, *'Het laatste oordeel: meningen ver nieuwe van euthanasie [The Last Judgment: Public Opinion concerning New Forms of Euthanasia]',* 1996, Baarn, Amvbo. See also, by the same authors, *''Citizens' Opinions on New Forms of Euthanasia: A Report from the Netherlands',* Patient Education and Counselling 35, 1998, at 63.

[45] See Chapter II on the Netherlands. See also Griffiths et al, op cit., fn 5 supra, at 14-15.

[46] See fn.44 supra, at 24-27.

uncompromising manner which they did by virtue of the fact that their political *bête noir* colleagues, the ideologically confessional Christian Democrats, no longer held power and consequently were not in a position to exercise the veto on ethical issues which they had insisted upon after the debacle on the abortion issue.[47]

Notwithstanding the increasing secularisation of its society and the softening, however tentative, of previous ideological tensions between the main confessional and secular political entities, the intrusion into the political arena of ethical issues such as abortion and euthanasia demonstrated clearly that not alone could a well-intentioned and consensual *Zeitgeist* on these issues be summarily dissipated, but also that undesirable ethnic and sectarian tendencies could be revived and re-activated with ease, thereby leading to a fractious political environment.

The opportunity provided for legislative action, therefore, could not be gainsaid. While there were fundamental differences in respect of the potential scope, of the criteria for licit performance and of the requisite control mechanisms that might be applied to the practice of euthanasia by doctors, it was recognised generally that, arising from the determination of the governing parties, legislative initiative, of whatever form was inevitable.

In summary, therefore, due to a combination of factors, chief among which were:

- a total absence of precedential jurisprudence;
- the virtual non-existence of a coherent prosecutorial policy;
- a nonchalant and insouciant approach on the part of the Order of Physicians;[48]
- the absence of a consensually co-ordinated approach by the authorities generally, and
- the exercise of a veto on alternative majority solutions[49] to ethical matters on the part of the Christian Democrats as well as their absence from Government for the first time in forty years,

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[47] See fn.13 supra.

[48] Between February and May 2000 the Joint Committee of the Senate (comprised of members of the Committees of Social Affairs and Justice respectively) dealing with the proposed Euthanasia Bill held hearings at which a wide spectrum of professional and other bodies were given an opportunity to express their views. The Vice-President of the Order of Physicians made the following statement: "the National Council [of the Belgian Order of Physicians] does not wish to pass judgment either for or against any legislative initiatives in this matter. Nevertheless, a pressing question in our minds is whether a legislative initiative will bring us greater legal certainty. Of course it will, some say, because everything will be established in a Law. We, the doctors and lawyers of the National Council, are however not so certain that legal certainty will thereby be assured. There is also the question of whether the doctor-patient relationship, to which we attach supreme importance, will not be undermined by the new connotation of the doctor as the bringer of death. As doctors, we feel very uncomfortable in such a role, perhaps because we are not yet used to it, but that does nothing to diminish our unease." See Parliamentary Proceedings, Senate, 2000 - 2001, no 2-244/24: 108.

[49] See fn 13 supra. Known as *Majorites de rechange* [*Wisselmeerderheid*]. Through their use legislation could be approved without the consent of one of the governing parties and with the consent of one or more of the

the approach by the Belgian Government to the legalisation of euthanasia, while necessarily somewhat disjointed and tentative initially, appears nonetheless to have been galvanised primarily by political opportunism rather than by deep-seated conviction as to the necessity for either legal clarity or the affirmation of an individual's right to determine the manner and timing of his/her death.

Compared to the relatively rich tapestry of socio-political and jurisprudential co-operative developments[50] which preceded the enactment of the Dutch *Termination of Life on Request and Assisted Suicide (Review Provisions) Act,* there was an almost complete absence of jurisprudential, prosecutorial, and medical dynamics in the endeavour to legalise euthanasia in Belgium. The motivational factors were of a purely political character.

The Bill providing for the right of a person to request euthanasia was passed by the Senate in October, 2001.[51] None of the amendments proposed by the Christian Democrats were accepted. The Bill was approved and enacted at a plenary session of the House of Representative in May, 2002.[52] Again, none of the amendments tabled by the opposition were accepted. When signed by the King on 22 June, 2002, the *Euthanasia Act* was given the force of law.

Subsequently, two pro-life organisations requested the Constitutional Court[53] to assess the Act in respect of Articles 10 - 11 of the Belgian Constitution (principles of non-discrimination) and Article 2 of the European Convention on Human Rights (the right to life). The Court dismissed the arguments submitted by the complainants and found that sufficient guarantees were provided to ensure that the principle of self-determination underpinning the new law would not result in discriminatory treatment for those incapable of making a free choice. The Act was approved by the Court in January, 2004.

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opposition parties. Their most usage was in 1990 when the Belgian abortion law was passed. This occurred when an alternative majority of Liberals (who were not part of the then Coalition Government) and the Socialists combined to the exclusion if the Christian Democrats (who were part of the Government) to ensure the passage of the Act. This led to the Christian Democrats insisting that their participation in any future Coalition Government would be contingent on an agreement that alternative majorities on ethical issues would not be permitted. This continued to be the situation until 1999 when, for the first time in almost forty years, the Christians Democrats did not form part of a Coalition Government.

[50] See Chapter II on the Netherlands.

[51] The final vote on the bill reflected the polarised political environment. Of the 75 members of the Senate, 68 were present for the vote. 44 voted for and 22 against. Two abstained. No opposition Senator voted for the bill.

[52] The vote was: 86 for, 51 against, 10 abstentions.

[53] Then known as the Cour d'Arbitrage/Hof van Arbitrage. The name was changed to the Constitutional Court in 2007.

As its title implies the new law does not contain provisions in respect of assisted suicide.[54] Prior to its enactment the law applicable to physician-assisted suicide was unclear and medical practice in respect of end-of-life decisions occurred in circumstances of grave legal uncertainty.[55] Termination of the life of another was classified as either murder or manslaughter. Article 393 of the Belgian Penal Code of 1867 relates to voluntary manslaughter and Article 394 to murder.[56] Unlike in the Netherlands euthanasia in Belgium was not a discrete offence. However, there were no prosecutions[57] and in the absence of case law it was unclear whether or not the justificatory defence of necessity, deemed applicable by the Dutch Supreme Court in the iconic 1984 *Schoonheim* case,[58] would find favour in Belgian jurisprudence.

However, as previously indicated, there was a complete absence of anything approaching a co-operative endeavour between the prosecutorial authorities and the medical profession in respect of either a desire for legal certainty or for the delineation of "*due care*" norms in the performance of any form of third party assistance with death.

It may well be that in such circumstances the Belgian legislature, as has been suggested by Nys, did not have a great deal of confidence in the willingness of the Order of Physicians in particular to support the practice of euthanasia in a constructive manner.[59] The Order had maintained a discreet distance both from the proposals to introduce legislation and from their enactment and eschewed responsibility for either the content or the maintenance of the new norms. "*The legal*

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[54] See fn.2 supra. Suicide has never been a criminal offence in Belgium. In the absence of any specific provision, as exists in the Netherlands, assistance with suicide was therefore also not an offence. Some jurists claim the law could have been interpreted in a manner which would have made assisted suicide indirectly punishable. They refer to Article 422bis of the Penal Code that deals with not providing help to someone in grave danger. See, in particular, Dijon, X, 'Le sujet de droit en son corps: une mise a l'epreuve du droit subjectif *[The Embodied Legal Subject: A Challenge to the Law of the Person]',* Ferdinand Larcier, Brussels, 1982. The Council of State in drawing the Government's attention to the exclusion of assisted suicide from the then *Euthanasia Bill* was of the view that if a doctor actively helped a person to commit suicide, Article 422bis of the Penal Code was applicable. See Parliamentary Proceedings, Senate, 2000-01, no 2 2-244/21:14. The Government did not respond to the *Council of State's* opinion. It is thought that the reason for not doing so related as much to the delay which an inclusion of assisted suicide would inevitably entail than any principled objection it may have had. An amendment providing for its inclusion would have meant the Bill being sent back to the Senate for further consideration and debate. This, apparently, was something which the Government did not want to contemplate and is symptomatic of its uncompromising approach to the many amendments which were proposed by opposition parties during the debates in both the Senate and the House of Representatives.

[55] See fn.14 supra.

[56] The Deontological Code [Code of Medical Ethics] of the Belgian Order of Physicians also forbade euthanasia. See fn.15 supra. In the event that any prosecution had taken place in respect of an act of euthanasia prior to the enactment of the new law it is likely that it would have done so under one or other of these provisions, depending on the particular circumstances of the case. Article 397 relating to poisoning might also have been relevant.

[57] This notwithstanding the fact that it was known that euthanasia was practiced. See *fn.15 supra.*

[58] *Nederlandse Jurisprudentie 1985, No.106*. See Chapter II on the Netherlands.

[59] See Nys, H, *'Belgian Law on Euthanasia and Other MBPSL',* Mechelen, Story-Scienta, 2005, at 329.

debate on euthanasia was not accompanied by internal preparation of guidelines among the medical profession."[60] Whereas the Royal Dutch Medical Association (KNMG) – together with the prosecutorial authorities and the judiciary – played a key role in the Dutch process of legal change, the same cannot be said of the Belgian Order of Physicians.[61]

6. Statutory Requirements

As a result of the enactment of the *Law on Euthanasia* there are specific requirements which must be met if an act of euthanasia is to be considered legal. The requirements can best be understood within defined parameters:

- where the patient is expected to die in the near future;
- where the patient is not expected to die in the near future;
- the request for euthanasia;
- the medical recording procedures;
- where there is an advance euthanasia request and
- the reporting procedures.

Before conducting an appraisal of the statutory criteria for the legal performance of an act of euthanasia, and of the mechanisms established for its review and control, and of their effectiveness, a brief contextualisation of such behaviour within the overall legal norms governing life-shortening medical behaviour which has the potential to shorten life is appropriate.

7. Medical Behaviour with the Potential to Shorten Life

Belgium is no different in the approach it adopts to such behaviour than many other jurisdictions within the Western jurisprudential tradition. However, given the irrefutable historical predominance of a conservative ethos in respect of ethical issues and the fact that religion had played an undoubtedly considerable influence in the formulation of public policy, it is of importance to clarify the status of such practices in order to distinguish precisely between their condonation and implementation, and the principles which underpin their legitimacy, and the criteria which now govern the licit performance of third party assistance with death.

The actual sources of law that govern medical behaviour which has the potential to shorten life are not inconsiderable, either in extent or provision. The Penal Code prohibits, under Article 425, the intentional non-provision of food or treatment to minors or incompetent patients and Article

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[60] See Vander Stichele, R et al, *'Drugs used for euthanasia in Flanders, Belgium'*, Pharmacoepidemiology and Drug Safety 13: 89-95, 2004.

[61] Nys, op.cit., fn.59 supra, at 329.

426 deals with a situation in which support for a minor or an incompetent person is not provided. These articles, together with Article 393 (*voluntary manslaughter*) and Article 394 (*murder*) might have proved of some relevance also in any case taken in respect of the early non-natural and unexplained death of a patient. Article 422bis relates to the non-provision of help to a person who is in a situation of great danger.

The provisions of the Penal Code have been complemented by the *Euthanasia Law* and the supplementary Act[62] which was passed in 2005, providing specifically for the role of pharmacists in the context of the availability and supply of euthanatica. The *Palliative Care Act*[63] and the *Act on Patients' Rights*[64] are also relevant in the context of the denominated right of every patient to palliative care and the unambiguous right of a patient to refuse medical care.[65]

During the passage of the legislation on euthanasia in parliament the Belgian Council of State advised the Government that its provisions would not interfere with the generally accepted position that a doctor is not obliged to continue medical treatment that is futile – in essence, treatment which no longer has any curative or palliative effect. Likewise, the possible shortening of life as a result of the administration of appropriate pain relief was deemed to be an acceptable side effect.[66] The Royal Decree of 1967[67] provided the basis for these exclusions.

While the *Law on Patients' Rights* establishes the right to refuse or withdraw consent for medical intervention (Article 8.4) such a refusal or withdrawal, however, does not mean that the patient is no longer entitled to medical care. If the patient, while competent to do so, has made a written

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[62] *Wet van 10 November tot aanvulling van de wet van 28 mei 2002 betreffende de eithanasie met bepalingen over de rol van de apotheker en het gebruik en de beschikbaarheid van euthanatica. Belgisch Staatsblad (13 December 2005).*

[63] *Wet van 14 juni 2002 betreffende de palliatieve zorg. Belgisch Staatsblad (22 October 2002)(effective 22 September 2002).*

[64] *Wet van 22 augustus 2002 betreffende de rechten van de patient. Belgisch Staatsblad (26, September 2003).*

[65] It should be noted also that a number of Royal Decrees have been published concerning the practice of health care professionals (*November, 1967*); establishing the manner in which an advance request for euthanasia is drafted, confirmed, changed or revoked (*April, 2003*) and regulating the method by which an advance request is registered and made available to the treating physician (*April, 2007*). Likewise, there have been a number of Advisory Reports published including the Report of the Belgian Council of State on the Euthanasia and Palliative Care Bills (Parliamentary Proceedings, Senate, 200-01, no 2-224.21. See *<http:www.senate.be>);* the Report of the Advisory Committee on Bioethics *'The Desirability of Legal Regulation of Euthanasia' (Raadgevende Comite voor Bio-ethiek 1997).* See also the Deontological Code *<http://195.234.184.64/web-Ned/deonton.htm>*

[66] See Advice of the Council of State, Parliamentary Proceedings (Senate 200-01, 2-244/21:ID).

[67] See fn.65 supra.

statement refusing *"a well-defined medical intervention"* and has not revoked this instruction while still competent, such an advance directive must be complied with.[68]

Both the *Deontological Code*[69] and the *Law on Patients' Rights*[70] reiterate the principle of informed consent.

Likewise, it is accepted medical practice in Belgium that a doctor can alleviate the symptoms and pain of a dying patient by the use of drugs even in circumstances where the dosage administered can, and more than likely will, hasten the moment of death.[71]

8. The Law

The Euthanasia Law deals extensively with (i) the patient; (ii) the doctor; (iii) the request for euthanasia; (iv) advance directives; (v) the Federal Control & Evaluation Commission and (vi)

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[68] Vague or imprecise language invalidates any such directive. In circumstances where a doctor does not have the opportunity to verify that the patient him or herself has provided such an instruction the obligation specified in Article 422bis of the Penal Code in respect of the duty to provide assistance to a person in great danger obtains.

[69] The Code states that a doctor is obliged, where such circumstances apply, to inform the patient, *"in a timely manner"*, that his or her life is ending. Likewise, he is obliged to outline for him or her the nature and extent of the assistance that can be provided. Specifically, the doctor must inform the patient, again *"in a timely manner"*, of his right to palliative care and, in an implicit reference to euthanasia, he is obliged to inform him or her of what medical care he is prepared to provide at the end of life. The requirement that this be done in *"a timely manner"* is to allow for the patient to approach another doctor in the event that his or her own doctor, for whatever reason, does not wish to provide a particular type of medical care, in other words where the doctor is not prepared, either for reasons of conscience or for medical reasons to perform euthanasia.

[70] In circumstances where a patient is no longer capable of exercising his/her rights, *Article 14* of the *Law on Patients' Rights* provides that they can be exercised on his/her behalf by a person nominated by the patient to do so. The *Law* also provides for situations where there is no designated representative, where the representative fails to act and where a doctor can override the decision of a representative of an incapacitated patient which, in the doctor's opinion, may pose a threat to the patient's life or lead to serious damage to his health.

[71] However, this acceptance is not based on any identifiable or unequivocal statement of law. There is also a dearth of case law on the issue. In one instance a court did find that it was an accepted medical practice to alleviate intense pain of patients who are in an incurable situation even where this has an unintended life-shortening effect. See Vansweevelt, T, *'Comparative Legal Aspects of Pain Management'*, in Book of Proceedings of the 16th World Congress on Medical Law, Vol. 1, Toulouse, 2006, at 377. It is clear that the distinction between intentional and foreseen shortening of life is not applicable at Belgian law. Article 393 of the Penal Code states that *"homicide with the intention of causing death is treated a murder."* The implication arising from this provision is that the doctrine of *'double effect'*, which is enshrined in the legal principles of Western jurisprudence, and which legitimates an unintended but foreseen shortening of the dying process through the administration of pain-relieving medication, does not obtain in Belgium. The matter as to the necessity or otherwise for a doctor providing pain relief which has life-shortening properties to comply with the criteria laid down in the *Euthanasia Law* in order to fireproof him or herself against possible criminal action is a matter of on-going debate. It would appear, however, that the law is uncertain in the matter. Nys makes the valid point that a doctor is obliged to alleviate pain at the request of, or in agreement with, a dying patient. *"However, when the administration of the drugs has the foreseeable consequence that the life of the patient will be shortened, it is up to the doctor top decide whether he accepts this consequences. In other words, the patient is in this respect at the mercy of the doctor who himself is at the mercy of the law."* See *Nys, H*, in Griffiths, Weyers & Adams, op.cit., fn.5 supra, at *304.*

special provisions, and with the particular conditions which must be observed in each category for an act of euthanasia to be deemed valid. For reasons of space, it is impossible to replicate in full the detail of these provisions. However, a brief resume is sufficient to provide a flavour of both their nature and their substance.

(i) The patient

The patient must be in *"a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated;"* [72] this condition must be the result of *"a serious and incurable disorder caused by illness or accident"* (this is the only objective requirement contained in the Act); the patient requesting euthanasia *"must have attained the age of majority"*, or be what is known as *"an emancipated minor;"*[73] and he *"must be legally competent and conscious"* at the time of making the request.

The Act makes no distinction between conditions of a physical or a mental nature[74] or origin.[75] Terminal illness is not required by the *Euthanasia Act* although Section 3.1 requires the doctor to

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[72] While the term is not specified in the Act the requirement that the patient must be enduring *"persistent and unbearable physical or mental suffering that cannot be alleviated"*, and that the condition be the result of *"a serious and incurable disorder caused by illness of accident"*, would appear to indicate a therapeutic relationship between the *'patient'* and the doctor whom performs the act of euthanasia. The Act, other than providing that only a doctor can legitimately perform euthanasia, does not specify that he/she be the patient's attending doctor. Nor does it require that the doctor possess any special medical competence. Prior to the passage of the Dutch *Termination of Life on Request and Assisted Suicide (Review Provisions) Act, 2002,* it was generally accepted that the doctor, arising from the esteem in which general practitioners are held in their own communities in that jurisdiction, who performed the act of euthanasia should, in principle, be the patient's attending doctor. That this was the case in practice is evident from the available statistics. See Regional Review Committees Annual Report, 2002: 18. However, in its Annual Report of 2005: 27 the Committees specifically states that the law and its legislative history were not sufficient grounds for regarding a treatment relationship as required. Instead, the decisive criterion is whether the doctor has such a relationship with the patient as to permit him or her to form a judgment concerning the requirements of due care.

[73] The age of majority in Belgium is 18. Euthanasia for minors remains a highly contested issue in Belgium. At the time of writing there is a proposal before the Senate to reduce the age of consent to an act of euthanasia from 18 to 12. For the most part an emancipated minor appears to be limited to exceptional cases of persons aged 16 years or over and requires at decision by a judge. For further discussion see Cohen-Almagor, *'Belgian Euthanasia Law: a Critical Analysis' (*2009) 35 Journal of medical Ethics 436*;* Vermeersch, E, *'The Historical and Ethical Background: The Belgian Law on Euthanasia'* (2002) 102 Acta chir belg 394. The provision in respect of an emancipated minor should be contrasted with *Loi du 22 aout 2002 relative aux droits du patient [Law on Patient's Rights], art 12§2,* which provides that minors can exercise patient rights in keeping with age and level of maturity. In short, if they can reasonably appreciate their circumstances, they may exercise rights on their own behalf.

[74] The Committee on Public Health of the House of Representatives provided an advisory role for the Committee of Justice when the latter was considering the *Euthanasia Bill*. It unanimously recommended that mental suffering alone should never suffice to legitimate euthanasia. See Parliamentary Proceedings, Chamber of Representatives, 2001-02, 50-1488/9:379. However, none of the recommendations of the committee were followed.

[75] There is no requirement that the person requesting euthanasia be either a Belgian citizen or a resident.

ensure that the patient *"is in a medically futile condition."*[76] Whatever elasticity of interpretation may be applied to the term *"medically hopeless situation"* it is clear that it is the patient alone who determines whether he is suffering from persistent and unbearable physical or mental suffering.

(ii) The Doctor

Similar to the Dutch law, only a doctor can perform euthanasia legally in Belgium.[77] Section 3 states explicitly that the doctor who performs euthanasia commits no criminal offence when he/she ensures that a number of conditions and procedures have been observed.[78]

Section 14 provides for a situation in which a doctor refuses to perform an act of euthanasia for medical reasons. The Act does not provide specifically for the situation in which a doctor refuses to perform euthanasia for reasons of conscience other than to state that no doctor may be compelled to perform euthanasia. Whether or which, he is obliged to inform the patient and those

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[76] The *raison d'etre* for not requiring a condition of terminal illness appears to have been arrived at as a result of confusion on the part of the legislators as to the meaning of *'terminal'*.

[77] No special competencies are required other than the requisite qualifications and a permit to practice from the Ministry of Health.

[78] The patient must have attained the age of majority or be an emancipated minor, and is legally competent and conscious at the time of making the request; the request is voluntary, well-considered and *"repeated"*, and is not the result of any external pressure; the patient is in a *"medically futile"* condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident. The Act does not define *'repeated'*. It is presumed that the request for euthanasia must be made more than once.
The doctor is obliged (i) *to inform the patient as to his/her condition and life expectancy and must discuss with him or her the request for euthanasia; (ii) must discuss with the patient alternative therapeutic and palliative courses of action, if any, and their consequences; (iii) together with the patient must come to the belief that there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary; (iv) must be certain that the patient's constant physical or mental suffering and of the durable nature of his/her request; (v) in order to assure himself of both the nature of the suffering and the durability of the request he must have several conversations with the patient spread over a reasonable period of time, taking into account the progress of his/her condition; (vi) must consult with another doctor, independent of both the patient and the patient's own doctor, as to the serious and incurable nature of the patient's disorder and must inform the other doctor of the reasons for his being consulted.* The second doctor must be qualified to give an opinion in respect of the disorder in question, *must review the patient's medical record, examine the patient himself, be certain if the persistent and unbearable nature of the physical or mental suffering, be certain if the fact that it cannot be alleviated and must submit a written report of his findings to the patient's doctor who, in turn, is obliged to inform the patient of the results of the consultation.*
There are additional requirements in circumstances where the patient is not expected to die imminently. In such a situation the doctor must also consult a psychiatrist or a specialist in the disorder in question and inform him or her why he or she is being consulted.
In the event that there is a nursing team in regular contact with the patient the request for euthanasia must be discussed with them and, if the patient so desires it, with duly nominated relatives. He must also ensure that the patient has the opportunity to meet and discuss his or her request with whomsoever he or she wishes.

"persons taken in confidence" by the patient[79], if any, of this fact in *"a timely manner"* and explain his reasons for such refusal.

Where a doctor refuses to perform euthanasia he must, within a reasonable timeframe, inform the patient or, where the patient is not conscious, the person of confidence nominated by the patient, of his decision and the reasons for his refusal. At the request of the patient or his person of confidence, the doctor must transfer the patient's medical record to a doctor nominated by the patient himself or his person of confidence. If the reason for the doctor's refusal to comply with the patient's request is based on medical grounds, those grounds must be noted in the patient's medical record.

(iii) The Request for Euthanasia

The Act differentiates between a current request (Section 3) and a request via an advance directive (Section 4*).*

Section 3.1 provides that the doctor must ensure, in order not to commit a criminal offence, that the request must be *"voluntary", "considered"* and *"repeated"* and *"must not result from any external pressure"*.

The request can only be considered when the patient has weighed up all the relevant factors and has, together with the doctor, come to the *"belief"* that there is no reasonable alternative to his/her situation.[80]

The doctor must satisfy himself that the request is durable. To do so he must have several conversations with the patient over a reasonable period of time. The request must be drawn up,

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[79] Allowed for under Article 4 of the Act. In the case of an advance request, one or more *"person(s) of confidence can be designated, in order of preference, to inform the attending doctor about the patient's wishes. Each person of confidence replaces his/her predecessor in the event of a refusal to act, hindrance, incompetence or death. The patient's doctor, the doctor consulted and the members of the nursing team may not act as "persons of confidence".*

[80] The issue of *'tired of life'*, similar to that which accompanied consideration of the *Brongersma* case in the Netherlands (*Nederlandse Jurisprudentie 2003, No. 167*) arose in Belgium in 2009. A 93-year-old lady (Van Esbeen) went on hunger strike to hasten her death after her request for euthanasia was denied. She was not suffering from a terminal illness. Her request was granted eventually. In its 2010 Report the Control and Evaluation Commission recognised that the *"ills of the elderly"*, such a *"poor sight, poor hearing, poor verbal skills and dependence on others"*, could amount to *"unbearable suffering"*. Wim Distelmans, the head of the Commission stated that the *"euthanasia law should be changed to enable seniors who are tired of life to be able to request this method." See Commission Federale de Controle et d'evaluation de l'euthanasie, Quatrieme Rapport aux Chambres Legislatives (Annees 2008 et 2009) (2010) 24 <www.health.belgium.be/eportal/Healthcare/Consultativebodies/Commissios/Euthanasia/Publications/index.htm?fodnlang=fr> accessed 20 February, 2013.*

written, dated and signed by him or her (section 3.4), if he or she is able to write.[81] It must be retained in the patient's medical record (section 3.5).

Apropos the patient's request, it will be recalled that the *Law on Palliative Care,* which was enacted simultaneously with the *Euthanasia Law*, stipulates that all patients be informed as to palliative care as an alternative treatment. Article 2 of the *Palliative Care Act* specifically provides for a right to such care at the end of life for every patient. The objective is to ensure that all patients in such circumstances are provided with the maximum quality of life and autonomy.[82]

(iv) The Advance Directive

Section 4 outlines the requirements for a request for euthanasia by an advance directive. While these appear to be more detailed than those listed for a current request they are in reality much the same except for one important difference.

The substantive criteria for a valid current request, as listed at Section 3.1 – *"voluntary, considered, repeated and not the result of any external pressure"* - are not explicitly required. If a

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[81] In the event that the patient, arising from a disability for example, is not capable of drafting, writing, dating or signing his request this can be done by the person designated by the patient. This person must not have any material interest in the patient's death, must have reached the age of majority, must indicate that the patient is incapable of formulating his request in writing and state the reasons why this is the case. The request must be drafted in the presence of the doctor and while it is not required that the doctor sign the request his name must be indicated in the document. While the patient can revoke the request at any time, should he/she do so the document must be removed from his/her medical record and returned to the patient, nonetheless the fact of the request together with the reports of consulted doctors are to be noted in the patient's medical record (Section 3.5).

[82] *Section 3.2* of the *Euthanasia Act* obliges a doctor, prior to complying with a patient's request for euthanasia, must discuss with him or her *'the possible therapeutic and palliative courses of action and their consequences.'* It would appear that this particular provision is the basis for the obligatory consultation with a specialised palliative care team, known as the *'palliative filter'* implemented in Catholic hospitals, mainly in Flanders. While euthanasia for competent terminally ill patients is permitted in these hospitals, as required under the law, it is performed only after the *'palliative filter'* has been engaged. The aim, apparently, of the usage of this *'filter'* is to ensure that there is sufficient communication and knowledge between and on the part of the providers of care for a patient who has requested euthanasia, of the palliative care alternatives. There is no specific provision for such a *'filter'* in the *Euthanasia Act* but the matter was discussed when the bill was being debated in the House of Representatives. The Commission for Public Health endorsed an amendment which, if accepted and passed, would have seen such a provision included in the final version of the *Act.* However, this amendment was not considered by the Justice Committee. Griffiths is of the view that since a doctor may, under Sections 3.2 and 4.2 of the Act, make his willingness to accede to a request for euthanasia subject to additional conditions, *"a palliative filter can be required by individual doctors and health care institutions."* See Griffiths et al, op.cit, fn 5 supra, at 316.
The requirement that the doctor discuss with the patient possible therapeutic an palliative care options could be interpreted as meaning that a patient who refuses treatment may, as a result, cause his or her condition to become *"medically hopeless",* a term which was not defined in the *Act.* A doctor could then legitimately – under the provisions of the Act – comply with the patient's request for euthanasia. Therefore, it is possible that the only objective requirement contained in the Act namely, that of a serious and incurable condition caused by accident or illness, could be created by the patient him or herself through a refusal to countenance alternative treatment!

person is no longer able to express his or her will, he or she, while legally competent and of age, or an emancipated minor, can rely on an advance directive instructing a doctor to perform euthanasia. The doctor must ensure, however, that the patient is suffering from a serious and incurable disorder, caused by illness or accident; is no longer conscious; and that the condition is irreversible given the current state of medical science.[83]

There are a number of conditions which must be complied with before an act of euthanasia on foot of an advance directive is carried out. These are not dissimilar to those which apply in a situation where the patient has made a voluntary and repeated request for euthanasia and where there is no reasonable alternative to his or her situation.[84]

However, a number of issues arise in connection with these criteria.

First, the request in an advance directive becomes effective in circumstances where the person concerned is no longer in a position to express his or her wishes. It does not mean that that there is an automatic right to euthanasia in such a situation. It simply means that the request contained in the directive becomes a valid request for euthanasia.

Second, in 2003 a Royal Decree, regulating the way in which an advance request for euthanasia should be drafted, confirmed, changed or revoked, contained a model advance request form.[85] While it was not stated that there was an obligation to use this particular model Section 4(1) of the

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[83] An advance directive can be drafted at any time. It must be composed in writing in the presence of two witnesses, at least one of whom has no material interest in the death of the patient. It must be dated and signed by the drafter, the witnesses and by the person(s) taken in confidence, if applicable.
In circumstances where the person who wishes to draft an advance directive is incapable of writing, due to permanent physical handicap, he/she may designate a person who is of age, and who had no material interest in the death of the person in question, to draft the request in writing, in the presence of two witnesses who have reached the age of majority and at least one of whom has no material interest in the patient's death. The advance directive must indicate that the person on question is incapable of signing and why. The directive must be dated and signed by the drafter, by the witnesses and by the person(s) taken in confidence, if applicable.
A medical certificate which states that the person in question is permanently physically incapable of drafting and signing the directive must be attached to the advance directive which is only valid if it is drafted no more than five years prior to the person's loss of ability to express his/her wishes. It can be amended or revoked at any time.

[84] See fn.72 supra. With regard to the condition that a another doctor be consulted a system known as **SCEN** was established in the Netherlands which allowed for consultation opportunities with those already trained in all aspects of euthanasia for doctors who were confronted with a request for early death. See Chapter II on the Netherlands. In 2002, a similar programme, known as **LEIF** (**Forum for End of Life Information**) was established in Flanders to fulfil the same purpose. The difference between the two programmes, however, is that whereas the Dutch system is specifically for general practitioners its Belgian counterpart includes not only general practitioners but also specialists. From an early stage the Regional Review Committees in the Netherlands welcomed and endorsed the **SCEN** system. The Federal Control and Evaluation Commission, which was established under the Euthanasia Act, has not expressed any view on the operation of **LEIF**.

[85] http://www.ejustice.just.fgov.be/cgi/welcome.pl.

Euthanasia Law states that the King (in effect, the relevant Government Minister) has the power to regulate the *"manner in which the advance directive is drafted, registered and confirmed or revoked, and the manner in which it is communicated to the doctors involved via the offices of the National Register".*

However, a Royal Decree published in 2007[86] stipulates that only requests in line with the *Decree's* template can be registered by the local authorities where the person concerned has drafted the request. The authorities are obliged to register the request and send it to the Federal Ministry of Health database. Where a doctor is confronted by a request for euthanasia as a result of an advance directive he is now obliged to consult this database prior to carrying out the request.

Section 4.1 states that in order to be a valid act of euthanasia the doctor must ensure that the patient is no longer conscious and that this condition, given the current state of medical science, is *"irreversible".* There is no requirement that there be *"unbearable suffering".* Presumably, this is because there was an assumption that patients in such a condition are incapable of suffering. This is one area where there is a notable difference between the Dutch and Belgian laws. In the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* a requirement of *"unbearable suffering"* continues to apply in the case of an advance request. There is general consensus in the Netherlands, however, that the recognition of written requests, especially in the case of patients suffering from dementia, is an empty gesture since the requirement of *"unbearable suffering"* continues to obtain. Patients who suffer from severe dementia are considered not to suffer and the suffering of other non-competent patients can be alleviated by pain relief and sedation.

(iv) Federal Control & Evaluation Commission

Any doctor who has performed euthanasia is required to complete a registration form which has been drawn up by the Federal Control and Evaluation Commission. This document must be delivered to the Commission within four working days of the act of euthanasia.[87]

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[86] <http://www.ejustice.just.fgov.be/cgi/welcome.pl>.

[87] There is some confusion as to the exact interpretation of what constitutes a *"serious"* departure from the requirements for legal euthanasia. The Dutch law leads to similar confusion. Not completing the necessary documents in the proper way is, on its face, just as serious a criminal offence as failure to comply with the substantive requirements concerning the patient's request, suffering and medical condition. The Council of State alluded to this issue during the parliamentary debates and averred that the law may not fulfil the requirement of proportionality. See Advice of the Council of State, Parliamentary Proceedings, Senate, 200-01, no 2-244/21: 15-16.

The composition and remit of the *Commission* are detailed in Section 6 of the Act. It is composed of sixteen members who are appointed on the basis of their knowledge and experience *"in the issues belonging to the Commission's jurisdiction."*[88]

The Commission now performs the role which would have been fulfilled previously by the public prosecutor in circumstances where a doctor had reported an act of euthanasia. Similar to the objective which led to the establishment of the Regional Review Committees in the Netherlands one of the primary aims of the Belgian Federal Control and Evaluation Commission is to encourage doctors – who are no less wary of the criminal justice system in Belgium than they are in the Netherlands – to report euthanasia cases. Consequently, the composition of the Commission provides not only for a professionally and socially oriented assessment of the actions of a doctor but also ensures that the criminal aspects of any such action do not obtrude.

The registration form which a doctor who has performed euthanasia must complete consists of two parts, both of which are confidential.[89]

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[88] The Act is very specific as to the competencies of the Commission members. Eight are doctors of medicine, of whom at least four are professors at a university in Belgium; four are professors of law or, alternatively, are practicing lawyers and four are members are drawn from groups who deal with the problem of incurably ill patients. Membership of the Commission cannot be combined with a post in one of the legislative bodies or with a post as a member of the federal government or one of the regional or community governments.
While respecting language parity – where each linguistic group has at least three candidates of each sex – and ensuring pluralistic representation, the members are appointed by Royal Decree enacted after deliberation in the Council of Ministers, for a four year term, which may be extended, from a double list of candidates put forward by the Senate.
The mandate of a member is terminated *de jure* if the member loses the capacity on the basis of which he/she was appointed. The candidates not appointed as sitting members are appointed as substitutes, in the order determined by the list.
The Commission is co-chaired by a Dutch-speaking and a French-speaking member. The chairpersons are elected by the Commission members of the respective linguistic groups. Its decisions are valid only if there is a quorum present of two-thirds of the members.

[89] The first document, which is sealed, containing the patient's full name and address, the full name, address and health insurance institute registration number of the attending doctor, the full name, address and health insurance institute registration number of the doctor(s) consulted about the euthanasia request, the full name, address and capacity of all persons consulted by the attending doctor, and the date of these consultations. In the case of an advance directive the full names of the person(s) taken in confidence must also be included. This document can only be consulted following a decision by the Commission. Under no circumstances can the Commission use this document for its evaluation of the particular case.
The document comprising the second part of the registration process contains: (i) the patient's sex, date and place of birth; (ii) the date, time and place of death; (iii) the nature of the serious and incurable condition, caused by accident or illness, from which the patient suffered; (iv) the nature of the constant and unbearable suffering; (v) the reasons why this suffering could not be alleviated; (vi) the elements underlying the assurance that the request is voluntary, well-considered and repeated, and not the result of any external pressure; whether one can expect that the patient would die within the foreseeable future; (vii) whether an advance directive has been drafted; (viii) the procedure followed by the doctor; (ix) the capacity of the

The Commission studies the completed registration form submitted by the attending doctor. On the basis of the second document the Commission determines whether the euthanasia was performed in accordance with the conditions and the procedure stipulated in the *Euthanasia Act*. In cases where there is doubt the members of the Commission may decide by simple majority to revoke confidentiality and examine the first part of the registration.[90]

The Commission may request the attending doctor to provide any information from the medical record dealing with the euthanasia.

It must hand down its verdict within two months from the date of first consideration of the case. If, in a decision taken with a two-thirds majority, the Commission is of the opinion that the requirements of the *Act concerning Euthanasia* have not been fulfilled it can notify the prosecutor of the particular jurisdiction in which the patient died.[91]

The Commission is required, as per Section 9, to submit reports *"the first within two years of the Act's coming into force and every two years thereafter."*[92]

In order to carry out these tasks the Commission may seek additional information from the various public services and institutions. This information is confidential. None of the documents obtained during this exercise may reveal the identities of any persons named in dossiers submitted for the purposes of the review. The Commission can decide to supply statistical and purely technical data, purged of any personal information, to university research teams that submit a reasoned request for such data. The Commission can also grant hearings to experts.

Within six months of submitting its first report and the Commission's recommendations, if any, a debate has to be held in both the Senate and the House of Representatives. The six-month period is suspended during the time that parliament is dissolved and/or during the time there is no government having the confidence of Parliament.

It is a matter of some interest to note that the Belgian Act, in contrast to the Dutch Act, does not specify what offence, if any, is committed by a doctor who fails to comply with the established

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doctor(s) consulted, the recommendations and the information from these consultations; (x) the capacity of the persons consulted by the doctor, and the date of these consultations; (xi) the manner in which euthanasia was performed and the pharmaceuticals used.

[90] If, after anonymity has been revoked, facts or circumstances come to light which would compromise the independence or impartiality of one of the Commission members, this member will have an opportunity to explain or to be challenged during the discussion of this matter in the Commission.

[91] To date there are no such recorded incidents.

[92] These are to consist of: (i) a statistical report processing the information from the second part of the completed registration forms submitted by doctors pursuant to the requirements laid down in Section 8 of the Act; (ii) a report in which the implementation of the law is indicated and evaluated; (iii) if required, recommendations that could lead to new legislation or other measures concerning the execution of the Act.

criteria. As noted previously, Belgian criminal law, unlike the Dutch Penal Code, does not include the distinct offence of ether euthanasia or assistance with suicide. Nys has posed the question: what offence does a doctor in Belgium commit if he performs euthanasia without meeting the conditions set down in the *Euthanasia Act?*[93] Is it manslaughter[94], murder[95], poisoning[96] or some other offence? The uncertainty is not ameliorated by the absence of case law on the matter.

The Belgian authorities, as has been demonstrated, decided to regulate euthanasia by means other than amendment of its Penal Code.[97] The Council of State, in its advice to Parliament during the debates on the *Euthanasia Bill,* observed that the failure to identify a specific offence appeared to be an infringement of the principle of legality in criminal law.[98]

(v) Special Provisions

The Act contains a chapter on what it refers to as *'Special Provisions'*. In Section 14 it makes clear that the request and the advance directive referred to in Sections 3 and *4* are *"not compulsory in nature."* No doctor may be compelled to perform euthanasia. Neither can any person be compelled to assist in performing an act of euthanasia. The requirements for a doctor who refuses to perform euthanasia are contained in this section. He or she is obliged to refer the person requesting either euthanasia or assisted suicide to a doctor whom he or she knows will comply with the request.

A person who dies as a result of euthanasia performed in accordance with the conditions established by the Act is deemed to have died of *"natural causes"* for the purposes of prior contracts he or she had entered into, in particular insurance contracts.

In 2011, **1133** reported acts of euthanasia were performed in Belgium and at the time of writing a proposal to reduce the age of consent of a minor to an act of euthanasia from 18 to 12 is before the Senate.[99] The matter has yet to be resolved.

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[93] Nys, H, in Griffiths, Weyers & Adams, op.cit., fn 5 supra, p.327.

[94] *Article 292 of the Penal Code.*

[95] *Article 394 of the Penal Code.*

[96] *Article 397 of the Penal Code.*

[97] There was some recognition of the problems attached to proceeding with legislation outside of the confines of the Penal Code during the debates in Parliament. However, adopting a different approach would have meant delay which was not a prospect the Government parties at the time were prepared to countenance.

[98] See Advice of the Council of State, Parliamentary Proceedings, Senate, 2000-01, no 2-244/21: 12-13. However, this advice was ignored.

[99] The biennial reports of the Federal Control and Evaluation Commission indicate a steady increase in the incidence of reported euthanasia cases. However, there are grounds for believing that there is a continuing problem with underreporting. Research conducted on deaths in 2007 estimated that only

9. Conclusion:

While it is beyond question that the promoters of the legitimation of euthanasia in Belgium – a predominantly Catholic country - were influenced greatly by the experience of the neighbouring jurisdiction, the Netherlands, the circumstances leading to the passage of the *Act Concerning Euthanasia, 2002,*[100] were entirely different. The formal legislative endorsement of euthanasia by the Dutch authorities represented the culmination of a lengthy jurisprudential, prosecutorial and medical co-operative engagement. No such co-operative dynamic occurred in Belgium.

The contrasting lengths of the respective legislative provisions are indicative of the different approaches adopted. The brief Dutch statute, *The Termination of Life and Assisted Suicide (Review Provisions) Act, 2002,* formalised a pragmatic combination of an established justificatory defence for a doctor who performs euthanasia on request and a list of the *'due care'* criteria underpinning the legality of such action. Other than the provision of statutory authority for the *Regional Review Committees* little, if anything, in the Dutch Act, was of a novel jurisprudential nature. As has been demonstrated the *'due care'* criteria' had been agreed previously by the prosecutorial authorities, the courts and the medical profession.

The Belgian legislation, on the other hand, contains very detailed definitional, substantive and procedural provisions. The authorities did not pursue the route, as did the Dutch, of amending the existing Penal Code. Instead they acted *de novo*. The *Act Concerning Euthanasia, 2002*, places greater emphasis on the rights of the individual, especially that of self-determination than is evident in the Dutch statute. The latter was predicated more on the achievement of legal certainty for doctors who performed euthanasia than on any overarching desire to provide greater scope for the already enshrined legal principles of self-determination and individual autonomy.

50% of euthanasia cases were being reported in the Flanders region and that the incidence of euthanasia approximated to **1.9%** of all deaths. See Bilsen, Cohen, Chambaere & Pousset, *'Medical End-of-Life Practices under the Euthanasia Law in Belgium',* (2009) 361 New England Journal of Medicine 1119: *"The most important reason given by physicians for not reporting a case to the review committee was that the physician did not perceive the act to be euthanasia **76.7%**)."* See also Smets, Bilsen, Cohen et al, *'Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases',* (2010) 341 British Medical Journal; Chambaere, Bilsen, Cohen et al, *'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey',* (2010) 182 (9) Canadian Medical Association Journal 895.
The profile of patients requesting euthanasia has remained relatively consistent since reporting began. The majority come from the Flanders region (**80%**). **80%** suffer from cancer. The age profile is **66-80.** However, the Reports of the Control and Evaluation Commission published to date indicate that euthanasia is being availed of by a younger cohort.

[100] The *Act Concerning Euthanasia 2002* legalised the practice of euthanasia by doctors, but assisted suicide, contingent on the fulfilment of detailed substantive and procedural requirements. See *fn.2 supra for further elucidation.*

Prior to the enactment of the Belgian *Law Concerning Euthanasia, 2002,* a doctor, as per *Articles 95* and *96* of the *Deontological Code*, could not intentionally cause the death of a patient or help him/her to take their own lives. The *Code* was amended after the passage of the *Euthanasia Act*. *Articles 95* and *96* of the current Code states that when a physician receives a question regarding the end of life from a patient, the physician has to inform him/her of all possible options and provide any medical and moral assistance required.

The Belgian *Order of Physicians*, unlike its counterpart in the Netherlands, the *Royal Dutch Medical Association (KNMG)*, considered legal regulation of euthanasia undesirable and believed the matter was best left to individual doctors. It did not appear to be unduly concerned at the putative absence of legal certainty for those of its members who did perform – albeit covertly – acts of euthanasia. The results of studies carried out in Flanders – where 60% of the Belgian population lives - in the late 1990s and the early 2000's, proved conclusively, however, that medical end-of-life practice for many physicians in Belgium did include euthanasia.

Unlike the Dutch prosecutorial authorities those in Belgium preferred a policy of non-engagement. This accorded with the perceived national disinclination either to acknowledge that euthanasia was in fact being practiced or that normative criteria for its regulation and control were required. The approach adopted towards the legitimation of euthanasia was galvanised primarily by political opportunism rather than by any deep-seated conviction as to the necessity for either legal clarity or the affirmation of an individual's right to determine the manner and timing of his/her death.

There are specific protocols governing the legal practice of euthanasia in Belgium. The *Act Concerning Euthanasia 2002* deals extensively with the patient, the doctor, the request for euthanasia, advance directives, the *Federal Control & Evaluation Commission* and special provisions.

The *Federal Control & Evaluation Commission* – not dissimilar to the Dutch *Regional Review Committees* - performs the role which would have been fulfilled previously by the public prosecutor in circumstances where a doctor had reported an act of euthanasia. As with the *Regional Review Committees* one of the primary objectives underpinning the establishment of the *Commission* was to encourage doctors to report those acts of euthanasia that they had performed to the relevant authorities. To date there is insufficient empirical data available as to the success or otherwise of this objective.[101]

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[101]See *fn.99 supra.*

In contrast to the Dutch *Act* the Belgian statute does not specify what offence, if any, is committed by a doctor who fails to comply with the established criteria. Unlike the Dutch Penal Code, Belgian criminal law does not include a distinct offence or either euthanasia or assisted suicide. The legitimate question has been posed, therefore, as to what offence a Belgian doctor commits if he/she performs euthanasia without meeting the conditions set down in the law. Is it manslaughter, murder, poisoning or some other offence? As has been pointed out by Nys[102] the uncertainty is not ameliorated by the absence of case law on the matter.

[102] See *fn.59 supra.*

Chapter IV – Altruistic Death in Switzerland

1. Introduction

The Swiss approach to third party assistance with death is at once unique and unremarkable: unique in that the determinative criterion it employs to ascertain culpability arising from the requested participation by one person in the self-induced death of another is essentially altruistic in nature; it decriminalises all such action other than in those instances where self-interest is involved.

It is unremarkable in that like many other jurisdictions imbued, to a greater or lesser degree, by the Western jurisprudential tradition which considers life to be of inherent value, it specifically proscribes voluntary active euthanasia.

Non-natural death in Switzerland is not trivialised. Causing intentional death is legally impermissible and a guilty finding attracts a lengthy custodial sentence. Similarly, both voluntary and involuntary manslaughter are proscribed and are accorded appropriate penal sanction.[1] In addition, suicide prevention is a stated and robust objective of the state authorities.

Notwithstanding its invocation of a base motive – *selfishness* – as the sole determinant of culpability in the provision of assistance with suicide[2] Switzerland's overall legal disposition in the matter of death, intended or otherwise, while different to other jurisdictions in its criminal categorisations,[3] is neither whimsical nor arbitrary.

However, if a not unreasonable perception of existential pragmatism is to be dissipated the apparent incompatibility of Switzerland's embrace of the principle of the sanctity of life and of its liberal approach to the evaluation of non-attributable criminal guilt for assistance in the

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[1] Article 111-115 of the Penal Code adopted in 1942.

[2] Article 115 of the Penal Code reads: "*Any person who, for selfish reason, incites someone to commit suicide or who assists that person in doing so shall, if the suicide was carried out or attempted, be sentenced to a term of imprisonment (Zuchthaus) of up to five years or a term of imprisonment (Gesfangnis).*" According to the French tradition the Swiss Penal Code distinguishes three types of imprisonment: Zuchthaus (*penitentiary*), Gesfangnis (*prison*), and Haft (*detention*). The only practical relevance of this distinction relates to the maximum length of imprisonment. In the case of intentional killing, for example, the minimum is 5 years, the maximum 20 years imprisonment.

[3] The structure of the law of homicide in Switzerland differs substantially from that in other jurisdictions. The law of intentional killing is not synonymous with murder. A person who intentionally kills another person will be guilty of *vorsatzliche Totung* (*intentional killing*) and the charge will only be increased to one of murder (*mord)* if it can be shown that the perpetrator acted with a "*reprehensible motive*" (*Qualifizierung*). In certain circumstances the perpetrator will be guilty of a lesser degree of killing (*Privilegierung*).

suicide of another, requires convincing jurisprudential, ethical and sociological explanation. Historical contextualisation is of assistance in this regard.

2. Historical Context

The eighteenth century witnessed a fundamental change in the criminal law's approach to suicide.[4] The medieval dogma – both religious and secular – which held that suicide was a crime was gradually abandoned.

Traditionally, the only suicides to escaped punishment at English law were those induced by insanity.[5] However, by the late 1700s and the early 1800s, enforcement of the common law's penalty of the forfeiture of the movable goods – but not the real property - of a person who had committed suicide had become a rarity.[6]

In Pennsylvania, in 1701, criminal penalties for suicide were rejected in its *Charter of Privileges to the Province and Counties*.[7] The view that *"there can be no greater cruelty, than the inflicting of a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender"*[8] was not uncommon. When drafting a bill to reform Virginia's laws Thomas Jefferson had written that the law should *"not add to the miseries of the party by punishments or forfeiture."*[9] The Massachusetts Supreme Judicial Court

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[4] This occurred throughout most of Europe and in North America.

[5] *"That a madman is not liable is true"* - Bracton, *On the Laws and Customs of England 424* (Samuel E. Thorne edition, 1968).

[6] *"In weariness of life or because he is unwilling to endure further bodily pain,"* ibid. Although Bracton advocated a lesser penalty for suicides undertaken out of weariness of life or abhorrence of pain, all acts of intentional self-destruction were condemned. That he made an exception in the case of those who committed suicide out of weariness of life or the abhorrence of pain is noteworthy because he took Roman statutes as a guide for his views on the suicide laws that would be applicable for England. See Meskill, W, *'Is suicide Murder?*, Columbia Law Review 379, 1903, at 380.

[7] *The Earliest Printed Laws of Pennsylvania, 1681-1713*, Cushing, J, ed., 1978: *"If any person, through Temptation or melancholy, shall Destroy himself, his Estate, Real and Personal, shall, notwithstanding, Descend to his wife and Children or Relations as if he had Died a natural death"*, at 209. By the beginning of the nineteenth century New Hampshire, Maryland, Delaware, New Jersey, North Carolina and Rhode Island had passed statutes or constitutional provisions repealing criminal laws against suicide. See *NH* Const. pt 2, art. 89 (1783); Md Const of 1776, decl. of rights, s.24; Del. Const. of 1792, art 1, s.15; NJ Const. of 1776, art.17; NC Const. of 1778; RI Pub. Laws, s.53, at 604 (1798).

[8] 2 Zephaniah Swift, *'A System of the Laws of the State of Connecticut'*, 1796, at 304. Swift was an early American treatise writer who later became Chief Justice of the Connecticut Supreme Court.

[9] 2 Thomas Jefferson, *'Papers of Thomas Jefferson 496, 496n'*, (JP Boyd, ed., 1952). Jefferson recognised at an early stage that suicide was a disease, op.cit., at 325. Modern studies suggest that as many as 90% of all suicides may suffer from a diagnosable medical disorder. See Conwell & Caine, *'Rational Suicide and the Right to Die: Reality & Myth'*, 325 New Eng.J.Med.1100, 1991, at 1101 *("90 to 100 per cent of [suicides] die while they have a diagnosable psychiatric illness")*; Schneidman, ES, *'Rational Suicide and Psychiatric Disorders,* 326 New Eng. J. Med 889, 1992; Hendin & Klerman, *'Physician-assisted Suicide: The Dangers of Legalisation'*, 150 Am. J. of Psychiatry 143, 1993; Stengel, E, *'Suicide and Attempted Suicide'*, 52 New Engl. J, Med 1964, arguing that one-third of people committing suicide suffer from *"a neurosis or psychosis or severe personality disorder"*; Robins, E, *'The*

explained that the state legislature's decision to repeal criminal penalties for suicide as one *"which may well have had its origin in consideration for the feeling of innocent surviving relatives."*[10]

The dissipation of penal sanctions against suicide was reflected in jurisprudential and sociological attitudes in Switzerland also.[11]

Nonetheless, the continued penal sanction for the participation by third parties in another's suicide was considered necessary.[12] Stooss, generally regarded as the father of the Swiss Penal Code, stated, for example, that *"anyone who induces the unfortunate [suicide] to commit the act or assists him therein deserves punishment; for the reasons that exclude punishment of the suicide do not apply to the participant."*[13]

The logical corollary to the qualification of self-interest contained in Article 115[14], however, is that in the absence of such motives, assistance with suicide is legally permissible.[15] The non-criminal character of assisted suicide is implicitly rather than explicitly stated.

Final Months' 10, 1081 *("94% of suicides studied had a mental disorder");* Barraclough, B, et al, *'A Hundred Cases of Suicide: Clinical Aspects,* 125 Brit.J.Psychiatry, 355, 1974 *("93% of suicides studied suffered from a mental disorder").* In its commentary to the Model Penal Code, the American Law Institute reflected the contemporary view, explaining that "*there is scant reason to believe the threat of punishment will have deterrent impact upon one who sets out to take his own life*" because such a person "*more properly requires medical or psychiatric attention."* Model Penal Code, s.210.5, cmt.2.

[10] Mink, 123 Mass., at 429. Gorsuch has stated that "*the change in attitude toward criminal penalties...was the result of a growing consensus that suicide often betokened a medical problem*." See his '*The Future of Assisted Suicide and Euthanasia'*, Princeton University Press, 2006, at 31.

[11] See Carl Stooss's treatise on the criminal law, '*Die Grundzuge des Achweizerischen Strafrechts, Base, Geneva, 1983*, at 15:*"Swiss laws rightly make no provision for the punishment of a suicide whose attempt has failed; in most cases he act stems from a mental disturbance, and in all cases from a state that calls for sympathy rather than punishment."* (translation provided by National Advisory Commission on Bioethics NEK/CNE in its '*Opinion no.9/2005'*, Bern, 2005.

[12] *"Incitement to and assistance in suicide is an act of such an immoral nature and the actions of the parties concerned involve such a breach of the legal order that the imposition of a specific penalty is advisable."* See Wellauer, V, *'Der Selbstmord: ibersondere Anstiftung und Behilfe zum Selbstmord' (Diss.jur.Fak.), Bern, 1896, at 94;* Stooss: "*But anyone who induces the unfortunate [suicide] to commit the act or assists him therein deserves punishment; for the reasons that exclude punishment of the suicide do not apply to the participant.*" Op.cit., fn.11 supra, at 26.

[13] *Ibid.*

[14] *See fn.2 supra.*

[15] *"If the qualification is deleted the Article will be applied more frequently, but it will then affect in particular people with honourable motives arising from loyalty – for example, men who out of friendship facilitated the suicide of a dishonoured comrade," Protokoll der zweiten expertenkommission*, 1918. *Article 102* of the Draft Penal Code formulated by the Federal Council in 1918 provided for a sentence of up to 5 years imprisonment for participation in a suicide for self-interested motives. See Report submitted by the Federal Council to the Federal Assembly on the draft Swiss Penal Code, 23 July, 1918, *BBI 1918 IV, at 32.* Criminal laws specifying penalties for involvement in suicide were in force in the cantons of Schaffhausen, Ticino, Berm, Fribourg and Neuchatel from the early 20th century. See also National Advisory Commission on Bioethics, *'Opinion no.9',* op.cit, fn.11 supra, 26.

The specific offence of inciting and assisting in suicide, other than for altruistic reasons, was incorporated into the Penal Code of 1942 as Article 115, and has remained unaltered ever since.[16] Its adoption, unlike that in respect of abortion, which was keenly disputed, was relatively uncontroversial.

In summary, therefore, Swiss law in respect of the provision of assistance with suicide is no different to that in other jurisdictions within the Western jurisprudential tradition. Penalisation accompanies such action.[17] Switzerland, however, is the only known jurisdiction in which *altruism* can be invoked in mitigation.

In truth, Article 115 was a compromise resolution of the extremes of absolute punishment and undifferentiated punishability.[18] An objective requirement for *assistance* is that the person in question must make a causal contribution to the attempted or accomplished suicide.[19]

In the matter of subjective requirements, the person providing assistance must, in the first instance, act with premeditation, that is, premeditation involving an awareness and acceptance of the possible consequences (*"Eventualvorsatz"*) with regard to the self-killing carried out by the person who, exercising control over the act and acting independently, commits suicide; the same kind of premeditation is required in relation to the incitement or

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[16] Swiss legislators believed it necessary to include a criminal provision for assisted suicide in order to prevent abuses (suicide itself not being illegal). They did so, however, in a manner which exculpated those who assisted others in committing suicide for altruistic reasons.

[17] In most European countries, including Austria, Italy, England/Wales, Ireland, Spain, Portugal and Poland, assisting suicide is a criminal offence. In other countries, such as Scotland, Sweden and France, while assisted suicide is not explicitly covered by criminal statutes, existing laws are interpreted to the same effect. No specific offence exists in German criminal law. Participation in an independent act of self-killing by a third party is essentially non-punishable, provided that it is limited to acts of assistance. There is no equivalent of Article 115 of the Swiss Penal Code in German law. See Ulsenheimer, K, *'Arztliche Sterbehilfe'*, in Laufs. A, Uhlenbruck, W, Oenzel,B, Kern, R, Krauskopf, D, Schlund, GH and Ulsenheimer, K (eds), *'Handbuch des Arztrechts'*, Beck, Munich, 2nd ed., at 1226. See also Report of Federal Ministry of Justice*: Die Rechtslage in Deutschland zur Sterbehilfe* (July, 2002). Under the Dutch *Termination of Life on Request and Assisted Suicide (Review Provisions) Act, 2002,* active euthanasia and assisted suicide are *"decriminalised"* under certain conditions. See Chapter II on the Netherlands. The Belgian *Law on Euthanasia, 2002*, does not expressly apply to assisted suicide. In 2003, however, the Belgian Order of Physicians announced that assisted suicide is equivalent to euthanasia so long as the provisions of the *Law on Euthanasia* have been followed. See *Tijdschrift van de Orde van Geneesheren, 2003, no.100.* In 2004, the Belgian *Federal Control and Evaluation Commission*, established under the *Law on Euthanasia,* in its first biennial evaluation report, stated that it considered assisted suicide to fall within the definition of euthanasia. See *FCEC 2004-05: 13-14, 21.* See also Chapter III on Belgium.

[18] *"While it was recognised that assisting in suicide essentially merits punishment, punishability was restricted to acts committed from self-interested motives, which amounts to a qualification of the general provisions concerning involvement in Article 26 of the Penal Code."* See National Advisory Commission on Bioethics *'Opinion no.9/2005'*, op.cit., fn.11 supra, at 30.

[19] Assistance, like abetment *("Gehilfenschaft")* under Article 25 of the *Penal Code*, may also take the form of *"psychological"* support.

abetment. Secondly, the person committing the offence must have acted for *"selfish reasons."*[20]

Permissibility of altruistic suicide is not overridden by a duty to save life.[21] Consequently, assistance with suicide is practiced in Switzerland with virtual impunity.

From the early 1980s onwards Swiss private right-to-die organisations[22] identified the implicit approval of assistance with suicide contained in the Penal Code[23] as an opportunity to provide such assistance untrammelled by fear of criminal prosecution. In the interim their services have been availed of exponentially, both by Swiss residents and non-residents alike.[24]

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[20] According to prevailing Swiss jurisprudence, indifference on the part of the person involved in the suicide is sufficient to rule out any such motivation. The reasons are deemed to be selfish if the offender is pursuing personal advantage. Such gains may be of a material nature, but also non-material or emotional, such as gratification of hatred, a desire for revenge, spite, etc. The qualification concerning the subjective reasons for the act means that involvement in suicide is partially prohibited, with punishability being the exception rather than the rule.

[21] See Sayid, M, *'Euthanasia: a comparison of the criminal laws of Germany, Switzerland and the United States'*, Boston College International Comparative Law Rev, 1983, 6, at 533.

[22] There are four right-to-die organisations in Switzerland: *EXIT Deutsche Schweiz*; *EXIT Association pour le Droit de Mourir dans la Dignite*; *DIGNITAS*; and *EXIT International*. The latter two offer assistance to people who are not resident in Switzerland. *DIGNITAS* was founded in 1998. There are unconfirmed reports that it has provided assistance with suicide to some 1000 persons in the period 1998-2012. Almost all assisted suicides take place within the regulations established by these organisations. Their modus operandi is exemplified by the regime at *EXIT Deutsche Schweiz (EXIT DS),* founded in 1982: it provides assistance only after an evaluation process which requires that the wish to die is deliberate and stable, the patient (known as a *'member'*, who pays a fee) suffers from a disease with a hopeless prognosis, and the suffering is unbearable, unreasonable and disabling. Most *'members'* considered eligible for help are close to death. *EXIT DS* routinely recommends both hospice care and notification of the family. Difficult cases are referred to *an* ethics committee for review. Those seeking assisted suicide must be examined by a doctor. No prescription for the requisite lethal dose of barbiturates - sodium pentobarbital – is issued until the patient's medical condition and decisional capacity has been ascertained. If deemed eligible, but his/her own doctor declines to participate, *EXIT DS* can refer the member to a collaborating physician who would consider assessing the *'member'* and prescribing the lethal drugs. The prescription is obtained at a local pharmacy by an *EXIT DS* volunteer and stored at its headquarters until the day of use. Prior to usage the member's decisional capacity is again assessed. At the time of death, the volunteer notifies the police, who attend with a medical officer. Provided that there are no indications that the assistance violated Swiss law, the case will be closed. The law is only violated when a selfish motive is empirically established.
See Dignitas: *'To Live with Dignity, To Die with Dignity. Accompanied suicides of members of Dignitas, by year and country of residency'*, available at *http://www.dignitas.ch/images/stories/pdf/statistics-ftb-jahr-wonsitz-1998--2011.pdf*
Dignitas: *'How Dignitas Works: On what philosophical principles are the activities of this organisation based?' http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf*
Exit: *'Melden Sie sich an' www.exit.ch/wDeutch/2110001/melden_sie_sich_an.php.*
Exit, Annual Report of the Control Committee 2009(2009) *http://www.exit.ch/wDeutch/2110058/archiv_jahresberichte.php?navanchore=2110066*
Exit, Annual Report *<exit.ch/wDeutch/2110058/aechiv_jahresberichte.php?navanchor=2110066>*

[23] Under the 1942 Code the competence for substantive law was largely transferred from the cantons to the confederation.

[24] See section 5 below

Private right-to-die societies provide assistance with suicide on their own premises, and in accordance with such regulatory controls as they themselves have developed, allied to those recommended by the Swiss Academy of Medical Sciences (SAMS).[25] Because selfish reasons are absent, however, this practice is not punishable.[26]

Following a recommendation in 2005 by the National Advisory Commission on Biomedical Ethics (NEK/CNE)[27] the facilitation of assisted suicide is now also available in a number of acute-care hospitals.[28]

The Commission, while averring that it was right, "*on ethical grounds*",[29] that assisted suicide should not be considered a criminal offence unless it is performed for "*self-seeking reasons*", nonetheless deemed it necessary to recommend additional regulations for the proper control

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[25] See Schweitzerische Akademie der Mweizinischenc Wissenschaften (2004), '*Care of patients in the end of life – Medical-ethical Guidelines of the SAMS'* (adopted and approved by the Senate of SAMS, 25 November, 2004) <*www.samw.ch/en/Ethics/Guidelines/Currently-valid-guidelines.html*> accessed 21 January, 2013. Historically, physician-assisted suicide was discouraged by SAMS. The decision to assist in a suicide is ultimately a matter of conscience for the individual doctor, *op.cit, para.4.1.* In January, 2012 the Central Ethics Committee of SAMS re-affirmed its position on assisted suicide. This led to a lively debate in the medical profession. In February, 2013 the Committee issued a tender for a study of "*attitudes of the medical profession for assisted suicide*."

[26] However, the argument that the payment of a membership fee, together with charges for assistance with an actual assisted suicide, constitutes material benefit and as such encompasses an element of selfishness, might be made. In 2007, a psychiatrist, Peter Baumann, was found guilty for assisting a suicide for "*selfish*" motives on the basis of a desire for publicity. He had allowed an assisted death to be filmed and broadcast on national television. Subsequently, however, he was acquitted by the Court of Appeal which reaffirmed the legal understanding of "*selfish*" motives as that of material gain. For further discussion see *Levy, G, 'Assisted Death in Europe and America', OUP, 2011.*

[27] National Advisory Commission on Biomedical Ethics, Opinion no. 9/2005. Behilfe zum Swizid <*www.bag.admin.ch/nek-cne/index.html?lang=en.* accessed 15 January, 2013.

[28] In 2000 Zurich City Council had lifted an existing ban on assisted suicide in nursing homes. See Ernst, C, '*Assistierter Siuizid in den Stadturcher Alters-und Krankenheimen [Assisted Suicide in Nursing Homes of the City of Zurich]*', Schweizerische Arztezeitung 82: 293-5. However, the Council maintained the ban on assisted suicide in city hospitals. In 2006, following a recommendation of the Commission on Biomedical Ethics, both the Lausanne University Hospital and the Geneva University Hospital decided to permit right-to-die organisations to provide on-campus assistance to terminally ill, non-ambulatory patients who seek suicide assistance but are unable to leave hospital. See Chapman, C, '*Swiss Hospital Lets Terminally Ill Patients Commit Suicide in its Beds'*, Brit. Med. J. 332:7, 2006. See also *Schweizerische Depeschenagentur [*Swiss News Agency*], 'Genfer Unispital lasst Sterbehilfe zu [Geneva University Hospital Allows Assistance in Dying]'*, Neue Zurcher Zeitung, 15 September, 2006. In 2007, the Zurich Cantonal University Hospital re-affirmed its ban on assisted suicide on its premises and adopted a stance of "*studied neutrality.*" See also Wasserfallen Jean Blaise, Chiolero Rene, Stiefel Friedrich, *'Assisted Suicide in an Acute Hospital: 18 months' Experience'*, Swiss Medical Weekly, 2008, 138 (15-16): 239-242. This study indicated that of the **54,000** patients admitted between the beginning of January, 2006, and the end of June, 2007, **six** requests for assistance with suicide were recorded, all within the first seven months after the introduction of the directive and in the context of severe and life-threatening diseases. However, only **one** of the six patients, living in a nursing home attached to the hospital, died by assisted suicide.

[29] *Op.cit., fn.27 supra, Recommendation No.3.*

of the modus operandi of right-to-die organisations,[30] together with protocols for the practice of assisted suicide in specific circumstances.[31]

The Commission, however, did not provide a prescriptive evaluation of the particular ethic underpinning the legality of assisted suicide in the absence of selfish motives; its advice was restricted solely to its proper practice, regulation and control.

In 2009, the Swiss Justice Minister presented two draft bills to the Federal Assembly, one of which proposed an outright ban on right-to-die societies, while the other advocated severe restrictions on the availability of assistance with suicide.[32]

These proposals were widely viewed as an attempt to restrict what is referred to as death tourism.[33] All parties represented in the Federal Council,[34] with the exception of the centre-right Christian Democrats, opposed the suggested restrictions. They regarded existing laws as sufficient for the regulation of private organisations providing assisted suicide services.[35] In the event, in 2011, the Federal Council announced that specific regulations in respect of organised assisted suicide would not be included in the criminal law.[36]

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[30] Ibid. The internal guidelines of right-to-die organisations invariably require a person seeking assistance with suicide to be suffering from a disease with *"poor prognosis, unbearable suffering or unreasonable disability."* See Dignitas: *'How Dignitas Works: On what philosophical principles are the activities of this organisation based?'*, available at http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf See also *Schweizerische Depeschenagentur [Swiss News Agency]*: *'Genfer Unispital lasst Sterbehilfe zu [Geneva University Hospital Allows Assistance in Dying]'*, Neue Zurcher Zeitung, 15 September, 2006. The Commission's recommendations for additional regulations are contained in its *Recommendations Nos. 5, 6, 7 and 8.*

[31] Including for the mentally ill, for children and adolescents, and for residents of acute care hospitals and long-term residential institutions.

[32] Including the need for a doctor's certificate stating that the patient suffered from an incurable and probably fatal illness, and for an informed decision to end life had been made voluntarily by the patient.

[33] The international publicity attaching to the putative ease with which non-residents, unable to avail of assisted suicide in their own jurisdictions arising from its criminal prohibition, could do so in Switzerland, had become a cause of reputational concern both at national and cantonal levels.

[34] The Federal Council (in German: *Bundesrat*; in French: *Conseil federal*; in Italian: *Consiglio federale*; in Romansh: *Cussegl federal)* is the seven-member executive council which constitutes the federal government of Switzerland. It was instituted by the 1848 Federal Constitution as the *"supreme executive and directorial authority of the Confederation."* (*Cst.Art.174*).

[35] In March, 2011, the canton of Zurich voted overwhelmingly – by a margin of **78%** - in favour of allowing non-residents to continue to avail of the services of DIGNITAS, the organisation most commonly associated in the international public mind with accessibility to assisted suicide in Switzerland. In an interview in March 2008, Ludwig Minelli, its founder, stated that in its first decade *Dignitas* had assisted 840 people to die, 60% of whom were German, with the remainder coming from France, Austria and the UK. By 2012 this number had reportedly exceeded 1000. See Dignitas homepage: <http://www.dignitas.ch> accessed 7 October, 2012.

[36] See Federal Department of Foreign Affairs, *'Assisted Suicide/ Euthanasia in Switzerland'*, 15th December, 2011: *"Switzerland's laws that prohibit killing continue to apply in full. Direct, active euthanasia (deliberate killing in order to end the suffering of another person) is therefore also forbidden. By contrast, both indirect, active euthanasia (the use of means having side-effects that may*

In 2012, the Central Ethical Committee of the Swiss Academy of Medical Sciences (SAMS) issued a position paper[37] on problems which it had identified with the practice of physician-assisted suicide. Notwithstanding the miniscule number of cases in which doctors had either been prosecuted or had had their licences to prescribe controlled substances revoked, the Committee nonetheless was apprehensive that in some instances action by doctors might be more accurately categorised as "*unacceptable realisations of physician-assisted suicide*", a practice which it considered unethical.[38] The question of whether people with mental disorders should be eligible for assisted suicide was also raised[39] and the need for action in other areas of the law was identified.[40]

In essence, the recommendations of the Commission on Biomedical Ethics, both in their specificity and taken as a whole, while symptomatic of a well-intentioned desire to tighten the existing regulations governing the practice of assisted suicide, were indicative also of a collective societal complicity prevalent in a carefully calibrated ambivalence, both legally and

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shorten life) and passive euthanasia (rejecting or discontinuing life-prolonging measures) – while not governed by any specific statutory provisions – are not treated as criminal offences provided certain conditions are fulfilled. No legislative action is need with regard to these forms of euthanasia. After several in-depths reviews of the situation, the Federal Council has come to the conclusion that criminal law I Switzerland does not require any explicit provisions on organised assisted suicide, as any abuses that may occur can be combated effectively by existing legal means."

[37] Schweizerische Akademie der Medizinischen Wissenschafter 2005 '*Betrenning von Patienten am Lebensende Medizinisch- ethische Richlinen. Schweizerische Arctezeitung 86. ['Care of patients in the end of life' – Medical-Ethical Guidelines].*

[38] Traditionally, SAMS had discouraged the involvement of doctors in assisted suicide. It did not regard such action as part of a physician's duties. See '*Medical-ethical guidelines for the medical care of dying persons and severely brain-damaged patients' (1995*), available at <www.samw.ch>, accessed 7 October, 2012. Following criticism (see Guillod & Schmidt, '*Assisted Suicide under Swiss Law*' (2005) 12 European Journal of Health Law 25), new guidelines were issued in 2004. These advised doctors that patient' wishes must be taken into account. While a doctor is not obliged to assist in a suicide, if he/she chooses not to do so he/she must diagnose and confirm a terminal illness which will result in death within days or weeks; he/she must discuss the alternatives with the patient and he/she must confirm both capacity and voluntariness. Most importantly, the doctor must not administer the lethal substance to the patient. See *'Care of Patients in the End of Life,'* op.cit., fn.37 supra, at 4.1. Non-medical experts played an increasing role in the formulation of guidelines from the 1980s onwards. They are treated with virtually the same respect normally accorded statutory provisions. While the 1999 *Task Force on Assisted Dying [Arbeitsgruppe Sterbehilfe*] averred that they were not legally binding nonetheless they continued to be of influence in cantonal health laws and are frequently cited in case law in respect of medical-ethical issues.

[39] It adopted a cautious stance on this matter and called for the prioritisation of psychiatric and psychotherapeutic care. Nonetheless, it did recommend that assisted suicide should not be provided in cases where suicidality is a manifestation or symptom of a mental disorder. It also examined the problem of young people who, although legally still minors, are mentally competent; assisted suicide in hospitals and care homes; the implications for health care professionals; and the issue of so-called "*death tourism*".

[40] It was of the view, for example, that in order to address specific problems that had been identified arising from the emergence of right-to-die organisations, such bodies needed to be subjected to state supervision. This would ensure that decisions on assisted suicide were arrived at in compliance with what was referred to as "*quality*" criteria. However, the federal authorities did not agree. They were not disposed to insert into the criminal law regulations regarding organised assisted suicide.

ethically, towards end-of-life issues, and manifested most particularly in its exclusion of culpability for altruistic involvement in assisted suicide.

However, other than that which it advocated for acute care hospitals - and which has been implemented in a number of such institutions[41] - many of its recommendations, while acknowledged generally to be of commendable value, remain unenforced.

3. The Law

Euthanasia is a criminal offence in Switzerland.[42] Direct, active euthanasia - deliberate killing in order to end the suffering of another person – is punishable as intentional homicide (*Vorsatzliche Totung*) under Article 111 of the Swiss Penal Code (*Strafgesetzbuch).* Prior to the introduction of the *Code* the formulation and application of the criminal law had been solely a cantonal matter.[43]

Article 111 states that a person who intentionally kills another person will be sentenced to a term of imprisonment (*Zuchthaus*)[44] of at least five years, provided that none of the special conditions set out in subsequent articles of the Code, specifically those referable to the crimes of killing on request (*Totung auf Verlangen*), and assisting someone to commit suicide (*Verleitung und Beihilfe zum Selbstmord*),[45] apply.

Notwithstanding the proscription of euthanasia[46] *per se* both indirect, active euthanasia – the use of means having unintended side-effects that may shorten life – and passive euthanasia

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[41] See fn.28 supra. Patients should not be restricted from receiving assistance with suicide within the curtilage of their campuses. Instead every effort should be made to facilitate competently made decisions for assisted suicide, either in the institutions themselves or, where this is not possible, elsewhere.

[42] See Hauser, R and Rehberg, J (eds): '*Schweizerisches Strafgesetzbuch [Swiss Penal Code]*', 1986, Orell Fussli, Zurich; Hurst, SA & Mauron, A, '*Assisted suicide and euthanasia in Switzerland: Allowing a role for non-physicians*', British Medical Journal, Vol.326 (1 February 2003), 271-3. See also Schwarzennegger & Sumners, '*Criminal Law and Assisted Suicide in Switzerland (Hearing of the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords, 3/2/2005), 2-3, www.rwi.uzh.ch/lehreforschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide-Switzerland.pdf* accessed 12 December, 2012.

[43] On coming into effect in 1942 all federal legislation that contradicted the new Code was abolished. The competence for substantive law was largely transferred from the cantons to the confederation. The cantons retained only the competence on the regulations of cantonal procedural law and cantonal tax legislation and violations.

[44] See fn.2 supra.

[45] Articles 114 and 115 respectively.

[46] Switzerland eschews the use of the term '*euthanasie*', evoking as it does unwelcome connotations of Nazi eugenic policies and practices. Instead the benign term '*sterbehilfe*' – which, in rough translation, means '*assisted dying*' – is employed. This term encompasses "*all medical acts and omissions that foreseeably or intentionally hasten the death of a terminally-ill patient, that is to say, it is the functional equivalent of medical behaviour that potentially shortens life.*" See Bosshard, G, in Griffiths et al, '*Euthanasia and Law in Europe*', *Hart Publishing, Oxford and Portland, 2008, at 463. Sterbehilfe* is

– rejecting or discontinuing life sustaining or prolonging measure are not treated as criminal offences in Switzerland provided certain conditions are fulfilled.

If anybody kills another person, at the latter's *"serious and urgent request"*, the punishment is less severe than that which applies to intentional homicide, provided that the perpetrator, irrespective of professional status or none, acts from *"honourable motives"*. Such an offence is governed by the terms of Article 114 of the Code which deals with *"death on request"* or *"Totung auf Verlangen"*.[47] This offence carries a lower minimum sentence than either murder or manslaughter.[48]

If, therefore, in order to relieve the suffering of a terminally ill patient, a doctor administers an agent that may also have the unintended side-effect of shortening the patient's life, or what is otherwise known as indirect active euthanasia, this act is not punishable, irrespective of whether the patient's consent has been given or not.[49] The legitimacy of this practice in Switzerland, as in other jurisdictions where it is employed, is commonly believed to reside in the doctrine of double effect.[50]

Likewise, in a situation where the doctor withholds or withdraws life-sustaining or prolonging measures, or gives effect to what is commonly referred to as passive euthanasia, such action is considered permissible on the grounds that a doctor cannot be expected to *"prolong fading life to the outermost limits of what is technically possible in the face of overwhelming contrary interests, particularly those of the patient concerned."*[51]

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normally divided into four categories: passive, indirect, active and assisted suicide. See *Arbeitsgruppe Sterbehilfe [Task Force on Assisted Suicide]: Report to the Federal Office of Justice and Police, 1999, at 12-14.*

[47] Article 114 reads as follows: *"Anyone who yields to an honourable motive, notably compassion, and who, when requested seriously and urgently by a person, bestows death on that person will be punished by imprisonment."*

[48] The minimum punishment is 3 days imprisonment (*Gesfangnis*), the maximum is 3 years imprisonment (*Gesfangnis*).

[49] The term active *Sterbehilfe* does not specify whether the decision was made at the explicit request of the patient or with his/her consent. The same holds for the terms indirect *Sterbehilfe* and passive *Sterbehilfe*. See Bosshard, G, *'Begriffsbestimmungen in der Sterbehiledebatte [Terminology in the Euthanasia Debate]'*, Swiss Medical Forum 5, 2005, 193-8.

[50] The doctrine of double effect is not directly referred to in Swiss jurisprudence. Death as a result of indirect active *sterbehilfe* - where the action is motivated by a desire to relieve pain and suffering, but not to kill, is considered natural. Passive *sterbehilfe* arises when death is caused by the underlying illness or disease and is not restricted to end-of-life decisions – a competent patient can refuse treatment at any time. See fn. 56 in Chapter II on the Netherlands and fn. 11 in Chapter VI on England.

[51] Stratenwerth, G & Jenny, G, *'Schweizerisches Strafrecht, BesondereTeil 1: Straftaten gegen Individualinteressen'*, 6th ed., Bern, 2003, at 24. The distinction between withholding and withdrawing is of little significance in either the legal or ethical debates on third party assistance with death in Switzerland. The term *'passive Sterbehilfe'* means largely the same thing as that which is referred to internationally as *'non-treatment decisions.'* See van der Heide et al., *'End-of-Life Decision-making in Six European Countries: Descriptive Study'*, Lancet 362, 2003, at 345.

If, on the other hand, the doctor merely procures the lethal means for a patient who wishes to commit suicide, and the patient acts independently, he is not liable to punishment unless his actions were prompted by self-interested motives.

Where the medical treatment is discontinued at the patient's express wishes, punishability does not arise provided the patient's decision has been reached autonomously and without any external pressure. If the patient is no longer capable of expressing his or her wishes, a previous declaration, such as an advance directive,[52] competently and voluntarily made, is decisive. In the absence of such a declaration, however, the medical duty to treat, or not, is determined by the dying patient's presumed wishes.[53]

Since all such cases essentially involve an act of killing undertaken with an awareness and acceptance of the possible consequences, the absence of penal sanction requires appropriate legal and ethical justification. A variety of exonerating factors have been invoked, including that of *'permissible risk'*, the *'doctor's professional duty'*- as contained in Article 32 of the Penal Code - or a state of *'necessity'*, otherwise known as *'conflicting duties'*.

However, other than in the recent exceptional instance of a case involving serial offences, prosecutions and convictions under Article 114 are virtually non-existent.[54]

Article 115 of the Penal Code deals with inciting and assisting another person to commit suicide (*Verleitung und Behilfe zum Selbstmord*). Such an act is not illegal if the person providing help is not motivated by self-interest[55] and in most cases the permissibility of

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[52] In its 1995 guidelines SAMS had stated *"if an advance directive is available to the physician which has previously been written by the patient while mentally competent, it shall be binding." Op.cit., fn. 37 supra.* In 2008, the Swiss Parliament adopted the *Law on the Protection of Adults ('Erwachsenenschutzrecht' or 'loi sur la protection de l'adulte')*. This law has not yet come into effect. As a result there is no specific law relating to advance directives at federal level. In some cantons, such as Argovia, Appenzell, Berne, Outer Rhodes, Geneva, Lucerne, Valais and Zurich, advance directives are covered by health care legislation. The *Law on the Protection of Adults* states that everyone can make an advance directive concerning the type of care that they would or would not like to receive in specific situations when they are no longer able to express their wishers. Advance directives are also governed by laws relating to the protection of privacy and personal liberty – Articles 27 & 28 of the Civil Code and Article 10 of the Constitution.

[53] The Advisory Commission on Biomedical Ethics recommends that in such cases, it is advisable to consult people close to the patient, relatives and friends, and to nursing staff. See *Opinion no.9/2005, op.cit., fn 27 supra.*

[54] In 2004 there was a criminal case in Lucerne in which the accused was charged with twenty-four killings and three attempts to kill. See *'Aus Uberforderung getotet. Luzerner "Todespfleger" muss wegen 24 Totungen und 3 Totungsversuchen vor Gericht'*, Der Bund, 15th January, 2004.

[55] See Cassani, U, *'Assistance au suicide, le point de vue de la penaliste', in Medicine et Hygiene, 1997, 55, at* 616-77. See also *Zeigler, S & Bosshard, G, 'Role of non-governmental organisations in physician-assisted suicide'*, British Medical Journal, 2007, 334, at 295-8. The logical corollary of the specificity of *"selfish reasons"* as the determinant of the offence of involvement in an assisted suicide is that such involvement is non-punishable if it is undertaken unselfishly. Involvement is taken to mean *'incitement'* and *'assistance'* (*"Verleitung und Behilfe"* in German, *'incitation et assistance'* in French and

altruistic assisted suicide cannot be overridden by a duty to save life.[56] There is no requirement for the involvement of a doctor. The patient need not be terminally ill. The governing criterion is that the motive be unselfish.[57] For legal validity[58] the mental capacity of the person requesting assistance is also required. Absent capacity, the resultant suicide would not be deemed a voluntary and free decision and the person assisting would face prosecution for intentional killing.

The specific constituent elements which distinguish the offence of assisted suicide at Swiss law are as follows:

(a) ***Physical elements***: There must be a genuine act of suicide.[59] The victim alone must causes his or her own death. He or she must exercise control over the act.[60] Acts of incitement – or instigation as per the language of Article 24 of the Code – or assistance – which encompasses abetment according to Article 25 – are punishable only in those cases where suicide is completed or is at least attempted.

The provisions concerning incitement and assistance relate to all persons, irrespective of their profession, training or institutional affiliation. They make no reference to specific contexts or situations in which people express a wish for support in committing suicide but are applicable in a general manner. The provisions essentially allow anyone – relative, friend or stranger - to offer services relating to the execution of a suicide, as long as the motives for the offer are not self-interested.[61]

'istigazione e aiuto' in Italian). In criminal law doctrine, as interpreted by the Committee on Biomedical Ethics (see *Opinion no.9/2005, fn.27 supra*), the term *'incitement'* applies to cases where a decision to commit suicide was provoked in some other person. For such an act to constitute *'incitement'*, it must also be the case that this other person committing suicide (i) *exercised control over the act and* (ii) *acted independently*. The objective requirements for this offence are the same as for instigation *("Anstiftung")* under Article 24 of the Penal Code.

[56] Stratenwerth, G, *'Schweizerisches Strafrecht'*, Bern: Stampfli, 1983 (BT1.1N 49).

[57] Articles *114* and 115 require contextualisation within the totality of the approach to non-natural death contained in the Penal Code. The relevant articles dealing with murder, manslaughter or *'voluntary'* culpable homicide, negligent killing or *'involuntary'* culpable homicide and infanticide are as follows: Article 112 (*Mord*), Article 113 (*Manslaughter/ Totschlag)*, Article 116 (*Infanticide/Kindestotund*), Articlke 117 (*Negligent killing/fahrlassige Totung*).

[58] Pursuant to the legal capacity provisions in Article 18 of the Civil Code: *"A person who lacks legal capacity cannot, unless a statutory exception applies, enter into any legal transactions."*

[59] *Opinion no. 9/2005, op.cit., fn.27 supra, at 30.*

[60] If another person is responsible for the killing, for example, if someone is driven to suicide through *"severe maltreatment"* or if a third party gives the willing victim a lethal injection, this is not a case of suicide but of deliberate killing, punishable under Articles 111-114 of the Penal Code

[61] See Bosshard, G, witness statement in *Carter v Canada 2012 BCSC 886, at para 592: "As a basis for an open practice of assisted suicide, Article 115 is interesting for two reasons. First, it makes no mention of doctors – the legality of assisting suicide, in the absence of self-interest, holds good for any person. Secondly, there is no mention of any medical precondition. The only prerequisite is implicit, namely that the individual wanting help to commit suicide must have decisional capacity, since*

(b) ***Mental Elements***: An intention is required on the part of the perpetrator to bring about a decision to commit suicide, or to support the execution of a suicide. By contrast, negligent participation is not punishable. In addition, the perpetrator must have acted from self-interested motives.[62]

The provisions of Article 115 are far-reaching, therefore, in that their applicability is not restricted other than by the requirement of an absence of self-interested motives. It neither restricts the practice of assisted suicide to physicians nor does it impose any requirements in respect of a particular illness or medical condition.

However, an entitlement to assistance with suicide is not encompassed by the Penal Code. What the Code does ensure is a liberty right – the right to avail of such assistance in circumstances where the person intent on committing suicide acts independently and the person whose help is required to give effect to that intention acts altruistically.

In summary, therefore, the following categories of assistance with death, their legal status and the requisite reporting requirements are as follows in Switzerland:

- **Passive sterbehilfe** (*withdrawing or withholding*) life-prolonging treatment is considered to be a natural death, is legal but must be reported to the civil authorities.

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otherwise he would not be 'Handlungsfahig' (have legal capacity) and his act could not be considered suicide."

[62]Issues of jurisprudential interpretation do arise, however, with regard to three specific matters: (i) *mental capacity*; (ii) *failure to prevent suicide* and (iii) *motive.*

(i) **Mental Capacity**: If *Article 115* is to be applicable, the person wishing to commit suicide not alone must be able to appreciate the significance of his/her proposed course of action but must also act in accordance with this understanding. If this does not happen, the parties involved may be liable to punishment for a crime of killing under *Article 111* of the Penal Code. While at first sight, a voluntary and considered act of suicide might appear to be questionable in the case of evident mental illness, nonetheless *Article 115* may be applicable if the person wishing to commit suicide is deemed to be of sound mind at a particular lucid interval. See *Stratenwerth, G & Jenny, G, 'Schweizerisches, Besonderer Tel 1: Straftaten gegen Individualinteressen', 6th ed., Bern, 2003, at 38-42;* (ii) **Failure to prevent suicide**: the question that arises here is whether a guarantor, such as a physician or a spouse, is liable to punishment for failure to save the life of the person committing suicide. At issue is whether a duty to save life exists, at least from the point at which the power to act disappears, such as when consciousness is lost. The prevailing view among Swiss jurists is that failure to act is only punishable if it springs from *"self-interested"* motives. See *Stratenwerth & Jenny, op.cit., fn.50 supra, at 40*: (iii) **Motive**: An act is only held to spring from *"self-interested"* motives if the party concerned is pursuing a material advantage. In Switzerland the concept is understood in a broad sense. This is particularly underlined by the fact that in the wording of *Article 115* the term *"intent or gain"*, which occurs elsewhere in the Penal Code, is not used. Nonetheless, the term *"self-interested motives"* does encompass the gratification of emotional needs, such as hatred, revenge or spite. The presence of a single self-interested motive is sufficient. In this regard the French version of the law – *"Celui qui, pousse par in mobile egoiste[...]"* – is more precise that the German and Italian versions –*"Wer aus selbstsuchtigen Beweggrunden [...]"* and *"Chiunque per motive egoistici [...]"* respectively. An attitude of complete indifference is not liable to punishment under *Article 115.*

- **Indirect sterbehilfe** (*pain and symptom relief with life-shortening effect, including terminal sedation*) is considered to be a natural death, is legal but must be reported to the civil authorities.
- **Assisted Suicide** is considered to be non-natural, is legal if not self-interested (Article 115 of the Penal Code) and must be reported to the criminal authorities.
- **Voluntary active sterbehilfe** (*euthanasia*) is considered to be non-natural, is illegal (Article 114 of the Penal Code) and must be reported to the criminal authorities.
- **Non-voluntary active sterbehilfe** (*termination of life without request*) is considered to be non-natural, is illegal (Article 113) and must be reported to the criminal authorities.

4. Practical Implications of Article 115

While the legal situation, in principle, allows for anyone, including relatives, friends and strangers, to give assistance with suicide,[63] in reality the development of an open and widespread practice of assisted suicide coincided, from the early 1980s onwards, with the establishment of various right-to-die organisations.[64]

The foundations for what later became known as the *'Swiss model'* were laid in an early decision by *Exit* DS *"not to strive primarily for greater liberalisation of active euthanasia...but rather to use the liberal legislation concerning assisted suicide to offer such assistance on request to severely ill people wishing to die."*[65]

The precise role which a doctor in Switzerland plays in assisting a person to commit suicide is to provide the requisite prescription for the controlled drug, sodium pentobarbital. The drug must be prescribed, dispensed and used according to the established rules of medical practice.[66]

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[63] See Bossard, *op.cit., fn.61 supra.*

[64] See *fn.22 supra.*

[65] See Bosshard, Fischer & Bar, *'Open Regulation and Practice in Assisted Dying: How Switzerland Compares with the Netherlands and Oregon'*, Swiss Medical Weekly 132, 2002, at 527-34. In the first decade of its existence Exit DS sent a *'suicide manual'* to every person over the age of 18 who had been a member for at least three months. The manual contained precise instructions for committing suicide by placing a plastic bag over the head or by taking a cocktail of drugs. See *Friucker, G, 'Aus freiem Willen: der Tod als Erlosung: Erfahrungen einer Freitodbegleiterin* [*Out of Free Will: Death as Deliverance: Experience of a Right-to-Die Organisation's Volunteer]', Zurich,* Oesch, 1999. The cocktail contained a considerable amount of hypnotics. The person who wished to die had to obtain the pills from different doctors by pretending to be suffering from insomnia. Some of the members of *Exit DS* found these instructions impracticable and, beginning in the early 1990s, the organisation offered personal guidance to members wishing to die. However, this only became possible after the initial hostility of the medical profession to Exit DS had ameliorated.

[66] Article 11(1) of the *Narcotics Law* reads: *Medical doctors and veterinarians are obliged to use, dispense and prescribe drugs only to the extent this is necessary according to the acknowledged rules of medical science.* www.admin.ch/ch/f/rs/812_121/index.html#fn1accessed 14 January, 2013.

Courts in Switzerland have held that, in principle, assisting in suicide is not incompatible with the rules of medical practice.[67] However, the patient's competence to decide to seek assistance with death must be ascertained prior to a prescription for the lethal cocktail being issued.[68] This means that the doctor must examine the patient wishing to die, in person, and assess the medical conditions giving rise to that wish. One court posited a requirement of the "*existence of a condition indisputably leading to death*" if doctors were to assist in this way.[69] However, the court did not specify what medical conditions are covered by this term.[70]

Subsequently, the Federal Supreme Court held that an incurable, permanent, serious mental disorder can be the cause of suffering comparable to that of a physical disorder.[71] While not necessarily in violation of the rules of medical practice a doctor who prescribes a lethal dose of pentobarbital in such an instance must nonetheless obtain a report by an expert in psychiatry showing that the patient's wish to die is not the expression of a curable, psychiatric disorder but "*a well-considered and permanent decision based on rational judgment.*"[72]

The guidelines issued by the Swiss Academy of Medical Sciences in 2004 advised physicians that they must take a patient's wishes into account.[73] SAMS also issued criteria to assist in

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[67] See *Schweirzerisches Bundesgericht* [*Federal Supreme Court of Switzerland*], *Entscheid 2A.4812006, 2006.*

[68] See *Verwaltunsgericht des Kantons Zurich* [Zurich Administrative Court], Entscheid der 3. Kammer VB Nr 99.00145, 1999; *Verwaltungsgericht de Kantons Aargau [Aargau Administrative Court],* Entscheid BE 2003.00354-K3, 2005.

[69] See Zurich Administrative Court decision, 1999, see previous footnote.

[70] The situation was not helped by the obiter comments that it was "*extremely questionable*" whether mental illness would meet this requirement.

[71] See *fn.67 supra.*

[72] *Ibid.*

[73] '*Care of Patients in the End of Life*', op.cit., fn. 25 supra. Section 4.1 provides: "*According to Article 115 of the Penal Code, helping someone to commit suicide is not a punishable offence when it is done for unselfish reasons. This applies to everyone. With patients at the end of life, the task of the doctor is to alleviate symptoms and to support the patient. It is not his task to directly offer assistance in suicide; rather he is obliged to alleviate any suffering underlying the patient's wish to commit suicide. However, in the final phase of life, when the situation becomes intolerable for the patient he or she may ask for help in committing suicide and may persist in this wish. In this borderline situation a very difficult conflict of interest can arise for the doctor. On the one hand assisted suicide is not part of a doctor's task, because this contradicts the aims of medicine. On the other hand, consideration of the patient's wishes is fundamental for the doctor-patient relationship. This dilemma requires a personal decision of conscience on the part of the doctor. The decision to provide assistance in suicide must be respected as such. In any case, the doctor has the right to refuse help in committing suicide. If he decides to assist a person to commit suicide, it is his responsibility to check the following preconditions:*

- *The patient's disease justifies the assumption that he is approaching the end of life;*
- *Alternative possibilities for providing assistance have been discussed and, if desired, have been implemented;*
- *The patient is capable of making the decision, his wish has been well-thought out, without external pressure, and he persists in this wish. This has been checked by a third person, who is not necessarily a doctor.*

establishing the ability of a patient to make decisions in accordance with Article 16 of the Civil Code.[74]

The procedure regarding the consent of a patent incapable of making decisions, who does not have a legal representative and who has also not nominated a health care proxy is not expressly regulated at Federal level. However, while not uniform, legal regulations do exist at cantonal level.

5. Developments in respect of euthanasia and assisted suicide between 1994 and 2005

The Advisory Commission on Biomedical Ethics (NEK/CNE) was established in 2001 by the Federal Council to advise the federal government and cantonal authorities on bioethical issues.[75] It issued its *Opinion No.9/2005* on assisted suicide in 2005. The genesis of the Commission was the availability of empirical, albeit confidential, data[76] traversing a wide spectrum of determinants ranging from (i) perceived abuses in the practice of assisted suicide; (ii) previous official and legislative initiatives on euthanasia and assisted suicide; (iii) death tourism; (iv) the numbers availing of assisted suicide through right-to-die organisations; (v) assisted suicide in hospitals and old peoples' homes, and (vi) the blurring of the distinction between assisted suicide and active euthanasia.[77] For contextualisation purposes a brief resume is appropriate:

- *The final action in the process leading to death must always be taken by the patient himself."*

[74] The ability to understand information regarding the decision that is to be made; the ability to correctly weigh up the situation and the consequences resulting from possible alternatives; the ability to weigh up, rationally, information obtained in the context of a coherent system of evaluation and, the ability of the patient to express his/her own choice.

[75] Federal Office of Public Health, *'The National Advisory Commission on Biomedical Ethics'*<www.bag.admin.ch/nek-cne/index.html?lang=en>accessed 20 January, 2013.

[76] The data available to the Commission has been complied privately by a number of right-to die organisations.

[77] Other issues, such as the provision of assisted suicide for mentally ill patients, the influence of modern medicine on dying and the role of doctors and health care personnel were also factors which impelled the establishment of the Commission.
In the matter of the provision of assisted suicide for mentally ill patients depression, in addition to somatic diseases, had been identified in some instances of assisted suicide. See Ulrich, EA, *'Exit': Behilfe zum Suizid zwischen 1990 und 2000 (*Diss.Med.Un.), Zurich, 2002, at 24. See also *Bosshard, Kiesewetter, Rippe & Schwarzenegger : 'Suizidbehilfe bel Menschen mit psychischen Storungen – unter besonderer Berucksichtigung der Urteilsfahigkeit: Expertenbericht zu Handen von Exit-Seutsche Schweiz', Zurich, 2004, at 5.* As a result, one right-to-die organisation, EXIT DS, had announced a moratorium on suicide assistance for the mentally ill. (In 1998, it emerged that a doctor working for EXIT – Meinrad Schar, Professor of Preventative Medicine at Zurich University – had prescribed a lethal dose of sodium pentobarbital for a mentally ill 29 year-old woman in Basel, without a thorough diagnosis. Suicide had been prevented as a result of the intervention of the cantonal medical officer. EXIT initiated discussion on the precautions that would need to be taken before the moratorium could be lifted. The moratorium was lifted in 2004. See Baezner-Sailer, E, *''Physician-assisted Suicide in*

(i) ***Perceived abuses in the practice of assisted suicide***

An Exit DS[78]study had established that **21%** of assisted suicide cases involved people whose medical conditions could not, on any objective prognostic criteria, be regarded as hopeless.[79] A small number of mental disorders, mostly depression, were also found to have been included.[80] In some cases these practices were construed as abuses, and efforts, via parliamentary initiatives, were made to revise the provisions of Article 115. One such initiative called for incitement to be criminalised in all cases and for tighter restrictions to be placed on assisted suicide.[81] This was rejected and the question of when assisted suicide should be considered an abuse remained unresolved from an ethical perspective.

(ii) **Official and legislative initiatives on euthanasia and assisted suicide**

There had been a number of attempts to change the law to permit euthanasia, or *direkt aktive Sterbehilfe*.

A proposal, in 1994, to revise Article 115,[82] led to the establishment three years later of a Working Group to examine the matter and to make recommendations. In its report, entitled "*Sterbehilfe/ Assistance au deces*",[83] a majority of the members supported the addition of a

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Switzerland: A Personal Report', in Birnbacher & Dahl (eds), 'Giving Death a Helping Hand' (vol.38, Part III, International Library of Ethics, Law and the New Medicine, 2008, at 141).
With regard to the influence of modern medicine on dying the Commission acknowledged that advances in modern medicine created the need for a renewed debate on the issue of third party assistance with death and for changes to the institutional and legal framework so as to permit greater self-determination in dying.
Following a lengthy consultation process the role of doctors and health care personnel was the subject of revised guidelines published by the Swiss Academy of Medical Sciences (SAMS) in 2004. These guidelines allowed for doctors, in certain cases, to provide individual patients with assistance in suicide on the basis of a *"personal decision of consequence"*. See *Schweitzerische Akadenie der Mweizinischenc Wissenschaften (2004), 'Care of patients in the end of life',* op., cit., fn.25 supra, at 4.1.

[78] See fn.22 supra.

[79] The study covered the period **1990** to **2000** and examined **748** cases. The medical conditions which could not be considered hopeless included such ailments as polyarthritis, osteoporosis, arthritis, chronic pain, blindness and general infirmity.

[80] Bosshard, G et al, *'Foregoing Treatment at the End of Life in 6 European Countries',* Archives of Internal Medicine 165.

[81] Colloquially referred to as the *Vallender Initiative*, no. 01.407, 2001. Vallender was an elected member of the National Council.

[82] By a national councillor, Victor Ruffy. He had submitted the following motion for consideration by the Federal Council: *"Despite all the means of prolonging life that are currently available, there still remain incurable diseases whose progression severely impairs human dignity. In view of this fact, growing numbers of people in our society wish to be able to participate in decisions concerning the end of their own life and to die with dignity. I therefore request the Federal Council to present a draft for a new Article 115 of the Swiss penal Code."* See Report of the Working Group on Euthanasia to the Federal Department of Justice and Police, March 1999, available at *<http://www.ofj.admin.ch/bj/de/home/them,en/geselischaft/gesetzgebung/sterbehilde.html>*

[83] Ibid.

new paragraph to *Article 114* (*mercy killing on request*)[84] which would provide for an exemption on compassionate grounds.[85]

However, this was rejected by the Federal Council in 2000.[86] It was firmly of the view that legal regulations were required in the matter of passive or indirect active euthanasia and it categorically excluded the possibility of providing for an exemption to the offence of killing on request.[87]

Meanwhile, a majority of the Task Force on Assisted Dying[88] - established separately by the Federal Council in 1999 - advocated the decriminalisation of euthanasia, subject to conditions similar to those applicable in the Netherlands.[89] It recommended that the provisions of Article 115 in respect of assisted suicide should remain unaltered. The *Cavalli* initiative[90] – in

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[84] Article 114, *Totung auf Verlangen* (*killing on request*). *See fn.47 supra.*

[85] *"If the offender has killed a person who is incurably and terminally ill, in order to release that person from intolerable and intractable suffering, the competent authorities shall not institute criminal proceedings, refer the matter to court or impose penalties."*

[86] In the alternative the Council expressed support for increased usage of palliative medicine.

[87] *"Even an exemption from punishability for direct active euthanasia formulated in a highly restrictive manner, as proposed by the majority, would be tantamount to a relaxation of the prohibition on killing other people, thereby breaking a taboo that is deeply rooted in our Christian culture."* Cf. Parliamentary Initiative (*'Strafbarkeit der aktiven Sterbehilfe. Neufassung von Artikel 115'*) submitted to the National Council, 27 September, 2000 (00.441).

[88] *Arbeitsgruppe Sterbehilfe, Bericht an das Eidgenossisches Justiz-und Polizeidepartement* [*Report to the Federal Office of Justice and Police], 1999*. The Arbeitsgruppe had defined four categories of *Sterbehilfe* - active, assisted suicide, passive and indirect as follows: *Direkt active Sterbehilfe* encompasses any act undertaken to end the life of a terminally ill patient in order to prevent further pain and suffering. As used in Switzerland the term *Sterbehilfe d*oes not specify whether the decision was made at the explicit request of the patient or with his/her request. *See Bosshard, G et al, op.cit., fn* 80 supra. The term *Suizidbeihilfe of Beihilfe zum Suizid* refers to prescribing and/or supplying agents, usually a lethal drug, in order to help someone to end his/her life. In international jurisprudential commentary such action is usually referred to as physician-assisted suicide, the implication being that that it is an act carried out with the assistance of a doctor. The analogous German term – *arzliche Beihilfe zum Suizid* - is rather unusual in Switzerland since non-physicians play an important role in the Swiss practice of assisted suicide. See *Bosshard, op.cit. supra.* Passive *Sterbehilfe* refers to withholding or withdrawing life-prolonging measures. Any distinction between withholding and withdrawing is irrelevant in the Swiss context. The term passive *Sterbehilfe* in that jurisdiction is akin to international usage of the term *'non-treatment decision'*. See Van der Heide et al *'End-of-Life Decision-making in Six European Countries: Descriptive Study'*, Lancet 362:345-50. *Indirekt active Sterbehilfe* refers to the use of agents such a opioids or sedatives to alleviate symptoms of a terminally ill patient, with the unintended side effect of shortening the patient's life. The doctrine of double effect is invoked in support of such practice.

[89] *Ibid.* An amendment to *Article 114* was suggested which would provide that *"if the perpetrator helps a person, who is in the final stages of an incurable disease, to die to bring to an end insupportable and incurable suffering, the competent authority will not proceed against this person, will or force him to appear before a court nor inflict a penalty."*

[90] See *Strafbarkeit der aktiven Sterbehilfe. Neuregelung [Punishability of Voluntary Active Euthanasia. Revision]. Parliamentarische Initiative [Parliamentary Initiative] 00.441.* Available at *<http://www.parlament.ch/afs/data/d/bericht/2000/d_bericht_n_k12_0_20000441_01.htm>* The Assembly refused to countenance the legalisation of direct active Stedrbehilfe. However, in a move which, for the first time, approved of the prevailing practice of assisted suicide involving right-to-die organisations it also rejected a proposal, known as the Vallender Initiative, which would have *restricted*

effect, an attempt to decriminalise euthanasia on foot of the Task Force's recommendation – was rejected by the Federal Council in 2001.

In 2003, the Justice Department requested the National Advisory Commission on Bioethics to examine the ethical and legal aspects of the euthanasia issue in its entirety and to prepare a report and develop proposals for legal regulations by the spring of 2004. This mandate, however, was cancelled by a newly constituted Federal Council at the end of 2003.[91] Nonetheless, the Commission proceeded with its analysis of assisted suicide.

(iii) ***Death Tourism***:

In the cantons of Zurich and Aargau the right-to-die organisation Dignitas[92] increasingly offered assisted suicide to non-Swiss residents. The figures provided by the Zurich City Police prior to the commencement of the *Bioethical Commission's* examination of the issue were: **3** cases in **2000**, **37** in **2001**, **55** in **2002** and **91** in **2003**.[93]

(iv) ***Numbers availing of assisted suicide through right-to-die organisations***

The number of deaths assisted by Exit Deutsche Schweiz trebled from **110** in the period **1990-1993** to **389** in the years between **1997** and **2000.**[94]

(v) ***Assisted suicide in hospitals and old peoples' homes***

In January, 2001, the City of Zurich introduced regulations allowing assisted suicide to be carried out in public hospitals and old peoples' homes. In 2004, a recommendation issued by the Ethics Committee of the Association of Medical/Social Institutions of Canton Vaud (AVDEMS) supported the option of assisted suicides in hospitals and residential homes contingent, inter alia, on the proviso that the individuals concerned no longer possessed a family home.[95]

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assistance in suicide performed by these organisations and prohibited doctors from prescribing lethal drugs.

[91] Commenting on the withdrawal of the mandate the National Advisory Commission on Bioethics, in its *Opinion no.9/2005*, op.cit., fn.27 supra, averred that *"it is to be presumed that the needs underlying the various initiatives have remained unchanged"*

[92] See fn.22 supra.

[93] See report in *NZZ am Sonntag, 22 February, 2004*. According to Dignitas's founder Ludwig Minelli some **840** people had been assisted with suicide between **1998** and **2008.** See fn.35 supra.

[94] See Bosshard, Ulrich & Bar, *'748 cases of Suicide assisted by a Swiss Right-to-Die organisation* (2003)133 Swiss Medical Weekly 310.

[95] See Jotti-Arnold, J et al: *'Assistance au suicide en EMS: recommandations ethiques et pratiques de la Chambre de l'ethique de l'AVDEMS'*, Revue Medicale Suisse, No.1, 5 January, 2005.

(vi) ***The blurring of the distinction between assisted suicide and direct active euthanasia***

A view prevailed in medico-legal circles that acts involved in assisted suicide, as practiced, could closely resemble those that could be regarded as constituting active euthanasia, that is, the termination of life on request.[96]

The Commission, therefore, was confronted by the ethical question as to whether the boundary dividing unacceptable circumstances of assisted suicide from those which were not, had been correctly drawn by the drafters of the Penal Code. The question of the scope of its enquiry also arose.[97]

Faced with the incompatibility of the medical imperative to preserve life on the one hand, and a doctor's duty to relieve pain and suffering on the other, the Commission held that a patient's request for help to die is ultimately an appeal to the moral conscience of the doctor, both as a treatment provider and as a human being.[98]

The setting in which a suicide, or its assistance, is planned or carried out was deemed to be of importance. Such acts in a private location were different to those carried out in an institutionalised context. Consequently, the moral conflict arising from such acts in acute care hospitals and long-term care residential institutions required attention.

In essence, how was the therapeutic function of such institutions to be reconciled with the intention of a patient/resident to commit suicide?

Traditionally, this function in Swiss hospitals precluded the practice of both suicide and assisted suicide on their premises. Where possible, patients who were determined to commit suicide were persuaded to do so in their own homes. While cities such as Zurich and Lugano

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[96] In cases where a straw was used to administer a lethal drug to a quadriplegic, for example, so that he/she only had to suck and swallow, or where the final act leading to the death of an extremely infirm patient merely consisted of opening a valve or pressing a switch, it was often difficult from a doctor's viewpoint to see what distinguished these acts from directly bringing about death at the patient's request.

[97] The enabling legislation - *Reproductive Medicine Act (FmedG), Art.28,* and the *Ordinance of 4th December, 2000, concerning the Swiss National Advisory Commission on Biomedical Ethics (VEK)* – provided that the Commission was responsible for considering ethical and legal matters in all areas of medicine. While the Commission believed that the application of Article 115 extended beyond this sphere it decided nonetheless to address the issue of assisted suicide in the context of medical practice only and to confine itself solely to this specific area. It did not concern itself with situation in which assisted suicide takes place between two individuals in a non-medicalised setting.

[98] Op.cit., fn.27 supra: *"This is precisely the tenor of the new SAMS guidelines on end-of-life care. It is self-evident that freedom of conscience makes it illegitimate to compel physicians or nursing staff to take part in a patient's suicide; moreover, this is in accordance with the Code of Ethics of the Swiss Medical Association which in Article 3 states that: 'Physicians are not to perform any medical acts or make any statements that they cannot reconcile with their conscience.'"*

had eased restrictions on the prohibition of assistance with suicide in such institutions exceptions to the general attitude were rare.[99]

The Ethics Committee of AVDEMS had found that the situation regarding the applicability of Article 115 was marked by arbitrariness and a lack of consistency in two respects:

First, the way in which requests are dealt with depended on whether someone considering suicide requested assistance from an institution or from a private organisation.

Second, arbitrariness resulted from the lack of a democratic debate on the introduction of restrictive criteria, such as those employed by various private organisations.[100]

While unquestionably impressive, all-embracing and possessed of an inherent consistency, nonetheless the National Advisory Commission's recommendations are only such when viewed from the perspective of an unquestioning acceptance and endorsement of the non-criminal nature of such an act when performed altruistically.

In effect, in averring that the criminal law should not be changed to strengthen the criteria for the evaluation of criminal responsibility for the involvement, on request, of an individual in providing assistance with a suicide, the Commission acknowledged from the outset the futility of attempting to bring rational and logical order to a jurisprudential disposition which allowed for the simultaneous proscription of killing and the approval of the involvement in the suicide of another, contingent on the absence of selfish reasons.[101]

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[99] The Commission found that individual case reports from institutions indicated that there were adverse effects on care staff in circumstances where care provision was discontinued because a patient was required to leave the hospital or care-home in which they resided – because these institutions did not provide assistance with suicide – in order to give effect elsewhere t their wish to die.

[100] No empirical evidence is to hand which would indicate that matters have changed appreciably in the interim.

[101] *Twin Poles*: From the Commission's perspective the ethical questions raised were the product of a conflict between the requirement to provide care for people at risk of suicide, on the one hand, and to respect the autonomy of a person contemplating suicide on the other. All regulations and guidelines arose from the tensions between these two ethical concerns. At the other pole lay respect for another person's autonomy, in particular respect for the wish to die with dignity. Respect for the autonomy of a person determined to commit suicide did not of itself provide a reason to help him/her carry it out. For assisted suicide an additional motive was required, which went beyond mere respect for self-determination. This could be the desire not to abandon the person concerned, and to provide support. However, respect for self-determination also involved respect for the autonomy of those who supported a person determined to commit suicide.
The state's duty to provide care applied not only – in terms of individual ethics – to the individual who wished to commit suicide, but also – in terms of social ethics – with respect to social development and the consequences which arose for other people: the practice of suicide and assisted suicide must not restrict other peoples' freedom of choice, for example, by making people who are disable or sick feel that they cannot be a burden on society and must opt for one or other. The entitlement to dignity and autonomy, and thus to freedom of choice and human rights, applied unconditionally to all people, regardless of their characteristics or abilities.

In the event, it satisfied itself solely with recommendations for greater regulation which, in essence, were reflective of a medico-legal culture that condoned the development and practice of a particular method of non-natural death, but one, however, which did not attract criminal sanction.

Other than that in relation to children and adolescents, the recommendations were adopted unanimously. A brief summary is sufficient to indicate the Commission's disposition in these matters:

(i) **Assisted suicide and termination of life on request**

A person's death should not be deliberately brought about by others. In the case of assisted suicide, the person concerned brings about his or her own death.

(ii) **Legality of Assisted Suicide**

The Commission failed to arrive at a unanimous conclusion on this particular issue.

The majority view was that the legal and ethical rules generally applicable in health care cases should be applied to children and adolescents.[102]

The minority view was that children and adolescents should not be assisted in suicide.[103]

(vii) **Hospitals and Homes**

The function of acute care hospitals and long-term care institutions was to preserve and restore health and quality of life, including at the end of life, and not to bring about death. In such institutions, therefore, suicide gives rise to considerable conflicts.

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[102] Ibid. Recommendation no. 4 stated: *"In general, a mentally competent minor freely exercises the highly personal right to accept or refuse health care. Mental competence is to be assessed individually. These principles are applicable in the event of a request of assisted suicide. For just as children suffering from an incurable terminal disease may refuse medical treatments, the possibility of a request for assisted suicide also being complied with in a terminal situation cannot be ruled out. Seriously ill children and adolescents who express a wish to be assisted in suicide may – depending on the circumstances – be suggestible and susceptible to the opinions of third parties. Often, their conception of themselves is still unstable. People accompanying such patients must be careful to ensure that they are in a position to assess their situation and prognosis fully and accurately."*

[103] Ibid, *at 69. "Children and adolescents are particularly prone to be influenced by external circumstances and other peoples' opinions. As their conception of themselves is often still fragile, they may be severely perturbed by external stresses or inner conflicts. They are, therefore, especially at risk of impetuous suicidal acts. Priority must also be accorded to counselling in cases of incurable terminal illness in childhood."*

- **Long-term care institutions**: If a resident desires assisted suicide, and has no other home but the institution, he or she should, if possible, be allowed to carry out the act there.[104]
- **Acute care hospitals**: Every such institution should clearly specify whether or not assisted suicide is to be permitted for patients.[105]

- Assistance with suicide in **psychiatric institutions** should not occur.

Institutional regulations should not frustrate a well thought-out personal decision to commit suicide. Neither should the conscientious objections of an individual physician or an individual care team. The option of being referred to another physician or transferred to another institution should be available, if desired.

(viii) **Health care professionals**

Assisted suicide was not part of the duties of health care professionals. In cases where physicians nevertheless assist in suicide, this is a personal decision.[106]

(ix) **Non-residents seeking assisted suicide**

There were no ethical grounds for a general prohibition on people who are not resident in Switzerland seeking assisted suicide there. However, a particular ethical problem did arise from the need to ensure that adequate investigations are performed and the duty of care is observed.

(x) **Social trends and risks**

Social trends – such as the changing demographic structure of society[107] and the rising cost of long-term healthcare - may pose a risk that people in extreme situations are pressurised, either by society and/or family members, to express a desire to commit suicide.[108]

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[104] Ibid. *"A special case is that of a wholly private institution that only accepts residents who have been informed at the time of admission that assisted suicide is not permitted on the premises. However, in accordance with the right of conscientious objection, the staff at long-term care institutions must never be forced to participate in an assisted suicide."*

[105] Ibid. *"If this practice is allowed, the institution should establish the necessary framework to enable the act to be carried out in the best possible conditions, without other patients being affected. But here, too, the right of conscientious objection is to be respected for all staff concerned."*

[106] Ibid at 70. *"If assisted suicide formed part of medical duties, every physician would be obliged to perform it when requested to do so by a mentally competent patient....when physicians use their medical skills to assist in a suicide they are not performing a medical duty....*[but]... having made a decision for or against assisted suicide, as dictated by their conscience, health care professional should not be subject to moral disapproval or sanctions by their profession."

[107] As the proportion of elderly people increase, so does the proportion of those in need of care.

Considerable attention, therefore, should be paid to suicide prevention.

(xi) **Requirements for legal regulations**

New regulations were recommended in order to ensure that:

- Before any decision to proceed with assisted suicide, adequate investigations are carried out for each individual case;
- Nobody can be obliged to assist a suicide;
- Assisted suicide is not carried out if suicidality is a manifestation of symptom of a mental disorder;
- In the case of the minority view expressed in Recommendation no. 6. Assisted suicide is not carried out in children and adolescents;
- Right-to-die organisations are subjected to state supervision.[109]

6. Recent Empirical Findings in respect of the Incidence of Assisted Suicide

At the time the Commission on Biomedical Ethics conducted its review of the nature and practice of assisted suicide the only data available to it were those statistics which had been compiled on a confidential basis by a number of the right-to-die organisations between 1994 and 2004. There is no central notification system in Switzerland.[110] The Commission has

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[108] *"People in need of care are especially vulnerable to this risk. Their freedom and self-determination could be jeopardised by the subjective feeling of pressure, on the one hand, and the availability of socially accepted assisted suicide on the other – even if people in need of care meet the criteria of mental competence and the right-to-die organisation does not act out of self-seeking motives. Society has a special responsibility towards people who are in need of care and support. Care facilities and services, particularly in the long-term care sector, must be provided in such a way that the desire for suicide is not promoted. This responsibility for prevention also involves the provision of support for carers, to ensure that their activities do not entail self-sacrifice and are duly recognised by society."*

[109] *"Precisely because a decision concerning assisted suicide has to be based on the individual situation of the person contemplating suicide, investigations need to be carried out with the greatest care. In the course of these investigations, not only is there a need to assess and ensure the individual's mental competence, the absence of social pressure, and the reason for, background to and consistency of the wish to commit suicide, but – in the interests of a concern for life – possible alternative prospects and options also need to be considered and explored with the individual concerned. This is only possible in the context of a non-superficial and longer-term relationship, and not on the basis of a single brief period of contact with the person wishing to commit suicide.*
Nobody can be entitled to receive assistance with suicide from a given person. Conversely, everybody has the right to refuse to assist a suicide, whoever they may be. Assisted suicide can only be carried out on the basis of as highly personal decision. This decision cannot be dictated by anybody – by institutions, by people close to the person wishing to commit suicide, or by this person him/herself. This conscience clause is particularly important for health care professionals and members of staff in health care institutions. Assisted suicide is not one of the services that a patient can claim to be entitled to receive by virtue of the carer's professional skills," at 73.

[110] See Fischer/Huber/Imhof et al, *'Suicide by two Swiss right-to-die* organisations' (2008) 34 Journal of Medical Ethics 810. See also Frei/Schenker/Finzen et al, *'Assisted suicide as conducted by a Right-to-Die Society in Switzerland: A descriptive analysis of 43 consecutive cases' (*2001) 131 Swiss Medical Weekly 375; Baezner-Sailer, E, *'Physician-Assisted Suicide in Switzerland: A Personal Report'* in Birnbacher &

estimated the frequency of assisted suicide at approximately **100** cases per year throughout the 1990s.[111] When the Dignitas statistics were included, this rose to **200** cases per year.[112]

In 2012, however, the Federal Statistics Office in Switzerland – a division of the Federal Department of Home Affairs – published the results of its own analysis of a consolidated matrix of confidential data for the period 1998-2009. [113] It concluded that in 2009 some **300** deaths, corresponding to **4.8 per 1000**, among persons residing in Switzerland were due to assisted suicide. In 1998 the number had been just under **50.** No corresponding data was available for the period prior to 1998.

The FSO also found that whereas in the early years slightly more men than women resorted to assisted suicide, since 2001 considerably more women have done so.

90% of those who availed of assisted suicide were **55** years of age or older. Persons under **35** accounted for just **1%** of such deaths, or just **20** persons in **12** years. The age distribution was

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Dahl (eds), *'Giving Death a Helping Hand (vol. 38, Part III, International Library of Ethics, Law and the New Medicine, 2008, at 141-143.*

[111] Op.cit., fn.27 supra, at 26.

[112] The rate of assisted suicides for Swiss residents has remained constant over the past ten years. According to the Commission, assisted suicide accounted of **0.4%** of all Swiss deaths in the year **2001-02.** Those performed by right-to-die organisations in the same period amounted to **137** cases (or **0.2%**) of all Swiss deaths. When assisted suicide for non-residents reported by Dignitas (**59** cases) are included, assisted suicide accounted for approximately **0.5%** of all deaths in Switzerland in **2001-02**. The **EURELD** survey conducted in **2001** indicated that assisted suicide accounted for **0.36%** of all deaths, **92%** of which involved right-to-die organisations. The survey reviewed **3248** deaths by way of a physician questionnaire. There was a **67%** response. See Van der Heide, Daliens, Faisst et al, *'End-of-Life Decision-making in Six European Countries: Descriptive Study'* (2003) 362, The Lancet 345-50 (the EURELD Study).

[113] Federal Statistics Office, *FSO News, 14 Health, Neuchatel, 03.2012*. For several years the FSO had received sporadic reports on assisted suicide but because the International Classification of Diseases (CD-10) of the World Health Organisation (WHO) had no dedicated code for assisted suicide such cases were initially classified as suicide by poisoning. However, the WHO rules stipulate that the disease to be entered as the cause of death should be the originating cause of the sequence that led to death. According to the FSO, assisted suicide, in this sense, *"is usually the last resort taken at the end of a serious disease."*

To enable the FSO to carry out its statistical analysis it was necessary to systematically complete data on cases which, although specially marked, had only be recorded sporadically. The organisations that provide assisted suicide services in Switzerland made the necessary information available while ensuring that all identifying information relating to the deceased persons was kept completely anonymous. The retrospective data was limited to the period **1998-2009**. For other cases in which it was only assumed that assisted suicide took place, *'suicide'* was entered as the cause of death. The FSO found that unclear cases were rare for the years after **2004.**

The Swiss Cause of Death Statistics were introduced in 1876. They are based on medical cause of death certificates. The diagnosis is indicated in words and the coding, in accordance with ICD-10, is carried out by the Federal Statistical Office in compliance with WHO rules. All collected data are treated anonymously and in the strictest confidence and are subject to the provisions of the *Federal Data Protection Act of 19 June 1992 (SR 235.1)*. Publications on the Cause of Death Statistics refer to persons who are resident in Switzerland, i.e. on the permanent resident population regardless of nationality and place of death.

similar for both men and women. However, from the age of **55**, a markedly higher proportion of women chose to seek assisted suicide.[114]

In an earlier study it had been established that assisted suicide in Switzerland accounted for **0.36%** of all deaths in **2001**. A retrospective analysis of all case files of assisted suicide kept during the period **1990-2000** by EXIT DS, the largest of Switzerland's right-to-die organisation, found that it had assisted **748** suicides among Swiss residents, or **0.1%** of total deaths and **4.8%** of total suicides.[115]The data revealed that the deceased were between **18** and **101** years of age, with a mean average of **72** years. Women accounted for **54.4%,** a significant over-representation in comparison with all other deaths.

Over the ten year period, the number of deaths by assisted suicide tripled from **110** in the first three years to **389** in the last three. This was a highly significant increase in relation to both total deaths in Switzerland, which remained constant, and total suicides, which decreased slightly over the same period. [116]

It would appear, therefore, that there are many more requests for assisted suicide than actual assistance

In his affidavit to the Supreme Court of British Columbia, in *Carter v Canada*,[117] referred to previously,[118] Georg Bosshard alluded to the findings of the FSO review of surveys of public and professional opinion concerning euthanasia which disclosed that Swiss doctors carry out

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[114] Assisted suicide was resorted to when life no longer appeared worth living and particularly in circumstances where the individual was suffering from a serious physical illness. In **44%** of cases, cancer was reported as the underlying disease, in **19%** a neurodegenerative disease, in **9%** cardiovascular diseases and in **6%** musculoskeletal disorders. *'Other diseases'* included pain syndromes, multi-morbidity and other pathologies. Depression was reported in **3%** of cases and dementia in **0.3%.**
The largest share, both in absolute and relative numbers, of cases of assisted suicide was recorded in the canton of Zurich, **700** persons, or **5.6 per 1000** deaths, in the **12** years covered by the review. In the canton of Geneva **100,** or **4.4 per 1000** deaths, were reported. The cantons of Appenzell Ausserrhoden, Vaud, Basel-Stadt und Schaffhausen were also above the Swiss average of **2.8 per 1000** deaths. It was established that since 1998 at least one person had resorted to assisted suicide in every canton.

[115] Bosshard, G, Ulrich, E and Bar, W, op.cit., fn.94 supra.

[116] In the Zurich canton, Exit DS assisted in **331** deaths. Of these **78.9%** were suffering principally from fatal disease, particularly cancer but also cardiovascular/respiratory disease, HIV/Aids and neurological disease. The remaining **21%** had primarily nonfatal diagnosis such as musculoskeletal disorders, chronic pain syndrome and diagnoses such as blindness and general weakness. The wish to die was related to mental disorder in **9** cases: **8** of depression and **1** of psychosis. The authors noted that **76%** of people in the non-fatal diagnosis groups were women. This could not be explained simply by their longer life expectancy since among the **331** cases the men were older than the women.

[117] *2012 BCSC 886.*

[118] See fn. 61 supra.

euthanasia and termination of life without explicit request in almost **1%** of all deaths, and that these findings *"provoked no reaction from Swiss public prosecutors."* [119]

Arising from the different approaches adopted towards assisted suicide in other jurisdictions, and in the absence of empirically probative data, the Federal Statistics Office was unable to conduct an international comparative analysis which would provide some indication of whether the incidence of assisted suicide per **1000** deaths in Switzerland was greater or lesser than in those countries, including some states of America, where assisted suicide has been either legalised or is judicially endorsed. It was possible, however, to compare their share of deaths from assisted suicide in **2009 – 4.8 per 1000 deaths** – with the findings of commissions and regional regulatory authorities in both Belgium and the Netherlands. In the former jurisdiction the number of reported cases of active euthanasia and assisted suicide had risen steadily since the introduction of the *Euthanasia Act 2002* and stood at **7.9 per 1000** deaths in **2009.** In the latter, the share of reported deaths from active euthanasia and assisted suicide was only **2.3 per 1000** in **2010**.[120]

7. Assisted Suicide and the European Convention on Human Rights

Historically, the European Court of Human Rights has addressed right to life issues solely within the parameters of Articles 3 and 8 of the Convention. In the main, the principles underpinning Article 2, while alluded to, are, in the main, invoked peripherally. The degree to which the margin of appreciation rubric is called in aid raises the not unreasonable suspicion that the Court has deliberately decided to side-step a need to address the life theory in any substantive way. Similarly, it is not unreasonable to infer that the Court is, wittingly or unwittingly, part of a global jurisprudential phenomenon, the objective of which is to recalibrate traditional paradigms in respect of end-of-life issues in a manner which

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[119] Ibid. at para. 592: *"There was a striking increase – a tripling – in the number of EXIT deaths over the 11-year study period. However, socio-demographic factors (age, gender distribution) and medical factors (diagnoses) relating to the deceased remained relatively unchanged. Since the quality of the records improved, we conclude that this increase stems more from a growing number of requests than from relaxation of the indications for assisted suicide or from progressive laxity in decision-making. Concern remains whether the persistence of the death wish was tested adequately in those cases where the prescribing physician was not the attending or family doctor, particularly when EXIT membership was of a short duration (sometimes less than a week). Such practice stands in contrast to Emanuel and co-workers' finding that. Among terminally ill patients who were seriously considering euthanasia or physician-assisted suicide, half changed their minds over the next few months."* A similar sentiment as to the absenvce opf a reaction from the Swiss prosecutorial authorities or the general public was alluded to by the Irish High Court in *Fleming v Ireland [2013] 2 IEHC,* at para 120.

[120] The FSO drew its statistical data from the Belgian Commission Federale de controle et d'evaluation de l'euthanasia *'Quatrieme rapport aux chambres legislative (annees 2008 et 2009)'* available at *www.health.belgium.be/filestore/19063733/H7849Rapport euthanasia FR.pdf* and the euthanasia dossier on the website of the Dutch Parliament *http://www.houseofrepresentatives.nl/dossiers/euthanasia*

accommodates a more liberal disposition in respect of the principle of self-determination. This is a matter which has been address in the Introductory Chapter and does not require principle repetition here.

However, the recent decision by the European Court of Human Rights in *Haas v Switzerland*[121] in the matter of the engagement of specific articles of the European Convention on Human Rights in the context of end-of-life issues, and the implications of that decision for Swiss law, is of particular relevance.

The applicant was a Swiss national who suffered from bipolar disorder and who wished to commit suicide. To this he sought sufficient quantities of a powerful barbiturate – sodium pentobarbital – which he proposed to self-administer. However, this drug was, and continues to be, available on prescription only and the Swiss public health authorities refused the applicant permission to acquire it otherwise.

When the Swiss Federal Court found against him,[122] the applicant maintained before the European Court of Human Rights that the refusal to sanction the drug amounted to a breach of Article 8 of the Convention on Human Rights.

In *Pretty v United Kingdom*[123] the European Court of Human Rights disagreed (or, at least, seems to have disagreed) with the opinion by the House of Lords in *R (Pretty) v Director of Public Prosecutions*[124] that Article 8 of the Convention was not engaged in circumstances where the applicant was suffering from a terminal illness and wished to die by means of assisted suicide. Crucially, however it did agree that Article 8 was not breached.

The finding in *Pretty* provided the context for the subsequent decision by the House of Lords in R (*Purdy) v DPP.*[125] In *Purdy* the applicant suffered from primary progressive multiple sclerosis. She anticipated that a time would come when she would find her continuing existence unbearable and would desire to end to her life. Accordingly, she intended to travel to Switzerland for this purpose. Her husband was willing to assist her to make that journey, but she was concerned that, were he to do so, he would be prosecuted under the applicable legislation in the United Kingdom. It was held that end-of-life issues were engaged by *Article*

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[121] *Haas v Switzerland (2011) 53 EHRR 33.*

[122] *Schweizeriches Bundesgesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006.* It was held that there was a distinction between the right to decide one's own death (under a right to privacy) and the right to commit suicide assisted by another person. The right to die was only a negative right (a liberty right) in that individuals are to be free form state interventions or prohibitions.

[123] *(2002) 35 EHRR 1.* ee Chapter VI on England.

[124] *[2001] UKHL 61, [2002] 1 AC 800.* See Chapter VI on England.

[125] *[2019] 3 WLR 403*. See Chapter VI on England.

8(1) ECHR and that any restrictions on the exercise of that right need to be justified in accordance with *Article 8(2) ECHR*.

In *Haas* the European Court stressed that the facts of the case were different from that in *Pretty* inasmuch as the applicant was not suffering from a terminal or degenerative illness. Nonetheless, the decision of the Swiss authorities was amply justified by the provisions of *Article 8(2) ECHR*.[126]

However, as was correctly stated in *Fleming v Ireland,*[127] individual judges of high international standing have taken a different view of this issue from time to time, the dissents of Lamer, CJ and Cory J. in *Rodriguez v Canada,*[128] and the separate opinions of Baroness Hale and Lord Brown in *Purdy v DPP,*[129] being notable examples.

However, this was not because judges are indifferent to or are insulated from acute human suffering.[130]

8. Conclusion

The legal permissibility of altruistic assistance with suicide creates something of an unreal ethical atmosphere in Switzerland. The reality of its practice would appear to obviate the need for the ventilation of those criteria normally considered essential in any evaluation of the putative legitimacy of a practice leading to earlier than natural death in democratic jurisdictions.

This is not to suggest however that the ethical parameters within which Switzerland arrived at its endorsement of the practice were, at the time of its adoption of the Penal Code, or are now, any different to those that apply in jurisdictions where criminalisation of assisted suicide is not ameliorated by an altruistic provision.

The practice of assisted suicide, however, is not universally endorsed in Switzerland. This includes the main churches.[131] Nonetheless, there is an underlying ambivalence in evidence

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[126] The ECtHR has consistently taken the view that a ban on assisted suicide will always be justifiable by reference to Article 8(2) ECHR inasmuch as Contracting States are entitled to think that such is necessary to prevent abuse and the exploitation of the vulnerable. See *Haas v Switzerland (2011) 53 EHRR 33, at paras 56, 57 and 58.*

[127] *[2013] IEHC 2.* See Chapter IX on Ireland.

[128] *[1993] 3 SCR 519.* See Chapter VIII in Canada.

[129] *[2009] 3 WLR 403.* See Chapter VI on England.

[130] *"It is rather because.....it is impossible to craft a solution specific to the needs of an individual plaintiff without jeopardising an essential fabric of the legal system – namely respect for human life – and compromising these protections for others and other groups of individuals who sorely need such protections", [2013] IEHC 2, at para. 120.* See Chapter IX on Ireland.

which appears to engender a resigned acceptance of the existential reality, which is reinforced by the comforting assurance of the relevant authorities that the appropriate regulatory controls are in place and that nothing untoward, such as direct active *sterbehilfe*, occurs.

While reliance on a base motive such as selfishness, rather than intention to kill, to define a criminal offence, particularly in the context of an awareness that the actions undertaken, however well-intention or compassionate, will result in the termination of a human life, is a concept which is foreign to Anglo-Saxon jurisprudence, nonetheless it is of pivotal importance in some continental jurisdictions, including Switzerland.[132] Therefore, any attempt at a rational explication of the Swiss disposition in the matter of the decriminalisation of altruistic assistance with suicide is futile in the absence of an acknowledgement of this legal reality.

Notwithstanding claims to the contrary, however, clear and explicit criteria for the applicability of Article 115 are absent. The law, whether liberally or restrictively interpreted, is currently applied in a relatively inconsistent manner. On the one hand, private right-to-die organisations that provide assistance with death require patients – or "*members*" as they are referred to - to meet specific requirements, such as, inter alia, mental capacity, earnest and repeated requests, incurable diseases, bleak diagnosis and intolerable suffering. On the other hand, certain institutions, such as nursing and retirement homes, refuse to even consider

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[131] In a section entitled *'Guiding Principle and Fundamental Values'* the Council of the Federation of Swiss Protestant Churches (SEK) stated that, in view of man's inalienable dignity, "*the attitude of each individual to his or her own death is to be respected.*" However, it did emphasise that the question of the end of life not only concerns the individual, but "*is of eminent social relevance in its implications and impact*", since, it averred, people require particular solidarity in the final stages of their lives. While the Council gave a broad welcome to the SAMS guidelines it proposed that the minimum requirements for assisted suicide specified by SAMS should be supplemented by two additional conditions being met: the patient's disease must involve intolerable mental and physical suffering, and the patient must be capable of expressing his/her wishes and have clearly expressed the wish to die. The Council also underlined society's responsibilities, together with the need to monitor assisted suicide through legislation and social institutions.
The position adopted by the Swiss Catholic Church was somewhat different. This was contained in a pastoral letter from the hierarchy entitled '*The Dignity of Dying*'. In a detailed consideration of the issues of the "*Christian dignity of dying*" and the "*dignity of the dying person*" it argued that autonomy only exists on the basis of, and within the limits of, the fundamental dependence of human life. "*The function of end-of-life assistance must be to ease the passage into the final and inescapable heteronomy of dying.*" This is facilitated by a religious conviction that, even in dying, the human person is "*in God's hands.*" In the section on assisted suicide, the pastoral letter noted that this procedure differed only minimally from active euthanasia, since all preparations are made by the assisting party and the patient only has to carry out the final action leading to death: *"It is difficult to see in this small difference more than a legal nicety."* Therefore, *"because it comes close to killing on request, we....categorically reject assisted suicide."* The bishops also called for the gap in Swiss criminal law to be remedied as a matter of urgency, particularly with regard to the provision of assisted suicide for the mentally ill, or on a commercial basis.

[132] See Sayid, M, '*Euthanasia: a comparison of the criminal laws of Germany, Switzerland and the United States*', Boston College International Comparative Law Rev., 1983, 6, at 533-62.

requests from patients or residents for assistance with suicide in order to avoid further pain or suffering.

Swiss-based right-to-die organisations continue to provide a commercial service in assisted death to both its own citizens and to those of other jurisdictions and are allowed to do so with virtual impunity, firstly, because of the legal endorsement of altruism as a criterion of non-culpability in the provision of assistance to a person wishing to commit suicide; secondly, because the regulatory regime in which it operates is not burdened by an excessively intrusive disposition on the part of the civil authorities and thirdly, because the medical profession has succumbed to the seductive and apparently logical proposition – to that profession at least - that because doctors do not perform the final act of death – they only supply the means by which this can be achieved by the person wishing to die - this behaviour is somehow excluded from the possibility of any critical stricture, including criminal prosecution.

As has been demonstrated by the findings of the analysis conducted by the Swiss Federal Statistics Office it is inevitable that the number of people availing of these services will increase exponentially in future years. Death tourism is now an ingrained definable characteristic of Swiss identity and one that will not be abrogated easily.

Chapter V – Euthanasia comes to Luxembourg

"In line with the Belgian model, under the strictest conditions this Law governs euthanasia or assisted suicide performed by a doctor on the request of a patient in a terminal situation..... The Law endeavours on the one hand to respect the freedom of conscience of the doctor who is free to respond or not to a request for euthanasia or assisted suicide. On the other hand, the legislator considered that this necessary respect for the freedom of the conscience of the doctor and of care staff should not justify forcing a patient in a terminal situation to continue to live in anguish and suffering which they deem unbearable."

- Ministry of Health, Luxembourg, in respect of *Loi du 16 Mars, 2009, sur l'euthanasie et l'assistance au suicide.*[1]

1. Introduction

On 16th March, 2009, the *Law on Euthanasia and Assisted Suicide*[2] came into effect in the Duchy of Luxembourg. As a result Luxembourg became only the third European country, after the Netherlands and Belgium,[3] to permit third party assistance with death, specifically voluntary active euthanasia and assisted suicide.

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[1] *'Euthanasia and Assisted Suicide: 25 Questions, 25 Answers'*, available at <www.sante.public.lu/fr/catalogue-pubications/sante-fil-vie/fin-vie/eujtanasie-assistance-suicide-25-questions-reponses-de-en/index.html> accessed November, 2012.

[2] Loi du 16 Mars 2009 aur l'euthanasie et l'assistance au suicide, available online at: <http://admdl.wollt.net/data/16309euthanasia.pdf> *accessed 10 November, 2012.* In February, 2008 the Luxembourg Parliament voted on two bills, the first relating to palliative care and the second providing for the legalisation of euthanasia. The *Palliative Care Bill* included provision for living wills as well as giving people the right to receive 40 hours paid leave to accompany a person at the end of their life. A previous bill on palliative care, submitted by the Ministry of Family in 2004 was rejected as was a revised bill presented by the Ministry of Health in 2006. However, the 2008 Bill was passed unanimously. The first bill proposing euthanasia was presented to Parliament in 2002 by two Deputies, Jean Huss of the Green Party and Lydie Err of the Socialist Party. No vote on this Bill took place. The 2008 Bill however was passed with 30 Deputies in favour, 26 against and 3 abstentions. In order that a bill can become law in Luxembourg it is necessary for two votes to take place in the Chamber of Deputies. In March 2008 the Council of State decided that the Palliative Care Bill and the *Euthanasia and Assisted Suicide Bill* had to pass the second reading together and that amendments were required to the proposal on euthanasia for the two bills to be compatible. The vote on both bills took place in December, 2008. Both bills were passed – the *Bill on Palliative Care* unanimously, the *Bill on Euthanasia and Assisted Suicide* by a small margin. However, neither came into effect until 16 March 2009 due to the refusal of the Grand Duke to sign the *Euthanasia and Assisted Suicide Bill* on grounds of conscience. A bill passed by Parliament could not become law and have effect without the signature of the Grand Duke. The impasse was resolved when parliament enacted legislation removing the Grand Duke's veto power.

[3] The law in the Netherlands permits both voluntary active euthanasia and assisted suicide. See Chapter II on the Netherlands. The 2002 Belgian *Law on Euthanasia* is silent on the matter of assisted suicide. However, in its first biennial evaluation report (September 2004), the *Federal Control and Evaluation Commission* stated that it considered assisted suicide to fall within the definition of euthanasia. See

However, both these actions are only decriminalised when performed by a doctor at the repeated request of a terminally-ill patient, who is suffering constant and unbearable physical and mental anguish, and in accordance with the formal and procedural protocols set out under the *Law.*

These procedural protocols, to a large degree, resemble the criteria laid down in the *Dutch Termination of Life on Request and Assisted Suicide (Review Procedures Act), 2002.*[4] A doctor who performs an act of euthanasia or provides assistance in suicide, at a patient's repeated entreaty, is immunised from either penal sanction or civil action for damages if he acts in accordance with specific conditions.

Assisted dying in Luxembourg is medicalised. There are no provisions allowing for euthanasia or assisted suicide to be performed by anybody other than a doctor. Specific grounds for doctors being excluded from the possibility of criminal proceedings have been inserted into Luxembourg's Criminal Code.[5]

Notwithstanding the legal endorsement of acts of euthanasia and assistance with suicide when performed by doctors both acts continue to be punishable offences if performed outside the new legal framework. There is no comparable provision in Luxembourg's Criminal Code to Article 115 of the Swiss Penal Code which permits the provision of *altruistic* assistance with suicide by members of all professions or none.[6]

Unlike the euthanasia laws in the Netherland and Belgium the Luxembourg Law was neither initiated nor supported by the main government party, the Christian Socialists.[7] It was proposed by two members of the opposition, Jean Huss of the Green Party and Lydie Err of the

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FCEC 2004-05: 13-14, 21. In reality, therefore, both voluntary active euthanasia and assisted suicide are legally condoned in Belgium. See Chapter III on Belgium.

[4] Available online at: <http://www.healthlaw.nl/euthanasie.html#act>

[5] Article 397-1: *"The fact of a doctor responding to a request for euthanasia or assisted suicide shall not fall within the scope of application of the present section if the fundamental conditions of the Law of 16 March, 2009, on euthanasia and assisted suicide are met."*

[6] Article 115 of the Swiss Penal Code states: *"Any person who, for selfish reason, incites someone to commit suicide or who assists that person in doing so shall, if the suicide was carried out or attempted,be sentenced to a term of imprisonment (Zuchthaus) of up to five years or a term of imprisonment (Gegangnis)."* See Chapter IV on Switzerland.

[7] The Catholic Church in Luxembourg vociferously opposed the introduction of the euthanasia and assisted suicide law. See *'Den Menschen im Sterben wurdigen. Stellungnahme der Kirche Luxemburgs zum Thema Euthanasie'* [*People Dying Worthy. Opinion of the Catholic Church of Luxembourg on Euthanasia*] (2002), available at http://www.cathol.lu/l'eglise-dans-la-societe-kirche-in/ethique-ethik/euthanasie-sterbehilfe/article/den-menschen-im-sterben-wurdigen accessed July 2012.

Socialist Party.[8] In the event, however, socialist ministers in the coalition government joined the opposition Liberal and Green Parties to ensure its passage.

Prior to the tabling of the legislative proposal there had been nothing to suggest that legal change to permit third party assistance with death was a matter of consuming political interest.[9] Likewise, there were no opinion surveys to indicate the level of public support, or lack of it, for such legalisation and no probative data as to the incidence, if any, of either euthanasia *per se* or assisted suicide prior to the enactment of the Law is extant, if it ever existed.

However, the absence of empirical data will no longer obtain following the establishment, under the new Law, of the National Commission for Control and Assessment,[10] the terms of reference of which provide for a report to the Chamber of Deputies every two years and must include statistical data as to the numbers requesting, and being accommodated with, euthanasia and assisted suicide.

In its first report, in March 2011, the Commission stated that only five people[11] had availed of euthanasia in the two year period of review since 2009. There were no recorded deaths by assisted suicide. In each case, according to the doctors involved, death was *"serene and rapid; it occurred within minutes."*[12]

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[8] Deputy Jean Huss stated at the time of the passage of the euthanasia and assisted suicide bill in the Chamber of Deputies in February, 2008: *"The Christian Social Party and the Catholic Church were against the euthanasia law, calling it murder but we said no, it's just another way to go."* Reuters, Wednesday, 20 February, 2008. He also said that fears that old people would be pressurised to commit suicide were groundless, given the checks and balances built into the law.

[9] In 2002 Deputies Huss and Err had tabled a Bill proposing euthanasia. However, the matter was never voted upon.

[10] Article 6, Loi du 16 Mars 2009

[11] **3 men** and **2 women**, all over the age of **60**. **3** died in hospital and **2** in their own homes. No acts of euthanasia were performed in a retirement home or in a public health care centre. In each case the medical diagnosis was incurable cancer. By the end of **March 2011, 681** (**396 women** and **285 men**) end-of-life declarations had been registered with the Commission outlining a variety of illnesses and disorders, physical and psychological, all of which were described as *"constant and unbearable"*. The Commission agreed that the nature and character of unbearable suffering must be examined in depth between the patient and the doctor. See *First Report of the National Commission for Control and Assessment to the Chamber of Deputies, March, 2011.*

[12] See *National Commission for Control and Assessment of the Law on Euthanasia and Assisted Suicide of 16 March, 2009, First Report, Years 2009 and 2010, 16 March, 2011* (English version published 23 April, 2011).

2. Definitions, Conditions and Procedures

The Law provides medicalised definitions of both euthanasia and assisted suicide.[13] For its valid application *"euthanasia is to be understood as the act, performed by a doctor, intentionally ending the life of a person who has expressly and voluntarily requested death. Assisted suicide is to be understood as the intentional assistance by a doctor to a person intent on committing suicide, or providing that person with the means to that end, having been expressly and voluntarily requested to do so by the person wishing to die."*[14]

The conditions and procedures attaching to a request for euthanasia or assisted suicide are contained in articles 2 and *3* of Chapter II of the Law

The specific conditions which must be met in order to protect a doctor from criminal prosecution are:

- *The patient is a capable*[15] *and conscious adult at the time of their request;*
- *The request is made voluntarily, after reflection and, if necessary, repeated, and does not result from external pressure;*
- *The patient is in a terminal medical situation and displays constant and unbearable physical or mental suffering without prospects of improving, resulting from an accidental or pathological disorder;*
- *The patient's request for euthanasia or assisted suicide is made in writing.*[16]

In all cases, and before performing euthanasia or assisting in a suicide, the doctor must comply with particular formal and procedural conditions, not dissimilar those invoked in both the Netherland and Belgium.[17]

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[13] Article 2. *See 'The request for euthanasia or assisted suicide, conditions and procedure, Loi du 16 Mars 2009 sur l'euthanasia et l'assistance du suicide',* published by the Ministry of Health, Luxembourg, in partnership with the Ministry of Social Security, the *National Commission for Control and Assessment, the Association for the Right to Die with Dignity, Letzebuerg a.s.b.l.* and the *Patientevertriedung a.s.b.l. An English translation of this document was provided by the Ministry of Health. It is this translation that is relied upon in this study. The author does not accept responsibility for the solecisms, syntactical or grammatical errors contained in the translation.*

[14] Article 1*: General Provisions, Loi du 16 Mars 2009 sur l'euthanasie et l'assistance du suicide.*

[15] From the context it is presumed that the word '*capable*' in the English translation means '*competent*'. Likewise '*incapable*' is presumed to mean '*incompetent*'.

[16] Article 2.

[17] The doctor must, inter alia:

- *Inform the patient of their state of health and their life expectancy, discuss their request for euthanasia or assisted suicide with the patient, bring therapeutic alternatives, including palliative care, and the consequences, to his/her attention.*

The patient's request for euthanasia or assisted suicide must be noted in writing. The document has to be drafted, dated and signed by the patient personally. If the patient is permanently physically unable to draft and sign the request, this is to be noted in writing by an adult person of their choice. The person chosen must mention the fact that the patient is unable to make his or her request in writing and indicate the reasons why this is so. In such a case, the request must be noted in writing and signed by the person who drafted the request in the presence of the treating doctor. The latter's name must also be indicated in the document. This document must be placed in the patient's medical file.

The patient may withdraw his or her request at any time, in which case the document must be removed from the relevant medical file and returned to the patient.

All requests, irrespective of number, made by the patient, as well as the procedures of the treating doctor and the results, including the report(s) of the consulted doctor(s), must be placed in the patient's medical file.

If he or she considers it necessary, the treating doctor may be accompanied or advised by an expert of his choice. The treating doctor can, if he or she wishes, annotate the medical file to indicate that he or she has been so accompanied or advised by an expert and can, again if he or she so wishes, placed the opinion or of this expert in the patient's file. If it is a formal medical report, the opinion or confirmation must automatically be placed in the patient's file.[18]

- *Be convinced that the patient's request is voluntary and that it is the patient's belief that there is no other acceptable solution to their situation. The nature and content of interviews with the patient in respect of these matters must be placed in his/her medical file.*
- *Ensure the persistence of the patient's physical and mental suffering and their recently expressed or reiterated wish. To that end, he shall hold several interviews with the patient, at reasonable intervals, having regard to the evolution and development of the patient's condition.*
- *Consult another doctor as to the severe and incurable nature of the disorder, specifying the reasons for the consultation. The consulted doctor must be impartial and independent of both the patient and the treating doctor. He must also be competent in the relevant pathology.*
- *Interview, unless the patient expressly objects, the person of trust appointed either in the patient's own end-of-life provisions or at the time of his/her request for euthanasia or assisted suicide.*
- *Interview, unless the patient expressly objects, the care team who are in regular contact with the patient.*
- *Ensure that the patient has had an opportunity to discuss his/her request for euthanasia or assisted suicide with those persons they expressly ask to meet.*
- *Check with the National Commission for Control and Assessment whether end-of-=life provisions have been registered in the patient's name.*

End-of-life provisions are addressed in Article 4. The establishment and terms of reference of the National Commission for Control and Assessment is provided for in Articles 6,7,8,9 &10.

[18] Article 3.

3. End-of-Life provisions

(a) Where patients are no longer able to express their wishes an adult and capable[19] person may make end-of-life provisions – or what are known in other jurisdictions as advance care directives – in writing specifying the circumstances and conditions under which they wish to undergo euthanasia. However, before such an end-of-life declaration can be implemented the treating doctor, on the basis of his medical knowledge and expertise, must have concluded that:

- *The patient is afflicted by a severe and incurable accidental or pathological disorder;*
- *That the patient is unconscious; and*
- *That the situation is irreversible according to prevailing medical scientific.*

The declarant may appoint an adult person of trust whose duty it is to inform the treating doctor of the declarant's most recent wishes in these matters.

End-of-life provisions may be made at any time. They must be noted in writing, dated and signed by the declarant.[20]

(b) Where the person who wishes to draft end-of-life provisions is permanently physically unable to do so, or to sign it, their wishes may be noted in writing by an adult person of their choice who must sign the resulting document in the presence of two adult witnesses. The document must specify the reasons why the declarant is unable personally to draft or sign the provision. It must be signed also by the two adult witnesses and, if necessary, by the person of trust appointed under the end-of-life provisions.[21]

The wishes of the patient contained in end-of-life provisions may be reiterated, revised or withdrawn at any time. The National Commission for Control and Assessment is obliged, once every five years from the date of registration of the provisions, to request confirmation of the declarant's wishes and any changes made must be registered with the *Commission.*

However, the stated wishes of the person wishing to die, either by euthanasia or by way of assistance with suicide, can be abrogated in circumstances where the treating doctor becomes

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[19] See fn. 15 supra.

[20] End-of-life provisions may also contain a section in which the declarant specifies the procedures to be followed, the funeral rites and the mode of burial.

[21] A medical certificate confirming permanent physical inability to draft, date and sign an end-of-life provision must be appended. The provision must be registered with the National Commission for Control and Assessment.

aware that the patient, notwithstanding the prior existence of a registered end-of-life provision, has changed his or her mind.[22]

Any doctor treating a patient at the end of their life or a patient in a terminal medical situation is obliged to obtain information from the *Commission for Control and Assessment* as to whether end-of-life provisions have been registered in the name of the patient.[23]

(c) A doctor who responds to a request for euthanasia in accordance with these end-of-life provisions will not be prosecuted for a criminal offence or be sued in a civil action for damages[24] if he believes that:

- *the patient is afflicted by a severe and incurable accidental or pathological disorder;*

- *the patient is unconscious; and that*

- *the condition is irreversible according to prevailing scientific knowledge.*

4. Official Declaration

A doctor who performs an act of euthanasia or who provides assistance in the suicide of a patient must submit the requisite official declaration of such action, duly completed, within eight days to the *National Commission for Control and Assessment.*

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[22] This provision is stated rather cumbersomely in the English translation of the Law: "*Nevertheless, there may be no euthanasia if, following the procedures he is obliged to follow by virtue of paragraph 3 hereinafter, the doctor obtains knowledge of an expression of the wishes of the patient after the end-of-life provisions have been duly registered, by means of which they withdrew their wish to undergo euthanasia.*" Paragraph 3 reads: "*The fact of a doctor responding to a request for euthanasia in accordance with the end-of-life provisions as provided in paragraphs 1 and 2 hereinbefore shall not be punished as a criminal act and may not give rise to a civil action of damages if the doctor observes: (i) that the patient is afflicted by a severe and incurable accidental or pathological disorder; (ii) that they are unconscious and (iii) that the situation is irreversible according to science at the time.*"

[23] Article 4.2.

[24] Article 397-1 of the Luxembourg Criminal Code. See fn.5 supra. In all cases, however, before performing an act of euthanasia, the doctor must comply with a number of formal and procedural conditions:

- He must consult another doctor as to the irreversibility of the patient's medical condition, and inform him/her of the reasons for the consultation. The consulted doctor must read the patient's medical file and examine the patient personally. Having done so he is required to draw up a report of his observations and diagnosis. If a person of trust has been appointed in the patient's end-of-life provisions, the treating doctor must keep that person informed of the results of this consultation. The consulted doctors must be independent of both the patient and the treating doctor and be competent in the required pathological field;
- In circumstances where there is a care team in regular contact with the patient, he must discuss the latter's end-of-life provisions with the care team or members thereof;
- In circumstances where person of trust has been appointed, he must discuss the patient's wishes with him/her; and
- Where a person of trust has been appointed, he must discuss the patient's wishes with those close relatives of the patient whom the person of trust designates.

5. The National Commission for Control and Assessment

The remit of the *National Commission for Control and Assessment*, established under the Law, is to guarantee the proper application of the law on euthanasia and assisted suicide. One of its key functions is to oversee the systematic registration of end-of-life provisions.

The *Commission* comprises nine members who are to be appointed *"on the basis of their knowledge and experience of the matters falling within the competence of the Commission."*[25]

Three of the nine members must be medical doctors. One must be proposed by the Medical Council and the other two, with specific qualifications and experience in the treatment of pain, must come from *"the organisation most representative of doctors and dentists."*[26] However, the *Law* does not identity this organisation.

Three members must be lawyers, including a barrister proposed by the Bar Council, a magistrate proposed by the Supreme Court of Justice and a professor of the University of Luxembourg.

Two members are required to represent an organisation whose objective is the defence of the rights of patients. Again, the *Law* does not specifically identify this organisation.[27]

The remaining member is to be drawn from the health professions on the proposal of *"the higher council of certain health professions."*[28]

Members of the *Commission* are appointed by the Grand Duke for a term of three years and their mandate is thrice renewable.

The *Law* is specific in respect of the capacity of the members:

"The capacity of the members of the Commission shall be incompatible with the mandate of a Deputy, or member of the Government, or the Council of State."[29]

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[25] Article 6.

[26] Ibid.

[27] If the patients' rights organisation and the higher council of certain health professions fail to nominate representatives within the required deadline the Minister for Health can nominate his or her own candidates for the posts.

[28] Article 6.

[29] Ibid. The Grand Duchy of Luxembourg is a constitutional monarchy with hereditary succession in the Nassau family. The Duchy is governed by a system of parliamentary democracy established by the constitution of 1868, which was last amended in 2000 to remove the power of veto by the Grand Duke over acts of parliament. In practice, executive power lies with the government which is appointed by the Grand Duke. In a unicameral system the Chamber of Deputies (Chambre des Deputes) comprises 60 members elected by universal suffrage under the d'Hondt method of party-list proportional representation, for a five year mandate. Deputies can table private members' bills. All bills are

The *Commission* elects a Chairman from among its members, establishes its own internal rules and requires a quorum of seven members to be present before it can validly deliberate on any issue. Decisions are arrived at by simple majority.[30]

The two basic tasks which the *Law* requires the *Commission* to fulfil are:

(1) to draw up an official declaration to be completed by a doctor each time he/she performs an act of euthanasia or provides assistance in the suicide of a patient. This document must comprise two sections, the first of which is to be sealed by the doctor.[31]

The anonymity of this section may only be lifted in circumstances where doubt exists as to whether the proper conditions and procedures have been met and followed. In such a situation the *Commission* can decide to open and examine its contents.

The *Commission* may also request the treating doctor to submit all those sections of the patient's medical file specifically referable to the request for euthanasia or assisted suicide. If, having reviewed the contents of the first section of the official declaration and, where deemed necessary, those elements of the patient's medical file in respect of the request for either euthanasia or assisted suicide, the *Commission* considers that the formal and procedural conditions provided for in Article 2.2 of the *Law* have not been fulfilled it must communicate its substantiated decision to the treating doctor and send the complete file, together with a copy of its decision, to the Medical Council. The Medical Council has one month from the date of receipt of the *Commission's* decision to make a ruling as to whether disciplinary proceedings are necessary. If the *Commission* is satisfied that one of the conditions laid down in Article 2.1 of the *Law* has not be met it is obliged to forward the entire file to the Public Prosecutor.

The second section of the official declaration is also confidential.[32]

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submitted to a second vote with an interval of at least three months between the two votes, unless the Chamber, in agreement with the Council of State (Conseil d'Etat) otherwise decides at a public sitting. The Council of State, comprising 21 members, expresses its views on bills and other matters referred to it by the Government of by the law.

[30] Article 6. In its first report to the Chamber of Deputies the Commission admitted that it was sometimes difficult to muster the requisite quota of 7 members.

[31] The sealed section will contain (i) the name and domicile of the patient; (ii) the name and domicile of the treating patient; (iii) the name, doctor code and domicile of the doctor(s) consulted with regard to the request for euthanasia or assisted suicide;
(iv) the name, domicile and capacity of all the persons consulted by the treating doctor, together with the date of the consultations and (v) if end-of-life provisions have been made the patient and a person of trust has been appointed, the name of that person.

[32] This section contains the following data: (i) the presence of otherwise of an end-of-life provision, and/or a request for euthanasia or assisted suicide; (ii) the age and gender if the patient;(iii) the severe and incurable accidental or pathological disorder from which the patient was suffering; (iv) the nature of the suffering which was constant and unbearable; (v) the reasons why the suffering specified was

(2) The second task which the *Law* requires of the *Commission* is to provide the Chamber of Deputies, within two years of the *Law* taking effect, and thereafter every two years, with

- *(a) a statistical report based on the information gathered in the second section of the registration document which doctors complete as per the requirement of Article 8 of the Law;*
- *(b) a report containing a description and assessment of the application of the present Law;*
- *(c) where deemed necessary, recommendations likely to result in a legislative initiative and/or other measures concerning the execution of the present Law.*

Within six months of the receipt of the first report from the *Commission* the Chamber of Deputies is required to debate the matter. The deadline of six months is suspended when parliament is dissolved "*and/or absence of government with the confidence of the Chamber of Deputies.*"[33]

6. Specific Provisions of the Law

Article 15 of the Law provides for conscientious objection to either the performance of or participation in acts of euthanasia or assisted suicide.[34]

7. Official interpretative guidelines

Shortly after the enactment of the *Law* the Ministry of Health, in partnership with the Social Security Ministry, issued a public information booklet which outlined, in ordinary language, its main provisions, particularly those in respect of the illnesses or disorders for which euthanasia or assisted suicide might be possible solutions; the circumstances in which a patient can make a direct request for either; the definition of unbearable suffering without prospects of improvement and the formal conditions and procedures which must be followed by a doctor

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described as without prospects of improvement; (vi) proof that the request was made voluntarily, after reflection and repeated and without external pressure; (vii) the procedure followed by the doctor; (viii) the qualification if the doctor(s) consulted, the opinion and the dates of those consultations;(ix) where applicable, the capacity of the persons and the expert consulted by the doctor, and the dates of these consultations and (x) the precise circumstances in which the treating doctor performed euthanasia or assisted in a suicide and by what means.

[33] Article 13.

[34] No doctor can be obliged to perform euthanasia or provide assistance with suicide. No other person can be obliged to participate in euthanasia or provide assistance with suicide. If the consulted doctor refuses to perform euthanasia or assisted suicide he/she is obliged, within 24 hours of arriving at this decision, to inform the patient and/or the person of trust, if one has been appointed, of this refusal and must specify the reasons underlying it. The doctor who refuses to respond to a request for euthanasia or assisted suicide is obliged, at the request of the patient or of the person of trust, to send the patient's medical file to their doctor of choice.

before he or she performs one or other act.[35] In its introduction the Minister for Health expressed the hope *"that the new legal framework will enable people at the end of their lives and those around them to overcome this ultimate and, unfortunately, sometimes extremely difficult phase in all dignity."*[36]

In his view *"Luxembourg is now one of the European countries doing all that it can to guarantee their citizens access to first class palliative care whilst preserving their right to decide on the end of their life in accordance with their beliefs. It is a matter of giving additional legislative answers aimed at providing the framework for medical practices with regard to the end of lie, respecting everyone's dignity and choice."*[37]

However, a number of matters of interest arise:

- **Potential for Abuse**

In endeavouring to provide a legal basis for the practice of euthanasia and assisted suicide the parliamentary draughtsmen were obviously acutely conscious of the dangers attaching to a general decriminalisation of assisted death:

"Pure and simple decriminalisation would in fact permit all sorts of abuses."[38]

However, while imitating, to a large degree, the statutory control mechanisms employed in the Netherlands it is obvious that concerted efforts were made to ensure that the type of accusations of abuse which had been made – and continue to be made - in respect of the actual practice of both voluntary active euthanasia and assisted suicide in that jurisdiction following the implementation of the provisions of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002*, could never be levelled at the regulatory provisions contained in the Luxembourg law.

This, however, is a matter on which a dispassionate judgement, based on empirical data provided by the *National Commission for Control and Assessment*, will be possible only over time. Given the fact that the *Commission* is required to produce a report for the Chamber of Deputies every two years only, it would appear unlikely that there will be sufficient information available to make such a judgment anytime in the near future.

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[35] See fns. 1 and 17 supra.
[36] See fn. 1 supra.
[37] Ibid.
[38] Ibid. at 12.

- **Underlying ethic of the Law**

The much vaunted balance between the autonomy of the individual to choose not to suffer unnecessarily, and to opt for an earlier than natural death, and the duty of a member of the medical profession to relieve pain and suffering but only to a degree that does not encompass intentional killing, and consequent criminal sanction, made by those who aver that this requires the legalisation of euthanasia or assisted suicide, or both, was not invoked by the proponents of a euthanatical regime in Luxembourg.

Neither was the '*necessity*' template which was used to underpin the legalisation of euthanasia and assisted suicide in the Netherlands.

Instead the requisite balance was identified as that which lies between respect for the '*freedom of conscience*' of a doctor to accede, or not, to a request for euthanasia or assistance with suicide and, in doing so, not to engender a situation in which a terminally ill patient is forced to await a natural death with attendant unbearable pain and suffering.

The underlying ethic is one which encompasses simultaneous respect for the freedom of conscience of a doctor and respect for the freedom of choice of a patient wishing to die an earlier than natural death.

In the view of the Luxembourg legislators the only feasible way in which to achieve this balance was by the exclusive decriminalisation of acts of assisted death when performed by doctors.

If the intention of enacting a law on palliative care at the same time as the passage of the *Euthanasia and Assisted Suicide Law* was to reassure those who feared either that an indiscriminate regime of assisted dying would ensue or that incompetent or disable persons would be subjected to involuntary euthanasia in the absence of an organised system of palliative care, as a calculated manoeuvre, it has been successful, to date at least.

The first report of the *National Commission for Control and Assessment*,[39] found that in each of the five cases of euthanasia in the years examined, 2009 and 2010, the procedure followed by the doctor was as set out in the registration document. In short, there were no abuses.

Similarly, given the strictures attaching to the drafting and implementation of end-of-life provisions the possibilities of incompetent or disabled people being subjected to acts of

[39] See fns.11 and 12 supra.

euthanasia would appear to be remote. There have been no recorded instances of involuntary euthanasia and no old person has been pressurised into committing suicide.

None of these established facts, however, including the carefully defined oversight role of the *Commission,* mitigate the reality now obtaining in Luxembourg in the matter of the legality of third party involvement and assistance with the death of another person namely, that euthanasia and assisted suicide are permitted when performed by doctors within specified parameters and in accordance with strict protocols. Assisted death has now been added to the list of national characteristics which are invoked as evidence of a modern and sophisticated jurisdiction.

- **Destination for death tourism**

It is not possible to predict whether, like its neighbour Switzerland, Luxembourg will eventually, if ever, become a death tourism destination for those who, due to its criminal proscription, cannot avail of assistance with earlier than natural death in their own jurisdictions.

Because there are no conditions regarding residency or nationality attached to the right to make end-of-life provisions and or in registering them with the *National Commission for Control and Assessment* contained in the new law the authorities in Luxembourg are unable to prevent - in theory at least, however difficult it might be to accomplish in practice - a patient from another jurisdiction from availing of the services of a compliant doctor to be either euthanized or to receive assistance in suicide within its borders. There are no formal requirements in the *Law of 16 March, 2009* which would prevent a non-resident from endeavouring to do so successfully.

However, the Law does require a close relationship between the patient and his/her doctor before acts of either euthanasia or assisted suicide can be facilitated. Since the doctor must be able to confirm that a request for either euthanasia or assisted suicide is made freely and without force the presumption is that there must be a reasonably familiar doctor/patient relationship in existence. The presumption also is that the doctor must know his patient sufficiently well enough to be able to determine these facts satisfactorily.

In any event, a doctor contemplating acceding to a patient's request for one or other form of assisted death must interview the patient several times, and both certify and check that the suffering being experienced is "*unbearable and without prospects of improvement*." However implausibly, and in an effort to discount any possibility of the Duchy becoming another

Switzerland, the Ministry avers that these provisions mean that *"the treating doctor must have treated the patient continuously and for a sufficiently long time before a decision to comply with a request for assistance with death is contemplated, let alone complied with."*[40]

Notwithstanding official assurances, however, that because of the conditions and protocols established under the *Law,* Luxembourg is impervious to such an eventuality, the relative ease with which its neighbour - admittedly under a more liberal criminal law regime which allows for *altruistic* assistance with suicide without penalty - became identified as *the* destination for assisted death should not be overlooked.

It is not inconceivable that, given the levels of human ingenuity which those intent on dying an earlier than natural death determinedly evince – mainly arising from a genuine desire to avoid further pain and suffering - the requirements of the current doctor/patient relationship in Luxembourg may be circumvented to a degree sufficient to allow non-residents to avail of euthanasia and assisted suicide legally in that jurisdiction.

The fact also that the *Commission for Control and Assessment* has concluded that death resulting from euthanasia *"must be considered a death by natural causes"* may prove an added difficulty for the authorities to successfully and permanently deter non-residents from travelling to Luxembourg to die *"naturally"*.

- **Terminal state**

According to the Ministry of Health the origin of the terminal state of health referred to in the Law *"is not important."*[41] The patient's health problems may result from any disorder which gives rise to *"unbearable physical or mental suffering."* However, this is not solely a matter of subjective consideration by the patient.[42] There is provision for objective assessment also.

Not alone is the treating doctor obliged to diagnose a terminal medical situation which, among other symptoms, manifests itself in constant and unbearable physical and mental suffering without prospect of improvement, resulting from an accidental or pathological disorder, he

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[40] Op.cit., fn.12 supra, at 26.

[41] Op.cit, fn.1 supra, at 13.

[42] Ibid., at 15. *"Although several objective factors can contribute to assessing the unbearable nature of the suffering, the assessment of the unbearable suffering is to a large extent a subjective and personal question from the patient and depends on their personality, their pain perception threshold, their conceptions and their values. The question of prospects of improvement of the suffering is one of a medical nature, but account should be taken of the fact that the patient is entitled to refuse the treatment of suffering, or even of palliative treatment, above all when such treatment involves side effects or modes of application which they deem unbearable. An in-depth discussion between the doctor and the patient is necessary in this regard. In view of the variability of these notions, depending upon the person concerned, the opinion of an independent doctor is required together with that of the treating doctor."*

must also consult another doctor as to the severity and incurable nature of the disorder from which the patient is suffering, prior to performing an act of euthanasia or providing assistance with suicide.

This is not merely a *pro forma* consultation. The consulting doctor must be independent both of the patient and the treating doctor, he must examine the patient personally and not rely solely on the patient's medical file or any information provided to him by the treating doctor, and must be competent as to the particular pathology in question.

The Ministry of Health relied on *"foreign experience"*[43] for an indication of the most frequently invoked diseases underpinning requests for euthanasia and assisted suicide. While it did not identify the *"foreign"* entities in question it would be surprising if they were anywhere other than the Netherlands and Belgium. Advanced instances of cancer, neuro-muscular illnesses involving terminal paralysis were given particular mention but *"any severe, incurable and irreversible disorder which meets the legal conditions"*[44] was also included.

- **The position regarding minors and patients under guardianship or trusteeship**

The *Law* provides that a doctor may only aid death by euthanasia or assisted suicide if the request is made by an adult patient who is capable and conscious at the time of the request or at the time his/her end-of-life provisions was drafted, signed and registered with the *National Commission for Control and Assessment.*

Consequently, a minor, or an adult person under guardianship or trusteeship, or an incapable[45] person cannot validly request euthanasia or assisted suicide.

Parents cannot decide on behalf of their minor child that he or she be euthanised because they deem the pain and suffering being endured is unbearable for the child.

Similarly, guardians or trustees cannot decide on behalf of an adult person under guardianship or trusteeship that he or she should either be euthanised or provided with assistance in suicide.

- **Other than the patient can anybody else decide on euthanasia or assisted suicide?**

The only person entitled to request either euthanasia or assisted suicide is a competent terminally ill patient displaying constant and unbearable physical or mental suffering without

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[43] Ibid at 13.
[44] Ibid.
[45] See fn.13 supra.

prospect of improvement. Nobody can substitute themselves for the patient in requesting either act to be performed. Consequently, neither a close relative nor a doctor can decide on euthanasia. Even when end-of-life provisions have been registered, the person concerned can change his or her request to die at any time and in all cases the doctor must respect the last wish of the patient. Where appointed, a person of trust does not decide on whether euthanasia or assisted suicide is appropriate. He or she does not speak personally. The role is solely to keep the doctor informed as to the patient's wishes.

- **Freedom of Conscience**

The Law recognises the freedom of conscience of a doctor who is requested to perform an act of euthanasia or to provide assistance with suicide. There is no legal obligation on any doctor to accede to such requests. Refusal can be given without impunity. Similarly, no carer or any other person is obliged to assist or participate in euthanasia or assisted suicide.

Notwithstanding a particular institution's ethos – be it a hospital, a retirement home or a rehabilitation centre – it cannot refuse a doctor permission to perform euthanasia or assisted suicide when the conditions laid down by the Law are met. Freedom of conscience is viewed as an individual and not an institutional matter.[46]

- **Breach of the Code of Medical Ethics**

The Code of Medical Ethics, approved by *Ministerial Order, dated 7 July 2007*, has not been amended to take account of the 2009 Law. However, the existing Code provides that observance of its rules and guidelines is conditional on the prevailing national legal and regulatory regime in force. A doctor who fulfils the legal requirements for the performance of an act of euthanasia or provides assistance in suicide cannot be criminally prosecuted, be subject to civil action for damages or be punished by the Medical Council.

8. Empirical data in respect of euthanasia and assisted suicide since the enactment of the 2009 Law

In compliance with *Article 9* of the Law the *National Commission for Control and Assessment* presented its first report to the Chamber of Deputies in March, 2011. Inter alia, this contained details of the procedures adopted by the Commission, the evaluation of the requisite conditions and illnesses for either euthanasia or assisted suicide in each case, the ages of the patients, the locations in which acts of euthanasia were performed (there were no instances of assistance with suicide), the number of end-of-life declarations registered by the end of March

[46] See Article 15.

2011 and the nature of the illnesses and disorders specified, the substances used in the performance of euthanasia, the procedures followed by the doctors involved, the *Commission's* decisions and recommendations in respect of the future application of the *Law*.[47]

"None of the examined cases raised the least doubt of irregularities and the Commission was thus able to accept unanimously each of the cases.....After lengthy discussions, the Commission came to the conclusion that death resulting from euthanasia must be considered a death by natural causes."[48]

- **Procedures followed by the doctor**

In those instances where euthanasia was performed death was caused by injecting biopental intravenously, resulting in deep unconsciousness, followed by an intravenous injection of a neuromuscular paralysing agent leading to cardio-respiratory arrest. In all cases "*a serene and rapid death within minutes*" was reported by the doctors involved. There were no instances of euthanasia being performed by an injection of morphine, either on its own or in combination with a sedative.

In each case the Commission found that the procedure followed by the doctor was in full compliance with the legal requirements vis-à-vis the registration documentation set out in Article 7 of the Law.

The provisions allowing for the revocation of anonymity, arising from doubts as to whether the proper procedures were observed, also contained in Article 7, did not need to be invoked. Similarly, no need to forward any of the cases examined to either the Medical Council or the Public Prosecutor was identified.

- **Recommendations concerning the application of the Law**

The *Commission* also made a number of recommendations in respect of the on-going application of the Law:

- *(i) Comprehensive information in respect of the correct practice of euthanasia as laid down in the Law should be made available to both the public and the medical*

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[47] From May to June, 2009, the Commission met weekly in order to finalise the official documentation required by the Law. In July, 2009, the Commission adopted these documents and made them publicly available via its website. Its regular monthly meetings thereafter were dedicated to the examination of the official euthanasia declarations it had received.

[48] *First Report of the National Commission for Control and Assessment to the Chamber of Deputies, March, 2011.* See fn.11 supra.

profession. There was an urgent need for dedicated guidelines for the medical profession.

This recommendation would appear to suggest that either the medical profession as a whole had expressed concern that the information supplied by the Ministry of Health was lacking in the necessary detail or that individual doctors had been found not to be in full possession of the requisite data.

The Commission did not elaborate on the reasons why it found it necessary to make this recommendation and no empirical findings have been published, either by the medical profession or by any state authority, to indicate that an informational lacuna exists, either at the corporate medical level or in the case of individual doctors.

Nonetheless the fact that the *Commission* charged with overseeing the proper application of the Law deemed it appropriate, in its first report to the Chamber of Deputies, to identify a need for a "*special*" brochure for doctors is indicative either of a nonchalant attitude to third party assistance with death on the part of the totality of the profession or a genuine apprehension on the part of the Commission that individual doctors might have failed to acquaint themselves satisfactorily with the provisions of the new Law.

- *(ii) The doctor involved in euthanasia should have free and unrestricted access to the drugs required to perform the act.*

The *Commission* did not state why it considered it necessary to make this recommendation. It is to be presumed that it did so in circumstances where difficulties in accessing the appropriate drugs for effecting a successful act of euthanasia had been brought to its attention either by representatives of the medical profession as a whole or by individual doctors.

It is to be presumed also that such difficulties, if such is the case, could only have arisen in particular situations where pharmacists were either reluctant, or refused, to supply doctors with the requisite drugs.

Whether or which, if such difficulties do obtain, it is indicative, at the very least, of a degree of residual opposition, however minimal, to the provision of assistance with death by a doctor.

If difficulties continue to be experienced by doctors, willing to perform acts of euthanasia or provide assistance with suicide, in obtaining the drugs necessary to comply with repeated request of a patient to die, doubtless this matter will form part of the second report of the *Commission.* It is noticeable that the *Specific Provisions* of *Article 15* make no mention of

respecting the freedom of conscience of a pharmacist who may, on religious, ethical or other grounds, feel unable to supply drugs in the knowledge that their use is the deliberate cause of the death of a human person.

Perhaps the possibility that persons other than doctors, nurses and health care providers might be imbued with conscientious doubts as to the moral or ethical propriety of participating, albeit not directly, in the death of another did not impinge sufficiently on either the proposers of the legislation or its drafters to allow for their inclusion in the new Law. This may be a matter which will arise in future reports of the *Commission.*

The other recommendations of the *Commission* were:

- *(iii) Medical studies must include instruction and training for trainee doctors to prepare them for those end-of-life situations, such as palliative care and euthanasia, with which they will inevitably be confronted during their future careers. Similarly, post-graduate and continuing learning programmes for members of the medical profession should include refresher training and instruction.*
- *(iv) Article 4 of the Law requires that the doctor treating an end-of-life patient or a patient whose condition is without hope of recovery must establish from the Commission of Control and Assessment whether the patient has registered his/her end-of-life provisions with the Commission. All hospitals and long-stay residential institutions, henceforth, should enquire, on a patient's admission, as a matter of course, whether an end-of-life document has been registered with the Commission.*
- *(v) No abuses or major difficulties have occurred which would necessitate legislative action.*

At the time of writing the report of the *Commission* for the years 2011 and 2012 had not been published.

Chapter VI – England and Wales

'Best Interests' death

1. Introduction

A dispassionate appraisal of the approach adopted and followed at English law in the matter of third party - and specifically medical - assistance with death, requested or otherwise, over the past quarter of a century would appear, at first sight, to be relatively straight-forward.

In the absence of legislative provision the common law proscription of unlawful killing is the dominant criterion.[1]

However, a number of underlying principles, such as the medical exception, the requirement of informed consent, the right of refusal of medical treatment, individual autonomy and self-determination, capacity and incapacity, and most especially that of medical futility, are inextricably interwoven with an intricate filigree of evolved legal mechanisms. These, both individually and collectively, are employed in the determination of the legality or otherwise of particular instances of non-natural death.

Of significance, but not exclusively so, among these mechanisms are those which incorporate specific moral values, including the principle of the *inviolability of life* at common law – which, in doctrinal terminology, is referred to as the *sanctity of life* - and the traditionally established legal construct of *double effect*, the essence of which is the distinction drawn between intention and foresight.

Likewise, the applied legal differential between acts and omissions is of pivotal importance in any appreciation of how the lawfulness of death resulting from either medical action or inaction can be readily accommodated within the legal architecture governing the prohibition of the deliberate termination of the life of one person by another.

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[1] In *R v Adams (Bodkin) [1957] Crim LR 365 (Central Crim Ct)*; see Palmer, H, *'Dr Adams' Trial for Murder'* [1957] Crim.Law Review 365. Devlin J stated: *"If the acts done are intended to kill, and do, in fact, kill, it does not matter if a life is cut short by weeks or months, it is just as much murder as if it were cut short by years."* See also *The Queen on the Application of Mrs Dianne Pretty v Director of Public Prosecutions [2002] 1 AC 800, [5] HL; Airedale NHS Trust v Bland [1993] AC 789, at 865, per Lord Goff, at 882, per Lord Browne-Wilkinson, and at 892, per Lord Mustill.* In *R v Cox (1992) 12 BMLR 38,* Ognall J in his summing-up to the jury stated that if the *"primary purpose"* of the administration of potassium chloride was to hasten death then it was murder. In his *'Samples of Lawmaking'*, London, 1962, at 94-95 Devlin, P stated: *"The deliberate acceleration of death must prima facie be murder and I do not see how under any system of law it can logically be otherwise. The certainty of death in the immediate future cannot, of itself, be a defence any more than the certainty in the remote future."*

It has been argued that these traditionally dominant constructs - incorporating as they do moral values expressed as principles – *"are based on unsound moral premises and are inherently insecure."*[2] Nonetheless, it is unarguable that, historically, they have provided, and continue to do so, the philosophical and intellectual foundations on which the edifice of prevailing orthodoxy regarding the common law proscription of intentional assistance with earlier than natural death has been firmly established. This is irrespective of the allegedly *"fragile, illusory and unstable nature"*[3] of the consensus to which they contribute.

The approval by the *House of Lords Select Committee on Medical Ethics*[4] of the principle of *double effect*, for example, and its recommendation that voluntary euthanasia should not be legalised[5] together with the failure of the most recent attempts[6] to have assistance with suicide legalised, are emblematic of their enduring legal relevance. While the *House of Lords Select Committee on the Assisted Dying for the Terminally Bill*[7] - sponsored by Lord Joffe - did not adopt a specific position either way in the matter of the legalisation of voluntary euthanasia, it did make a number of recommendations which future proposals for the legalisation of assisted dying should take into consideration.

At first sight this might be thought indicative of a softening of approach by the legislative authorities in the matter of provisions which would allow for lawful assistance with death. On careful examination, however, it is obvious that the pervasive influence of traditional evaluative criteria underpinning the approach to such assistance, at least in so far as the formal law is concerned, has not diminished to any appreciable extent. Similarly, there has been no diminution in the opposition to all forms of assisted dying by the medical profession.[8]

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[2] Price, D, *'What Shape To Euthanasia After Bland? Historical, Contemporary and Futuristic Paradigms'*, 125 Law Quarterly Review 14 2-174 (2009), at 142. *"These predominantly rule-based perspectives are typically unyielding and not susceptible to compromise, resulting in polarised and intractable debate," Ibid.*

[3] See Kamisar, *Y, 'Physician-Assisted Suicide: the Last Bridge to Active Voluntary Euthanasia' in Keown, J. (ed), 'Euthanasia Examined: Ethical, Clinical and Legal Perspectives'*, Cambridge University Press, 1995, at 242. See also *Price, D, op.cit., fn.2, supra, at 171.*

[4] *Report of Select Committee of Medical Ethics (HL Paper 21-1 of 1993-4, at para 243).*

[5] Ibid., at para 262.

[6] By Lord Joffe in the House of Lords

[7] *Select Committee on the Assisted Dying for the Terminally Ill Bill, First Report (2005).*

[8] The British Medical Association's policy on assisted dying was re-affirmed in 2006. It insists that physician-assisted suicide, voluntary euthanasia and non-voluntary euthanasia should not be made legal in the UK. *"If euthanasia were legalised there would be a clear demarcation between those doctors who would be involved in it and those who would not."* The Association's opposition is based on the belief that *"permitting assisted dying for some could put vulnerable people at risk of harm; such a change would be contrary to the ethics of clinical practice, as the principal purpose of medicine is to improve patients' quality of life, not to foreshorten it; legalising assisted dying could weaken society's*

A balanced overview of the current jurisprudential disposition in England and Wales in the matter of physician assistance in dying would be impossible, therefore, without due recognition being given to the robust impact which traditional mechanisms have brought to bear historically on the incremental development of both English common law and, where they exist, criminal statutory provisions.

The influence of these mechanisms is clearly discernible in the judicial reasoning adopted and followed in a number of iconic cases, particularly those in which incapacity, together with a medical prognosis of futility, predominate and where the lawfulness or otherwise of the withdrawal of life-sustaining medical treatment was in issue, among them being *Airedale NHS Trust v Bland*[9] and *Re A (Conjoined Twins)*[10].

The application, for example, of the template of *double effect*[11] is palpably in evidence in those cases, albeit rare,[12] where doctors are prosecuted for the attempted unlawful killing of

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prohibition on killing and undermine the safeguards against non-voluntary euthanasia. Society could embark on a 'slippery slope' with undesirable consequences; for most patients, effective and high quality palliative care can effectively alleviate distressing symptoms associated with the dying process and allay patients' fears; only a minority of people want to end their lives. The rules for the majority should not be changed to accommodate a small group." See BMA (Ethics): *'What is current BMA policy on assisted dying?' at* www.bma.org.uk/practical-support-at-work/ethics/bma-policy-assisted-dying accessed 10 October, 2012. A request by the *Healthcare Professionals for Assisted Dying* that the British Medical Association move from opposition to *"studied neutrality"* in the matter of assisted suicide, was defeated by the Association's annual conference in June, 2012. See The Independent, 27 June, 2012. A robust exchange of juristic views between John Keown and David Price regarding the BMA's policy in the matter of the withdrawal and withholding of artificial nutrition and hydration, can be found at Keown, *'Beyond Bland: A Critique of the BMA guidance on withholding and withdrawing medical treatment',* Legal Studies (2000) 20 LS 66; Price, *'Fairly Bland: an alternative view of a supposed new 'Death Ethic' and the BMA guidelines',* Legal Studies (2001) 21 (4) 618; Price, *'My view of the sanctity of life: a rebuttal of John Keown's critique',* Legal Studies (2007) 27 (4) 549.

[9] *[1993] AC 789.*

[10] *[2001] Fam 147.*

[11] See fn. 56, Chapter II on the Netherlands. The seminal case in which the principle of double effect was applied is that of *R v Adams (Bodkin) [1957] Crim LR 365 (Central Crim Ct).* The dicta of Devlin J merit reiteration: *"The doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life."* The prosecution alleged that Dr Adams had intentionally killed the patient so that he could inherit property she had left him in her will, and that he had done so by deliberately injecting her with excessively large doses of morphine. Devlin J directed the jury that murder was the *"cutting short of life, whether by years, months or weeks."* However, he added: *"But that does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect upon a patient's life of the medicines which he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life."* See Devlin, P, *'Easing the Passing',* London, 1985, at 171; also Palmer, H. *'Dr Adams' trial for murder'* [1957] Crim LR 365. Gleny Williams defines double effect thus: *"The principle of double effect is a doctrine that distinguishes between the consequences a person intends and those that are unintended but foreseen and may be applicable in various situations where an action has two effects, one good and one bad. In the medical context it is usually relied on when a doctor increases pain-killing medication to a patient; the doctor foresees that the patient may die, although that is not his*

patients. Following the finding in the non-medical case *R v Woolin,*[13] however, the validity of the applied differential between intention and foresight would appear to be in question. Intention as commonly accepted at English criminal law encompasses the notion that a consequence is intended if it is either the actor's purpose or desire, or is foreseen by the actor as morally certain to occur.[14] This is not the approach adopted where the defendant is a doctor. A less stringent approach, and a much narrower definition of intention, is invoked in those instances in which medical personnel are involved. Consequently, many pain relief cases are excluded from the ambit of the criminal law.[15]

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intention", See *'The Principle of Double Effect and Terminal Sedation'*, Medical Law Review, 9:41-53, 2011.

[12] Per Lord Mustill in *Airedale NHS Trust v Bland [1993] AC 789, at p. 892*: *"Prosecutions of doctors who are suspected of having killed their patients are extremely rare, and direct authority is in very short supply. Nevertheless, that 'mercy killing' by active means is murder was taken for granted in the directions to the jury in R v Adams (unreported), 8 April, 1957; R v Arthur (unreported), 5 November, 1981 and R v Cox (unreported), 18 September, 1992."*

[13] *[1998] 4 All ER 103. In R v Moloney [1985] AC* 905 the Law Lords had distinguished intention and foresight. However, this distinction has now to be viewed in the light of the decision in the non-medical case of *Woolin* where the Law Lords appeared to rule that a consequence foreseen as virtually certain is intended. *"The implications of this for doctors who foresee that their palliative care will shorten life are disturbing: are such doctors now prima facie liable for murder?"* See *Keown, J, 'Euthanasia, Ethics and Public Policy: An Argument Against Legislation'*, Cambridge University Press, 2002, at 28. The general juristic view is that *Woolin* was a retrograde step. It is argued that it may have a chilling effect on the provision of much-needed palliative care and leave patients dying in pain and distress. *"A ruling which hinders good medicine is clearly bad law."* (Ibid, at 29). While of undoubted significance within the totality of jurisprudential debate in respect of the continued applicability of the doctrine of *'double effect'* in particular cases, and notwithstanding the trenchant view of one jurist that the Law Lords *"appear to have sleepwalked into conflating intention and foresight of virtual certainty, with potentially dire results for palliative care" (Ibid, at 29.)*,the impact of the *Woolin* judgment is not of such relevance to an historical overview of the evolution of the common law in the matter of assisted dying as to demand exclusive treatment.

[14] See *R v Moloney [1985] AC 905*. Cf. also *Re J [1990] 3 All ER 930, at 938* per Lord Donaldson MR. Delivering the leading judgment in *Moloney* Lord Bridge stated, *at 927-28*, *"The first fundamental question to be answered is whether there is any rule of substantive law that foresight by the accused .....is equivalent or alternative to the necessary intention. I would answer this question in the negative."* He added: *"I am firmly of the opinion that foresight of consequences, as an element bearing on the issue of intention in murder, or indeed any other crime of specific intent, belongs, not to the substantive law, but to the law of evidence."* The point being made was palpably clear – the fact that the accused foresaw death did not mean that he intended death; the accused's foresight was merely evidence for the jury to take into account in deciding whether it was the accused's *purpose* to kill. See Smith & Hogan, *'Criminal Law'*, 13th ed., 2011, at 54.

[15] Devlin J's directions to the jury in *Adams(Bodkin) [1957] Crim LR 365 (Central Crim Ct)* that *"the doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life"* were followed in *R J (A Minor)(Wardship: Medical Treatment) [1991] Fam 33, 46 (CA)* (*"the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so"); Airedale NHS Trust v Bland [1993] AC 789, at 867-8, per Lord Goff; Re A (Children) (Conjoined Twins: Surgical Separation) [2001] Fam 147, 199 (CA).* Cf. Also *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, 2005: [15]* (quoting the Attorney General that it is not murder *"where a doctor acts to do all that is proper and necessary to relieve pain with the incidental effect that this will shorten a patient's life").* See also Mason & McCall Smith, *'Law and Medical Ethics'*, 8th ed., Oxford University Press, 2011, at 602, where the authors claim that the *"deeply*

The interpretation accorded to intention within the specific confines of the doctrine of *double effect* and that accorded it generally at English criminal law are starkly different. In the Court of Appeal decision in *Re A (Children) (Conjoined Twins: Surgical Separation)*[16] Ward LJ said that it could be difficult to reconcile the doctrine of *double effect* with *Woolin*[17] but, nonetheless, he could *"readily see"* how the doctrine would work in cases where pain-killers are administered to deal with acute pain. Price points out that the doctrine was initially formulated to permit *"flexibility of moral evaluation in cases were bad results flowed from inherently laudable or appropriate actions",*[18] the locus classicus being instances of death resulting from conduct taken in self-defence.

Another criterion, that of the legal differential between acts and omissions, reached its apogee in the finding in *Airedale NHS Trust v Bland*[19] where the withdrawal of life-sustaining medical treatment from a patient in a permanent vegetative state, albeit capable of independent breathing and whose death was not imminent – in short, he was not terminally ill - was deemed lawful on the basis that such a withdrawal was an *'omission'*, not an *'act'*. The judicial reasoning adopted and followed in *Bland* set the scene for a similar finding by the Irish superior courts in *Re a Ward of Court (Withholding of Medical Treatment) (No. 2)*[20] a short time later.

However, while these legal mechanisms had enormous significance historically within the jurisprudential matrix governing life and death issues, a new philosophical orientation began to emerge in the last decades of the twentieth century. Its defining contours were the diminution of medical paternalism and the recalibration of the concept of individual rights, particularly those of informed consent and refusal of unwanted medical treatment, even in circumstances where death is the inevitable outcome. Consequently, a subtle, but nonetheless discernible, relegation of the common law principles underpinning findings as to who should be let live and who should be permitted to die occurred. A more pragmatic curial estimation of whether life or death happens to be in a patient's actual *'best interests'* was the new criterion.

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entrenched" sympathy by the courts towards doctors who are charged with criminal offences arising from the treatment of patients was clearly demonstrated in the case of Dr. Moor; Dyer, C, *'British GP cleared of Murder Charge'* (1999) 318 BMJ 1306; Gillon & Doyle, *'When Doctors Might Kill their Patients'*, (1999) 318 BMJ 1431.

[16] *[2001] Fam 147.*

[17] *[1998] 4 All ER 103.*

[18] *Op. cit., fn. 2, supra, at 146.*

[19] *[1993] AC 789*

[20] *[1996] 2 IR 73.*

In consequence, a *'quality of life'* criterion emerged as an integral and authoritative element in end-of-life decision-making at English common law.[21] The genesis of this new criterion can be traced to findings in specific cases, beginning in the late 1980s, in which the lawfulness or otherwise of the non-treatment, or the discontinuance of life-sustaining medical treatment of incompetent children suffering with disabilities, including those of an uncomplicated character, was in issue.[22]

The statutory endorsement of the *'best interests'* test,[23] some twenty-five years after it was invoked in a series of cases presided over by the Master of the Rolls, Lord Donaldson, affirmed conclusively the primacy of a new benchmark, that of *'quality of life',* in judicial determinations involving life and death, especially in those cases in which incompetence had been determined.

Traditional jurisprudential criteria were subjected to a type of constructive judicial ambiguity, resulting in the gradual discontinuance of their automatic invocation as the exclusive and unassailable reference points in the determinative matrix regarding continued life or guaranteed death. A polite jurisprudential fiction was permitted to take hold whereby the adamant rejection of formal legal endorsement of assistance with death comfortably co-existed with an insouciant disregard of the reality obtaining in the application of the law in practice.

The contention, therefore, is that apart from those rare cases in which doctors are prosecuted for the crime of the attempted unlawful killing of a patient, and in which the efficacy of the doctrine of *double effect* can be demonstrated,[24] or where a hospital authority seeks curial guidance as to whether a particular procedure, if followed, will result in criminal charges,[25] the common law as practised is symptomatic of its innate ability to accommodate a suite of alternative and novel criteria, referred to in emollient terms as the *'best interests'* test.

This test, while possessed of the undoubted merit of enabling judicial findings to be made, based on a medical prognosis of futility, in seemingly intractable circumstances associated

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[21] See Keown, J, *op.cit, fn.13 supra, at 43-44.*

[22] While the genesis of the concept of *'best interests'* can be traced to early guardianship jurisprudence it gained prominence, and widespread acceptance, in cases involving the sterilisation of mentally incompetent patients in the late 1980s. See *T v T [1988] 1 All ER 613; F v West Berkshire Health Authority [1989] 2 All ER 545.*

[23] In the *Mental Capacity Act, 2005.*

[24] *As in R v Adams (Bodkin) [1957] Crim. LR 365 (Central Crim. Ct.).* See fn.1 supra.

[25] As was the case in *Airedale NHS Trust v Bland [1993] AC 789* where the differential between *'acts'* and *'omissions'* was invoked and applied.

with the end of human life, particularly where the selective non-treatment of children with disabilities, and those in which adult patients no longer possess capacity, is in issue, has the added advantage, based on the inherent jurisdiction of the courts,[26] of not leaving itself open to a charge of disavowing the continued relevance of established norms where appropriate.

Paradoxically, therefore, the common law, which proscribes the intentional killing of one person by another, has evolved to a position whereby judges, and judges alone, can decide whether it is no longer in the *'best interests'* of an incompetent patient to be allowed to continue living. Likewise, based on a medical prognosis as to the unlikelihood of a future desirable *'quality of life'*, judges can decide whether he or she should die. This, it is submitted, is a matter which demands greater critical analysis and exposition than it has received heretofore. In particular, both the substance and reach of this new *'best interests'* paradigm demand clinical and forensic examination.

The fact that such a critical analysis is deemed necessary might be regarded as indicative of a reluctance to acknowledge that the common law is not a static, inflexible entity incapable of adaptation or change. The contrary, however, is the case. Throughout the millennia the common law has shown itself eminently capable of adjusting to prevailing societal circumstances, including advances in science and medicine, without either disavowing or engendering elemental jurisprudential principles.

It is not intended either to ignore or to discount the potency attaching to certain principles in the evolution and development of common law jurisprudence in the matter of assisted death. However, it is suggested that a rational explication is required of how, over a relatively short period of time, these principles have come to be reformulated within the existing matrix of the criminal law. The manner in which this has occurred is of specific relevance. On the one hand the common law evinces a resolute adherence to the established rubric of the unlawfulness of the intentional termination of life, and on the other hand, it displays a pragmatic readiness to accommodate criteria whose ultimate objective is the legitimisation of certain procedures, including selective non-productive treatment, which result in earlier than natural death, but which do not invite the slightest taint of criminality.

The stark reality would appear to be that the criminal proscription of unlawful killing and judicial findings that death may be in an incompetent patient's *'best interests'*, even in circumstances where death is not imminent, have been deemed not to be mutually exclusive concepts. This reality graphically defines the paradoxical legal landscape in respect of third

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[26] See dicta of Sir Stephen Brown P in *Re C (A Minor: Medical Treatment) [1998] Lloyd's Rep Med 1 Fam Div: "What the court is being asked to do in this case if to exercise* ***its inherent jurisdiction*****....."**

party assistance with death in a jurisdiction which has repeatedly eschewed attempts to ameliorate its laws regarding both mercy-killing and assistance with suicide.

While it is not being argued that established principles have been either emasculated or abandoned, nonetheless it is contended that English common law has demonstrated an evolutionary capability of facilitating, and accommodating, a new template, that of *'best interests'* which, having been tried and tested in the furnace of pragmatic law, was ultimately incorporated in the *Mental Capacity Act, 2005,* which came into effect in 2007.

2. Structure

The most beneficial framework within which to demonstrate the manner in which English common law, without any corresponding negative or deleterious impact on the criminal prohibition of unlawful killing, has been subtly reconfigured to permit judicial determinations which result in the earlier than natural deaths of incompetent patients, is to outline, in the first instance, the criminal character of third party assistance with death, including euthanasia and assistance with suicide.

This necessarily involves, first, a review of those rare cases in which doctors have been prosecuted for the attempted murder of their patients and which are graphically illustrative of the efficacy attaching to the principle of *double effect.*

Second, and in order to identify the jurisprudential reasoning on which the current law is based, to trace the application of the *'best interests'* test via a continuum of cases in which the continued treatment, or not, of children with disabilities was in issue, beginning immediately after the unsatisfactory finding in *R v Arthur.*[27]

Third, the application of the *'best interests'* paradigm, together with the invocation of the legal differential between acts and omissions, will be examined in cases involving adults who no longer possess competency.

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[27] *(1981) 12 BMLR 1.* The testimony of medical witnesses in *Arthur* – in which a paediatrician was tried for attempting to murder a Down's syndrome baby by sedation and starvation – disclosed that sedation and starvation of new born babies with Down syndrome was accepted as ethical by a responsible body of medical opinion. Citing this testimony, the judge directed that it was lawful for a doctor intentionally to starve such a baby to death if the doctor and the parents decided to do so. See Keown, op.cit., fn.13 supra, at 258. See also Gunn & Smith, *'Arthur's Case and the Right to Life of Downs' Syndrome Child'* [1985] Crim LR 705 who concluded (at 715) that, according to Arthur, such a baby has no right to be fed if the doctor and parents decide to let it die; David Poole QC, *'Arthur's Case (1) A Comment'* [1986] Crim LR 383. It is a matter of some irony that the genesis of the long and careful deliberation in *Airedale NHS Trust v Bland [1993] AC 789* can be traced to the finding in *Arthur.* See Mason & McCall Smith, op.cit, fn.15, supra, at 491,525 and 529. For a particularly critical analysis of the judge's summing up in *Arthur* see LIFE publication: Anon., *'Regina v Arthur: A verdict of the judge's summing up in the Trial of Dr Leonard Arthur',* November, 1981 (n.d.).

Lastly, and as indicative both of the current establishment disposition in the matters of euthanasia and assisted suicide it is necessary to review briefly the findings of the House of Lords Select Committee on Medical Ethics[28] which was established in the immediate aftermath of the finding by the Law Lords, now the Supreme Court of England and Wales, in *Airedale NHS Trust v Bland*[29], and those of the House of Lords Select Committee on the *Assisted Dying for the Terminally Ill Bill* in 2005,[30] together with an analysis of the judicial reasoning applied in *Pretty,*[31] *Purdy*[32] and *Nicklinson.*[33]

Before embarking on this task, however, it is necessary to contextualise a number of established common law principles which are of significance to a proper understanding of the English jurisprudential approach to third party assistance with death, the most significant of which are:

(a) the medical exception;

(b) the issue of consent, and

(c) the right of person to refuse unwanted medical treatment.[34]

It is sufficient to outline the primary characteristics attaching to each and to cite the relevant case law on which they are based and from which they derive their continued sustenance.

(a) Medical Exception

In *Airedale NHS Trust v Bland* Lord Mustill stated that *'bodily invasions in the course of proper medical treatment stand completely outside the criminal law'.*[35] In truth, this was but a pragmatic affirmation by the Supreme Court of the entrenched and unassailable status of the medical exception at English law.[36]

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[28] Op.cit., fn. 4 supra.
[29] *[1993] AC 789.*
[30] Op.cit., fn.7 supra.
[31] *R (Pretty) v DPP [2001] UKHL 61, [2002] 1 AC 800.*
[32] *R (On the application of Purdy) v DPP [2009] UKHL 45.*
[33] *Nicklinson v Ministry of Justice [2012] EWHC 2381 (Admin).*
[34] The symbiotic relationship between the latter two obviates separate treatment here notwithstanding the fact that both are capable, in their own right, of lengthy disquisition and evaluation.
[35] *Airedale NHS Trust v Bland [1993] AC 789, 891.* See also *R v Brown [1994] 1 AC 212, 258-9 (HL)* which found that it is legitimate to perform *"surgical treatment in accordance with good medical practice and with the consent of the patent"; AG's Reference (No.6 of 1980)[1981] QB 715, 718 (CA, Lord Lane CJ)* which listed exceptions to the general rule that consent is no defence to assault causing actual bodily harm, including *"reasonable surgical interference"* on the basis of necessity in the public interest.
[36] See Lewis, P, *'England and Wales', in Griffiths & Weyers' 'Euthanasia and Law in Europe',* Hart Publishing, Oxford, 2008, at 349.

(b) Consent and the Refusal of Medical Treatment

Without the patient's consent invasive medical treatment could amount to both battery and assault.[37] For consent to be valid the patient must first have the capacity to consent; second, the consent must be voluntary and third, the patient must understand, in broad terms, the nature of the treatment to which he has consented. While patient consent to medical treatment prevents it from being a civil wrong and a criminal assault it does not provide a defence to the infliction of actual or grievous bodily harm.[38] Reasonable and proper surgical interventions, are lawful and in the public interest. At common law, therefore, it appears that rather than being based on patient consent, reasonable and proper medical treatment does not fall within the purview of the criminal law. At civil law consent will prevent a doctor from being liable for the tort of battery and contingent on the prior consent of the patient to a particular treatment there is no possibility of action for the recovery of damages in tort arising from alleged unlawful touching.

Lord Mustill encapsulated the position pithily (as did his judicial colleagues, Lord Templeman, *at 231*, Lord Jauncey *at 245* and Lord Slynn *at 276), in R v Brown [1994] 1 AC 212, at 266 "Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability. Actual consent, or the substitute for consent deemed by the law to exist where an emergency creates a need for action, is an essential element in this immunity; but it cannot be a direct explanation for it, since much of the bodily invasion involved in surgery lies well above any point at which consent could even arguably be regarded as furnishing a defence. Why is this so? The answer must in my opinion be that proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own."*

Lord Goff, *at 868*, alluded to the "*established rule*" that a doctor may, "*when caring for a patient who is, for example, dying of cancer, lawfully administer pain-killing drugs despite the fact that he foresees that an incidental effect of that application will be to abbreviate the patient's life*". However, it is only envisaged to apply in circumstances where the patient is beyond recovery and where the treatment administered is in accordance with proper medical practice. This is clear from Devlin J's reference to what is "*proper and necessary*" to relieve pain and suffering and to "*proper medical treatment.*"

[37] '*Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault*', Cardozo J in *Schloendorff v New York Hospital, 105 NE 92 (1914).*

[38] As established in *R v Donovan [1934] 2 KB 498* guilt or innocence is not contingent on the victim's prior consent: "*if an act is unlawful in the sense of being itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it.*" The common law position with regard to the effect of consent on the question of criminal liability for murder is unequivocal – a person cannot lawfully consent to his or her own death. See *R v Cato [1976] 1 All ER 260; Airedale NHS Trust v Bland [1993] AC 789, 890 (Lord Mustill).* With the exception of the crime of rape where the absence of consent is an essential component of the crime, consent is irrelevant to the criminal law. The prohibition on consent applies not only to death but also to the infliction of bodily harm. See *Attorney General's Reference (No.6 of 1980) [1981] 1 QB 715,* per Lord Lane.

The principles of autonomy and the protection of bodily integrity govern a person's right to refuse unwanted medical treatment.[39]

The importance of patient autonomy was emphasised robustly by three judges of the Appeal Court in *Re T (Adult: Refusal of Treatment).*[40]

The Master of the Rolls did cite one possible exception, however, to the right to refuse treatment: *"The only possible qualification is a case in which the choice may lead to the death of a viable foetus. That is not this case, and if and when it arises, the courts will be faced with a novel problem of considerable legal and ethical complexity."*[41]

Such a case did arise when a woman wanted to refuse a caesarean section on religious grounds. In *Re S (Adult: Refusal of Treatment),*[42] Sir Stephen Brown granted a declaration that the operation would be lawful. In subsequent cases, however, the Court of Appeal confirmed that pregnancy does not diminish a competent adult patient's right to refuse unwanted medical intervention.[43]

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[39] In *Bland* Lord Goff stated: *"[T]he principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so."* Lord Mustill, in the same case, expressed similar sentiments: *'If the patient is capable of making a decision on whether to permit treatment....his choice must be obeyed even if on any objective view it is contrary to his best interests.'*

[40] *[1993] Fam 95.* Extracts from each of their judgments highlight the law's enthusiastic embrace of the principle:

Staughton LJ stated that an adult *"whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment. Thus far the law is clear."*

Butler-Sloss LJ averred that *'a man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety. A decision to refuse medical treatment by a person capable of making the decision does not have to be sensible, rational or well-considered."*

Lord Donaldson MR said: *"An adult patient who, like Miss T, suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered....This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."*

[41] *Ibid.*

[42] *[1992] 4 All ER 671.*

[43] In *Re MB (An Adult: Medical Treatment) [1997] 2FLR 426* Butler-Sloss LJ questioned the correctness of the decision in Re S [1992] 4 All ER 671 and declared that *"a competent woman who has the*

The robustness of the law's protection of a competent patient's right to insist on the withdrawal of life-prolonging medical treatment is graphically illustrated in *Re B (Adult: Refusal of Treatment),*[44] where Butler-Sloss P reiterated the fundamental principles that now apply in such cases namely, that competent patient has an absolute right to refuse treatment irrespective of the consequences of her decision. Ms B was granted a declaration that she had mental capacity and that, arising from their refusal to grant her request, the doctors who had been treating her had been doing so unlawfully.[45]

The legal parameters within which medical treatment of a person who lacks capacity or whose capacity is in doubt, are provided for in the Mental Capacity Act 2005, which preserves the common law presumption of capacity and the principle that patients have a right to make what would appear to others to be irrational or unwise decisions. Section 2 of the Act introduces a two-stage test for the establishment of incapacity which, first, entails a diagnostic requirement that a person is suffering from *"an impairment of, or disturbance in the functioning of, the mind or brain"* and second, a requirement as to whether the person in question is able to make a decision for himself. This secondary requirement is a statutory

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capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequences may be the death or serious handicap of the child she bears, or her own death." In *St George's NHS Trust v S [1999] Fam 26* the emergency caesarean which had been performed against S's wishes was held to be a trespass. A pregnant woman's right to refuse medical intervention which could save the foetus she was carrying was upheld, even if, in the words of Judge LJ, her decision might appear to be *"morally repugnant".*

[44] The salient facts were as follows: Ms B was tetraplegic, suffering complete paralysis from the neck down. She had respiratory problems, and was connected to a ventilator. She had repeatedly requested that she be removed from the ventilator, but the clinicians treating her were reluctant to comply. They advocated that Ms B attend a rehabilitation unit which offered a slim chance of improvement in her condition. Ms B rejected this course of action and repeated her refusal on several occasions. Ultimately, the President of the Family Division attended at Ms B's bedside in order to hear her story at first hand.

[45] In a particularly poignant passage in her judgment Butler-Sloss stated:

"Unless the gravity of the illness has affected the patient's capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy. There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient. I do not consider that either the lack of experience in a spinal rehabilitation unit and thereafter in the community or the unusual situation of being in an ICU for a year has had the effect of eroding Ms B's mental capacity to any degree whatsoever...I am therefore entirely satisfied that Ms B is competent to make all relevant decisions about her medical treatment including the decision whether to seek to withdraw from artificial ventilation. Her mental competence is commensurate with the gravity of the decision she may wish to make."

version of the common law test which governed decisions in respect for capacity before the Mental Capacity Act came into effect in 2007.

The terms of this test were formulated by Thorpe J in *Re C (Adult: Refusal of Treatment)*[46] in which the lawfulness of a chronic paranoid schizophrenic patient's refusal to agree to the amputation of a gangrenous leg was in issue. C's solicitor sought, and was granted, a declaration that no amputation should take place without his client's written consent. Quoting with approval the dicta of Lord Donaldson in *Re T*[47]Thorpe J stated that, *prima facie*, every adult has the right and capacity to accept or refuse medical treatment. He acknowledged that this might be rebutted by evidence of incapacity but the onus to do so must be discharged by those seeking to override the patient's choice. When capacity is challenged its sufficiency is to be determined by the answer to the question: has the capacity of the patient been so reduced (by his chronic mental illness) that he did not sufficiently understand the nature, purpose, and effects of the proffered medical treatment?

While this is a decision at first instance only it is important nonetheless in that it was the first in which a test for mental capacity was judicially formulated and the terms of which are now reflected in the Mental Capacity Act 2005. Thorpe J's test was approved by the Court of Appeal in *Re MB (An Adult: Medical Treatment).*[48]

The right of a competent adult patient to refuse medical treatment, either contemporaneously or by way of advance directive, should be noted here. The nature of this right, while not absolute,[49] is such that a doctor must comply. Lord Donaldson MR in *Re T*

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[46] *[1994]1 WLR 290.* The terms of the test devised by Thorpe J merits repetition. He endorsed the analysis of the expert medical witness in the case, Dr E, who had identified three stages: first, comprehending and retaining treatment information; secondly, believing it and thirdly, weighing it in the balance to arrive at choice. The judge went on to state: "*Applying that test to my findings on the evidence, I am completely satisfied that the presumption that Mr C has the right of self-determination has not been displaced. Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.*"

[47] *[1993] Fam 95.*

[48] *[1997] 2 FLR 426.*

[49] For example, under s.63 of the Mental Capacity Act, 1983, "*the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, nor being a form of treatment to which sections. 57, 58 or 58A applies, if the treatment is given by or under the direction of the approved clinician in charge of treatment.*" This section applied to competent adults. If a competent adult patient was consenting to treatment, there would be no need to resort to the power contained in *section 63*. In practice this section enabled treatment for mental disorder to be given to a competent adult who had refused to consent to treatment, without the need for a second opinion. See Jackson, E, '*Medical Law: Text Cases & Materials*', Oxford University Press, 2nd. ed., 2010,

(Adult: Refusal of Treatment)[50] underlined the scope of this right: *'the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent'*. This does raise, however, the uncomfortable medico-legal question as to whether a doctor who removes a feeding tube from a patient whose intention is to end his life, and assures the patient that he can be kept comfortable while he dies from an absence of nutrition, is assisting a suicide.[51]

Where the withdrawal of medical treatment is carried out in the knowledge that it will cause the death of the patient the latter's consent is irrelevant and the doctor could be charged with murder. To avoid such a conclusion the courts, as in *Bland*, commonly attribute such a withdrawal to an '*omission*' rather than an '*act*'. Notwithstanding this, however, it is possible to commit murder by omission.[52]

3. The Current Law in respect of Euthanasia and Assisted Suicide

The significance attaching to the complex nexus of philosophical, moral and ethical ingredients which contribute to the identity of the law as applied in respect of third party assistance with death requires contextualisation within the boundaries of the common law which specifically prohibits unlawful killing and assistance with suicide.

In short, a murder or manslaughter charge is competent where someone intentionally takes the life of another person, irrespective of the prior consent of the victim. Consensual homicide is not a separate offence at English law. Neither is mercy-killing. Motivation[53] is not

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p.320. This would appear to have been radically out of step with the then increasingly dominant principle of patient autonomy. See Richardson, G, *'Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions'* (2002) 65 Modern Law Review, 702-23.

[50] *[1993] Fam 95.*

[51] This matter was dealt with by Lord Goff in *Airedale NHS Trust v Bland*: *"In cases of this kind [a refusal of treatment] there is no question of the patient having committed suicide nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with the patient's wishes."*

[52] An omission will only constitute the *actus reus* of murder if the defendant was under a duty to act, as in the case of a mother's duty to feed her child. If a doctor's failure to provide medical treatment to a patient results in the patient's death, a charge of murder is possible. If the charge is murder the patient's consent is irrelevant. Because the patient's right to refuse unwanted treatment suspends the doctor's duty to provide medical treatment the doctor's omission no longer constitutes the *actus reus* of murder.

[53] See *Airedale NHS Trust v Bland [1993] AC 789, 867 (Lord Goff); 890 (Lord Mustill).* The compassionate motive of a doctor does not protect him from criminal liability for murder. See Lord Hailsham in *Hyam v Director of Public Prosecutions [1975] AC 55, at 73,* for an insightful discussion of the distinction between *'intention'* and *'motive'*. The *Criminal Law Justice Act, 2003, s.269, SCH 21, [11](f)* does allow for judicial discretion in respect of any reduction in the minimum period to be served

germane to the innocence or guilt of an offender. Likewise, both necessity[54] and duress[55] are inapplicable as defences to unlawful killing. The act of suicide has been decriminalised[56] but the provision of assistance to a person intent on committing suicide is a crime under the *Suicide Act, 1961*,[57] and remains so notwithstanding the clarification provided by section 59 of the *Coroners and Justice Act, 2009*.[58]

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in prison by a person convicted of unlawful killing contingent on a *"belief by the offender that the murder was an act of mercy."*

[54] Necessity is not available as a defence to a charge of murder. This was established in *Dudley v Stephens (1884-5) 14 QBD 273* and confirmed by the House of Lords in *Howe [1987] AC 417 (HL)*. See also *Pommell [1995] Cr App R 607 (CA); Rodger [1998] 1 Cr App R 1433 (CA)*. However, see *Bourne [1939] 1 KB 687, [1938] 3 All ER 615 (KB)* where necessity was allowed as a defence to the crime of procuring a miscarriage. (It should be noted that these two reports differ in substantial respects). See also *Re A (Children)(Conjoined Twins) [2001] Fam 147* where the defence of necessity was allowed. In his *'The Sanctity of Life and the Criminal Law'*, Faber, London, 1956, at 286, 290, Glanville Williams argues that the common law doctrine of necessity provides a better explanation for exempting a doctor from criminal liability than the principle of double effect. In his view, the doctrine of necessity refers to a choice between competing values in circumstances where the ordinary rule has to be departed from in order to avert some greater evil. Necessity was the basis for the initial judicial endorsement of euthanasia on request in the Netherlands. See Chapter II on the Netherlands.

[55] See *Howe [1987] AC 417*, per Lord Mackay, where the choice apparently made by the defendants to prefer their own lives over those of their victims whom they had killed in response to threats by another that if they did not do so, they themselves would be killed., was not accepted.

[56] Section 1 of the *Suicide Act, 1961*, provides: *"The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated."*

[57] Section 2 of the *Suicide Act, 1961, created a new offence of complicity in another's suicide.*

[58] Section 59 of the *Coroners and Justice Act, 2009*, clarified the law on assisted suicide. The Lord Chancellor explained the rationale on the second reading of the Bill in the House of Commons: *"Both the Law Commission and an independent review identified confusion about the scope of the law on assisted suicide....[Section 59] does not substantively change the law, but it does simplify and modernise the language of section 2 of the Suicide Act, 1961, to increase public understanding and to reassure people that the provision applies as much to actions on the internet as to actions off-line."* The main purpose of this Act was to amend the law relating to coroners, to the investigations of deaths and to the certification and registration of deaths; to amend the criminal law; to make provision about criminal justice and about dealing with offenders; to make provision about the Commissioner for Victims and Witnesses; to make provision relating to the security of court and other buildings; to make provision about legal aid and about payments for legal services provided in connection with employment matters; to make provision for payments to be made by offenders in respect of benefits derived from the exploitation of material pertaining to offences; to amend the Data Protection Act, 1998; and for connected purposes.

Section 2 in its amended form provides:

(1) A person (D) commits an offence if: (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and (b) D's act was intended to encourage or assist suicide or an attempt at suicide.

(1A) The person referred to in subsection (1)(a) need not be a specific person (or class of person) known to, or identified by, D.

(1B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

(1C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.

(2) If on the trial of an indictment for murder or manslaughter of a person it is proved that the deceased person committed suicide, and the accused committed an offence under subsection (1) in relation to that suicide, the jury may find the accused guilty of the offence under subsection (1)."

Subsection 4 provides that "...no proceedings shall be instituted for an offence under this section except

In *Inglis*[59] Lord Judge CJ cited the English Law Commission's *Report on Murder, Manslaughter and Infanticide*[60] which stated:

"The law of England and Wales does not recognise either a tailor made offence of 'mercy' killing or a tailor made defence, full or partial, of 'mercy' killing."[61]

The Chief Justice said that the court could not improve on the Commission's "*careful analysis of this profoundly sensitive issue.*

In *Airedale NHS Trust v Bland*[62] Lord Mustill was emphatic that euthanasia was not lawful at common law:

"It has been established for centuries that consent to the deliberate infliction of death is no defence to a charge of murder. Cases where the victim has urged the defendant to kill him and the defendant has complied are likely to be rare, but the proposition is established beyond doubt by the law on duelling where even if the deceased was the challenger his consent to the risk of being deliberately killed by his opponent does not alter the case."[63]

In *Nicklinson v Ministry of Justice,*[64] Lord Justice Toulson adverted to the fact that the judges in *Bland* were acutely aware of the profoundly difficult ethical questions which the case presented.

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by or with the consent of the Director of Public Prosecutions."

[59] *[2010] EWCA Crim 2637, [2011] 1 WLR 1110.*

[60] (2006) Law Comm 304.

[61] *Ibid at 7.4.*

[62] *[1993] AC 789.* For a jurisprudential critique of both *Airedale NHS Trust v Bland* and the Irish case *Re a Ward of Court (withholding medical treatment)(No.2)2 IR 79 see Chapter IX on Ireland, 19-27.*

[63] *Ibid at 892.* In the matter of *'mercy' killing'* Lord Mustill said: *"Prosecutions of doctors who are suspected of having killed their patients are extremely rare, and direct authority is in very short supply. Nevertheless, that 'mercy killing' by active means is murder was taken for granted in the directions to the jury in R v Adams (unreported), 8 April, 1957, R v Arthur (unreported), 5 November, 1981 and R v Cox (unreported), 18 September 1992, and was the subject of direct decision by an appellate court in Barber v Superior Court of the State of California, 195 Cal.Rptr.4584 and has never so far as I know been doubted. The fact that the doctor's motives are kindly will for some, although not for all, transform the moral quality of his act, but this makes no difference in law..."* Ibid. Consent to '*mercy killing*' is not an applicable defence: *"So far as I am aware no satisfactory reason has ever been advanced for suggesting that it makes the least difference in law, as distinct from morals, if the patient consents to or indeed urges the ending of his life by active means. The reason must be that, as in the other cases of consent to being killed, the interest of the state in preserving life overrides the otherwise all-powerful interests of patient autonomy."* Ibid. Statements to similar effect were made by Lord Goff, *at 865 and Lord Browne-Wilkinson, at 882.* The textbooks were equally unequivocal: *"English law admits of no defence of mercy killing or euthanasia."* See Smith & Hogan, op.cit., fn.14 supra, at 589.

[64] *[2012] EWHC 2381 (Admin), at para 60.*

They had reached their decision on the legal basis that Anthony Bland's condition was such that the doctors no longer had a legal duty to continue invasive care and treatment, and accordingly the omission to continue such treatment would not be unlawful. They emphasised two things: first, that the law drew a crucial distinction between an omission to maintain treatment and the administration of a lethal drug, however unsatisfactory such a distinction might seem to some people from an ethical view point; and second, that it must be a matter for Parliament to decide whether the law should be changed, taking into account the complex humanitarian, ethical, and practical considerations.[65]

Within the totality of this legal matrix, therefore, it is incontestable that euthanasia - most commonly defined and understood as the active, intentional termination of a patient's life by a doctor who is of the belief that death is of benefit to that patient - constitutes anything other than murder at English law. On conviction murder is punishable by a mandatory sentence of life imprisonment.

Liability in circumstances where death is the result of a deliberate intervention undertaken with the express purpose of ending life to relieve intractable pain and suffering is determined on the basis of ordinary criminal law provisions. However, the right of competent individuals suffering from a terminal illness to refuse life-sustaining treatment (including nutrition and hydration) is established in law and is not considered to fall within the category of assisted

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[65] Lord Goff had stated, at 865: *"I must however, stress....that the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring the patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which...the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: see R v Cox (unreported), 18 September, 1992. So to act 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. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control. It is true that the drawing of this distinction may lead to a charge of hypocrisy...But the law does not feel able to authorise euthanasia, even in circumstances such as these; for once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others."*

death.[66] The courts in England do not distinguish the practice of intentional intervention *"to shorten the final process of dying when a patient's vital functions are failing"* – colloquially referred to as *help in dying* – from euthanasia or termination of life without request.[67]

While there have been prosecutions, no doctor who has complied with a patient's request to end his life has ever been convicted of the full offence of murder. The verdicts in such cases indicate a sympathetic and entrenched reluctance on the part of British juries to convict a medical practitioner of a serious crime when the charge arises from what is presented by the defence as merely the application of considered medical judgment.[68] In *R v Arthur,*[69] for example, Farquharson J instructed the jury to *"think long and hard before deciding that doctors of the eminence we have heard ....have evolved standards which amount to committing crime."*[70]

In *R v Moor*[71] a doctor, who had admitted during a media debate on voluntary euthanasia to having helped patients to die, was prosecuted for the murder of an 85-year-old man who had been suffering from bowel cancer. He had allegedly injected him with a lethal dose of diamorphine. By unanimous verdict he was acquitted. The outcome was hardly surprising in view of Hooper J's direction to the jury.[72]

In *R v Carr*[73] a doctor who, having been repeatedly requested for help to die by a patient suffering unbearable pain as a result of inoperable lung cancer, administered a massive dose of phenobarbitone which led to the death of the patient two days later, was charged with

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[66] See *R T (Adult: Refusal of Treatment) [1993] Fam 95*. See also discussion in *Select Committee on the Assisted Dying for the Terminally Ill Bill [HL], Vol 1: Report (The Stationary Office, 2005) paras. 48-62 (Assisted Dying for the Terminally Ill Bill [HL] 2005 Report).*

[67] See dicta of Devlin J in *R v Adams*: *"If the acts done are intended to kill, and do, in fact, kill, it does not matter if a life is cut short by weeks or months, it is just as much murder if it were cut short by years."* This was reprised by Lord Mustill in *Airedale NHS Trust v Bland [1993] AC 789*: *"It is intent to kill or cause grievous bodily harm which constitutes the mens rea of murder, and the reason why the intent was formed makes no difference at all."* Lord Justice Taylor in *Re J (A Minor) [1991] 11 Fam LR 366* was equally adamant: *"the court never sanctions steps to terminate life. That would be unlawful. There is no question of approving, even in a case of the most horrendous disability, a course aimed at terminating life or accelerating death. The court is concerned only with the circumstances in which steps should not be taken to prolong life."*

[68] See Mason & McCall Smith, *op.cit., fn.15 supra, at 602.*

[69] *(1981) 12 BMLR 1.*

[70] Ibid. See also fn.27 supra.

[71] *Unreported.* See The Times, 12 May, 1999.

[72] *"You have heard that this defendant is a man of excellent character, not just in the sense that he has no previous convictions but how witnesses have spoken of his many admirable qualities. You may consider it a great irony that a doctor who goes out of his way to care for George Liddell ends up facing the charge that he does."*

[73] Unreported. See The Times, 30 December, 1986.

attempted murder. Notwithstanding the nature and quantum of evidence against him together with an unfavourable summing-up by the judge in the case, he was acquitted.

There has been one instance only in which a doctor has been convicted for the attempted murder of a patient. In *R v Cox*[74] the prosecution claimed that the consultant rheumatologist had intentionally administered a dose of potassium chloride, which is devoid of therapeutic effect, to an elderly patient whose extreme pain could not be controlled by pain-killing drugs. There was evidence that the patient had repeatedly requested Dr Cox and others to relieve her pain and suffering by killing her.[75] Dr Cox was given a twelve month suspended sentence and having been formally reprimanded by the General Medical Council, he was allowed to return to practice less than a year after his conviction.

That doctors are entitled to administer pain-killing drugs notwithstanding the accepted fact that they may simultaneously hasten the moment of death was first adverted to, and applied, by Devlin J in *R v Adams*.[76] In that case it was found that if the restoration of health – which, together with principle of *primum non nocere,* is deemed incontestably to be the first purpose of medicine – can no longer be achieved *"there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life."*[77] This distinction between intention and foresight is at the core of the established doctrine of *double effect*[78] Results that are intended from an individual's actions are distinguished from consequences that are merely foreseen as likely, but unintended. This doctrine has been embraced in a number of cases where doctors have been prosecuted for the unlawful killing of patients.[79]

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[74] *(1992) 12 BMLR 38.*

[75] Ognall J averred that *"there can be no doubt that use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will in fact hasten the moment of death, but please understand this....what can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.....potassium chloride has no curative properties...it is not an analgesic. It is not used by the medical profession to relieve pain..., injected into a vein it is a lethal substance. One amphoule would certainly kill...the injection here was therefore twice that necessary to cause certain death."*

[76] *[1957] Crim.LR 365 (Central Crim. Ct). See fn.1 supra.*

[77] *Ibid.*

[78] See fn.11 supra. See also fn.56, Chapter II on the Netherlands.

[79] A doctor who intends a good consequence – the relief of pain and suffering – will not be found guilty of the crime of murder solely on the basis that, as a result of the administration of analgesics, he foresaw that a bad consequence, namely the death of the patient may result, even though he did not intend to cause death. However, intention to cause death can be inferred, as it was in *R v Cox (1992) 12 MLR 38*, when a doctor uses a drug whose only medical function is to cause death. Provided that the drugs that caused a patient's death can plausibly be used as pain-killers or sedatives, it will be difficult to disprove a doctor's assertion that his principle aim was the relief of pain and suffering.

Devlin J's direction in *R v Adams* was followed in *Re J (Wardship: Medical Treatment)*[80] where Lord Donaldson stated that *"[t]he use of drugs to reduce pain will often be justified, notwithstanding that this will hasten the moment of death."* It was also followed in *R v Cox*[81]. The charge to the jury in *Cox* there was cited with approval, albeit in a civil context, by Lord Goff in *Airedale NHS Trust v Bland.*[82]

The House of Lords Select Committee on Medical Ethics has strongly defended the role of the *double effect* in traditional medical ethics.[83]

The doctrine may be at odds with ordinary principles of criminal law. To be guilty of murder a patient's death does not have to be the sole purpose of the defendant's action. As is evident from the opinion of Lord Steyn in *R v Woolin,*[84] the criminal law permits of an inference by a

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In *R v Adams [1957] Crim.LR 365 (Central Crim Ct), see fn.1 supra*, counsel for the defence argued successfully that the doctor had intended to relieve his patient's pain by administering massive doses of morphine and diamorphine. Writing ex-curially the judge in the case, Patrick Devlin (See his *'Easing the Passing', 1985*) pointed to the almost diaphanous nature of the difference which can exist between lawful palliative care and murder: *"If he really had an honest belief in easing suffering, Dr Adams was on the right side of the law; if his purpose was simply to finish life, he was not....A narrow distinction. But in the law, as in all matters of principle, cases can be so close to each other that the gap can only be perceived theoretically."*

[80] *[1990] 3 All ER 930; (1992) 6 BMLR 25*

[81] *(1992) 12 BMLR 38.*

[82] *[1993] AC 789*: *"[It is] the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life....Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on that basis, the treatment will be lawful."*

[83] *Op.cit., fn.4 supra*. The Committee stated: *"Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while acknowledging that the doctor's intention and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect. If this intention is the relief of severe pain or distress, and the treatment given is appropriate to that end, then the possible double effect should be no obstacle to such treatment being given."*

The New York State Task Force also distinguished the intentional termination of life from palliative care even when the latter foreseeably hastens death. See *'When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (Report of the New York State Task Force on Life and the Law)', 1994.*

[84] *[1998] 4 All ER 103.*

jury that a person had the requisite *mens rea* for murder if he engaged in conduct which was virtually certain to cause death, even if this was not his primary purpose.[85]

This conflation of intention and foresight has convulsed sections of the jurisprudential community in recent years particularly in respect of the consequences it may entail for the continued application of the doctrine of *double effect*. But, as has been pointed out elsewhere, Lord Steyn did not go so far as to say that, where death is inevitable, *"the inference must be irresistible that he intended that result; rather he merely suggests that in such cases the inference may be irresistible."*[86]

The invocation and application of the doctrine of *double effect* can be summarised as one which allows an action which has a good objective to be performed despite the fact that the objective can be achieved only at the expense of a co-incidental harmful effect.

Its application, however, is not unconditional. The action itself must be either good or morally indifferent, the good effect must not be produced by means of the ill-effect, and there must be a proportionate reason for allowing the expected ill to occur. It is implicit, therefore, that the good effect must outweigh the bad and this may involve a value judgment.[87]

4. The '*Best Interests*' Test

It will be recalled that at the outset the proposition was put forward that a novel jurisprudential mechanism - that of a patient's '*best interests*' - had evolved over the last quarter of the twentieth century which, notwithstanding the absence of legislative provision for third party assistance with death and the absolute proscription at common law of the unlawful killing of one person by another, irrespective of either consent of motivation, and which incontestably includes euthanasia, eventuated in unilateral judicial determinations as to who should be allowed to continue living, and based solely on the acceptance of a medical prognosis of futility.

It was contended also that the genesis of this mechanism could be traced to the judicial reasoning adopted and followed in a number of cases in which the selective non-treatment of

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[85] *"Where a man realises that it is for all practical purposes inevitable that his actions will result in death or serious harm, the inference may be irresistible that he intended that result, however little he may have desired or wished it to happen."*

[86] *"Although Lord Steyn envisages circumstances in which intention may be inferred from the inevitability of death, by implication there could also be times when this may not be the case, and an example might plausibly be the provision of palliative care."* Jackson, E, *op. cit., fn.49 supra, at 871.*

[87] See fn.11 supra. See also fn.56, Chapter II on the Netherlands.

children with disabilities was in issue and that the criteria invoked ultimately suffused the entire jurisprudential approach to assisted dying in the English jurisdiction.[88]

Inevitably, therefore, any consideration of the introduction of a *'best interest'* paradigm involves the issue of futility. There is an undoubted attractiveness attaching to the concept of futility *per se.* It encompasses the notions of completeness and closure.[89] But in the context of medical treatment there is a requirement for a more nuanced approach – one which differentiates between the effect of a particular treatment and the benefit of that treatment. The former evokes purely medical considerations while the latter connotes the involvement of a more moral character, specifically value judgments as to the quality of life envisaged post-treatment. This differentiation has been described pithily as that between *physiological* and *normative* futility.[90]

However, where a doctor assumes the role of *quality of life* provider, as distinct from the generally accepted one in which the objective is the restoration of health, the question of the futility of treatment attains an enormously greater significance. Medical intervention may result in the patient being kept alive but a prognosis of futility may be advanced as justification for non-treatment which results in death.

As has been neatly pointed out elsewhere, in such circumstances *"futility then becomes not futility in the face of death but rather, futility in the face of an unacceptable quality of life, which is a far more subjective construct, and one which the competent patient himself will doubtless have a view."*[91]

It is salutary to note that an uncritical adoption of the term *'futile treatment'* within the medico-legal vocabulary may be accompanied by positive dangers of abuse, such as the resurgence of inappropriate paternalism, the erosion of patient autonomy, the unjustified avoidance of the duty to treat and the introduction of disguised and arbitrary rationing of

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[88] See Keown, *op.cit.,fn. 13 supra.*

[89] Four alternative definitions of futility were identified by Jecker & Pearlman in their *'Medical Futility: Who Decides?'* (1992) 152 Arch Intern Med 1140. They are: *(i) treatment which is either useless or ineffective; (ii) that which fails to offer a minimum quality of life or a modicum of medical benefit; (iii) treatment that cannot possibly achieve the patient's goals and (iv) treatment which does not offer a reasonable chance of survival.* Schneiderman and Jecker have suggested the following benchmark: *"A treatment which cannot provides a minimum likelihood or quality of benefit should be regarded as futile and is not owed to the patient as a matter of moral duty."* See Schneiderman LJ & Jecker NS *'Futility in practice'* (1993) 153 Arch Intern Med 1140.

[90] Mohindra, R K, *'Medical Futility: a conceptual model'* (2007) 33 J Med Ethics 71.

[91] Mason and McCall Smith, *op.cit., fn.15 supra, at 476.* See also Lelie, A and Verweij, M, *'Futility without dichotomy: Towards an ideal physician-patient relationship',* (2003) 17 Bioethics 21. See also Keown, *op.cit., fn.13.supra.*

resources.[92] Mason and McCall Smith suggest that the creation of an ephemeral duty *"not to treat"* might be added to this list.[93]

Following the finding in *Re J*[94] the test of intolerability which had been adopted previously in *Re B (A Minor),*[95] was abandoned. The criterion of intolerability related to the deemed intolerable nature of the child's life if treatment had been provided. The courts accepted that this meant that continued life would not always be in a child's best interests.[96] In *Re J* a more balanced approach was advocated and followed thereafter, particularly by Lord Donaldson MR.

Cases in which the treatment, or not, of children are rehearsed arise in instances where parents wish a particular treatment to continue notwithstanding the belief on the part of attending medical personnel that this treatment should be withdrawn, and where parents refuse to consent to a procedure that doctors believe is necessary to save a child's life.

An example of the former was provided in *Re C (A Minor: Medical Treatment)*[97] where the unanimous medical opinion was that a 16-month-old baby should be removed from a ventilator on the basis that continuance was likely to cause her increasing distress. The

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[92] See Schneiderman and Jecker, *op.cit., fn.89 supra, at 15.*

[93] *Op.cit., fn.15 supra, at 477.*

[94] *[1991] Fam 33.*

[95] *(Wardship: Medical Treatment) [1981] 1 WLR 1421.* The salient facts of the case were that a child who was born with uncomplicated Down's syndrome, having been rejected by his parents, was provided with nursing care only after he had developed pneumonia. The directions for the treatment were contained in the attending paediatrician's notes. The baby dies within three days of his birth. In a controversial direction to the jury Farquharson J essentially held that a parent's rejection of a Down's syndrome child was sufficient reason to sanction non-treatment. While it has been *"consigned to legal history for the oddity it is" (see 'After the trial at Leicester', Lancet, 1981, 2, at 1085)* nonetheless the judicial opinions expressed may not have been greatly at odds with medico-legal sentiments at the time. A statement by the President of the Royal College of Physicians shortly after the trial is emblematic of a widespread view then obtaining among paediatricians to the effect that *"where there is an uncomplicated Down's case and the parents does not want the child to live.....I think there are circumstances where it would be ethical to put it upon a course of management that would end in its death."* The President went on to state: *'I say that with such a child suffering from Down's syndrome and with a parental wish that it should not survive, it is ethical to terminate life."* The decision of Farquharson J was overturned by the Appeal Court.

[96] A guidance protocol for situations in which it may be ethical and legal to consider withholding or withdrawing life-sustaining medical treatment from a child was issued by the Royal College of Paediatricians and Child Health after a series of cases in which these issues were traversed. See Royal College of Paediatrics and Child Health, *'Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice'*, 2nd ed., 2004.

[97] *[1998] Lloyd's Rep Med 1 Fam Div.* While this case is at the latter end of the continuum of those being cited here as evidence of the evolution of the *'best interests'* criterion, nonetheless it is empirically probative of the durability of the test in the period since it was first applied by Lord Donaldson MR.

proposal was to remove her from the ventilator and not to engage in resuscitation or re-ventilation if a further respiratory collapse occurred. The parents were Orthodox Jews and believed that such a course of action would indirectly shorten their child's life, a proposition which ran counter to their vitalist religious beliefs. The doctors sought a declaration that the proposed non-treatment would be lawful. Granting the declaration on the basis of the child's *'best interests',* Sir Stephen Brown P stated: *"What the court is being asked to do in this case is* ***to exercise its inherent jurisdiction***[98] *to approve the course of treatment which is now proposed by the doctors and for which they cannot gain the consent of the parents."* He concluded: *"it is a sad feature of this matter that there is, in fact, no hope for C, and what has to be considered is her* best interests *to prevent her from suffering as would be inevitable if this course were not to be taken."*

In the earlier case of *Re B (A Minor) (Wardship: Medical Treatment)*[99] Templeman LJ overturned the decision by Farquharson J at first instance that the parent's wishes in respect of the child's non-treatment be respected. His reasoning is particularly noteworthy in that it held that court *"in this particular instance [has] to decide where the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die".*[100]

The latter option was preferred on the basis that the evidence merely showed that if the operation took place and was successful then the child might live the normal span, albeit with the handicaps of *"a mongoloid child and it is not for this court to say that life of that description ought to be extinguished."*[101] The judge at first instance had erred in that the duty

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[98] Author's emphasis.

[99] *(1981)[1990] 3 All ER 927, [1981] 1 WLR 1421 CA.* As has been pointed out by Brazier & Cave, *'Medicine, Patients, and the Law,* Penguin, 4th.ed., 2007, at 382, a confused picture emerged. A baby with Down's syndrome was ordered to be saved, yet Dr Arthur (*Re Arthur (1981)* 12 BMLR 1)was found not guilty of a crime in relation to his treatment of a severely damaged Down's infant. *"The acquittal of Dr Arthur tells us little about the law. The confusion over pathological evidence may have irretrievably prejudiced the jury against the prosecution's case. The baby's multiple abnormalities should have been irrelevant to the reduced charge of attempted murder. When Dr Arthur ordered nursing care only, he thought that he was dealing with a Down's baby as entitled to survive as Alexandra (the baby in Re B). Did the jury see it that way? As Mason puts it: 'Murder, in the popular sense of the word, was the one thing of which Dr Arthur was certainly innocent.'" Brazier & Cave* were citing Mason, *'Human Life and Medical Practice',* (1988), Edinburgh University Press, at 63.

[100] *[1981] 1 WLR 1421, at 1424.*

[101] *"There may be cases, I know not, of severe proved damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion, but in the present case the choice which lies before the court is this: whether to allow an operation to take place which may result in the child living for 20 or 30 years as a mongoloid or whether (and I think this brutally must be the result) to terminate the life of a mongoloid child*

of the court was to decide whether it was in the *'interests'* of the child that an operation should take place.

Templeman LJ's comments that there may be cases *"of severe proved damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion"*[102] has been interpreted as an acceptance by the court of an essential prognostic difference between mental and physical handicap and, as to the latter, laying the foundations for a quality of life therapeutic standard rather than one based on a rigid adherence to the principle of the sanctity of life.[103]

This, it is suggested, is not too far distanced from the primary contention of this thesis that the genesis of a new paradigm, based on the deemed *'best interests'* of a patient and contingent solely on a therapeutic quality of life criterion, and not on the traditional paradigm of the inviolability of life, can be traced to cases in which the continued treatment of children with disabilities was in issue.

Re B attained an added importance in that it was the case that convinced Lord Donaldson that there was a need for a balancing exercise in assessing the course to be adopted in the *'best interest'* of children suffering with disabilities. The subsequent cases in respect of infants, rather than neonates, over which he presided are, it is suggested, indicative of the beginnings of the influence of medical futility in the judicial reasoning applied in cases where the lawfulness of the withholding or the withdrawal of life-sustaining medical treatment was in question.

In *Re J (a minor) (wardship: medical treatment)*[104] the child was not dying. She was brain-damaged and suffered repetitive fits. There were periods when his breathing stopped and ventilation was required. The medical prognosis was that in the event of further respiratory failure he could be rescued. It was also thought probable that if the necessary treatment was withheld he would die. The issue confronting the court was what should be done if another respiratory failure occurred. The Court of Appeal held that it would not be in *J's 'best*

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because she also has an intestinal complaint," Ibid. Dunn LJ stated: "She should be put in the position of any other mongol child and given the opportunity to live an existence," ibid, at 1425.

[102] Ibid. *In Re C (a minor) (wardship: medical treatment) [1989] 2 All ER 782* a decision was handed down which permitted a hospital authority to treat a moribund child in such a way as to allow her life to end peacefully and with dignity. It was specifically said to be unnecessary to administer antibiotics or to set up intravenous infusions or nasogastric feeding regimes. The court was adamant that the welfare, well-being and interests of the child were the dictating factors in the decision.

[103] See Mason McCall Smith, *op.cit., fn.15 supra, at 481.*

[104] *[1990] 3 All ER 930.*

interests' to be re-ventilated *"unless to do so seems appropriate to the doctors caring for him given the prevailing clinical situation".*[105]

Lord Donaldson MR stressed that while there was a strong presumption in favour of action to prolong life, nevertheless, the person who makes the decision must look at it from the assumed view of the patient.[106] Significantly, Lord Donaldson emphasised that any decision taken was one which would affect death by way of a side-effect – the debate was not about terminating life but solely about whether to withhold treatment designed to prevent death from natural causes.[107]

On appeal it was decided that the judge had been entitled not only to grant the declarations sought but to continue them when the matter returned to court after the parents claimed that there had been an improvement in the child's condition and requested that the declaration of the lawfulness of non-treatment be set aside. In another case entitled *Re J,*[108]

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[105] The quality of life in J's case was extremely low, even without the added effect of further hypoxic episodes. The decision that it would not be in his best interest to be re-ventilated was one, according to the judge, which emanated from a co-operative enterprise between doctors and parents, or in the case of wardship, between the doctors and the court with the view of the parents being taken into consideration. Whatever decision was arrived at, must be made in the child's *'best interests'*.

[106] This view revealed a tendency on the part of the Master of the Rolls to favour the *'substituted'* judgment test – preferred in American jurisprudence over that of *'best interests'* – which requires decisions to conform with those which the incompetent individual would have made were his or she competent and is based on respect of the individual's autonomy interests. A trans-Atlantic influence on English jurisprudence in the matter of third party assistance with death may not be as remote as might be suggested by those who proclaim the purity of the common law. For example, it is unquestionable that the genesis of the *'substituted judgment/best interest'* syndrome can be traced to early end-of-life determinations in California. See In the matter of *Claire Conroy (1985) 486 A 2d 1209 and Bouvia v Superior Court (1986) 225 Cal Rptr 297 (Cal CA).* The *'substituted judgment'* test is not favoured by the English courts and it has been rejected by the UK Law Commission. The *'substituted judgment'* criterion was also rejected by the Irish Courts. Se *Re a Ward of Court (Withholding Medical Treatment) (No.2) [1996] 2 IR 79, per O'Flaherty J.* Section 4 (6) of the UK Mental Capacity Act, 2005, provides that the person making the determination of what is in the incompetent person's *'best interests'* must consider, so far as is reasonably ascertainable *(a) the person's past and present wishes and feelings; (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.*

[107] Taylor LJ asked: *'at what point in the scale of disability and suffering ought the court to hold that the best interests of the child do not require further endurance to be imposed by positive treatment to prolong its life? Clearly, to justify withholding treatment, the circumstances would have to be extreme'* and he went on to state that he considered *'the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. I say to 'that child' because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable.'*

[108] *Re J (a minor) (medical treatment) [1993] Fam 15.*

the Court of Appeal refused to entertain the suggestion that it should direct clinicians to provide treatment against their best clinical judgment.[109]

It is evident from the examination of cases thus far that judges in England and Wales consider themselves to be the ultimate arbiters of a child's *'best interests'*. The test which the courts apply when dealing with applications for a declarations as to the lawfulness of the withholding or the withdrawal of life-sustaining treatment is that of *'best interests'* or the *'welfare'* principle. The courts are largely guided by medical evidence as to whether life-prolonging treatment should be withheld or withdrawn from a child. The courts, however, will not order doctors to treat patients contrary to their clinical judgment. In *Re Wyatt (A Child) (Medical Treatment: Parents' Consent),*[110] for example, where the medical opinion was *"unanimous"* that invasive medical treatment would not be in the child's *'best interests'* Hedley J agreed: *"I do not believe that any further aggressive treatment, even if necessary to prolong life, is in her best interests."*

That judges at first instance may give undue weight to the reasons for the refusal of parents to consent to particular procedures was seen in *Re B (A Minor) (Wardship: Medical Treatment)*[111]. While the views of parents are considered they do not have determinative weight. The duty of the court was to decide whether the proposed operation was in the *'best interests'* of the child. A parent cannot demand treatment which a medical team does not consider to be in the child's *'best interests'*.[112]

The legal arguments in *Re T (a minor) (wardship: medical treatment)*[113]revolved around whether the refusal of the parents to consent to a liver transplant for their eighteen month

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[109] Balcombe LJ stated: *"I agree with Lord Donaldson that I can conceive of no situation where it would be proper ...to order a doctor, whether directly or indirectly, to treat a child in a manner contrary to his or her clinical judgment. I would go further. I find it difficult to conceive of a situation where it would be a proper exercise of the jurisdiction to make an order positively requiring a doctor to adopt a particular course of treatment in relation to a child."*

[110] *[2004] EWHC 2247 (Fam).*

[111] *[1981] 1 WLR 1421 CA. Templeman LJ* in the Court of Appeal stated that the judge in the lower court *"was much affected by the reasons given by the parents and came to the conclusion that their wishes ought to be protected."* In this regard he had erred. See also Cazalet J in *A National Health Service Trust v D [2000] 2 FLR 677: "those views [of the parents] cannot themselves override the court's view of the ward's best interests".*

[112] See also *Re J (A Minor) Child in Care: Medical Treatment)[1993] Fam 15, 27, 29 (CA); Re J [1991] Fam 33, 41 (CA); Re R (A Minor) (Wardship: Medical Treatment) [1992] Fam 11, 22, 26 (CA). In Re C (Medical Treatment) [1998] 1 FLR 384 (HC).* Citing the authority of the cases over which Lord Donaldson MR had presided – in particular *Re J (A |Minor) [1990] 3 All ER 930; Re J (A Minor) [1993] Fam 15 and Re R (A Minor) (Wardship: Medical Treatment) [1992] Fam 11* – the court found that it was in the child's *'best interests'* to have ventilation withdrawn in order to prevent suffering: *"[To follow the wishes of the parents] would be tantamount to requiring doctors to undertake a course of treatment which they are unwilling to do. The court could not consider making an order which would require then to do so."*

[113] *[1997] 1 All ER 906*

old son who, after an earlier unsuccessful operation, needed the transplant in order to survive beyond the age of two-and-a-half, accorded with the child's *'best interests'*. The unanimous medical opinion was that the transplant would be in his *'best interests'*. The trial judge had refused to grant a declaration to the doctors and had instead focused on what was described as the reasonableness of the parents' decision. In the Court of Appeal, however, Butler-Sloss LJ stated that *"the welfare of the child is the paramount consideration"* and averred that the court retains the power to overrule the decision of even a reasonable parent in the *'best interests'* of the child. While the Court of Appeal concluded that to order the transplant over the parents' refusal would not be in the child's *'best interests'* nonetheless it did not resile from the steadfast position that a court, and only a court, *"is the ultimate and omniscient guardian of a child's best interests"*.[114] This position has been re-affirmed in the most recent cases involving the treatment of children.[115]

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[114] This case has been subjected to cogent criticism; see Bainham, A, *'Do Babies have Rights?'* [1997] 56 (1) Camb LJ 48.

[115] *Wyatt v Portsmouth NHS Trust [2005] EWHC 693; Portsmouth NHS Trust v Wyatt [2004] EWHC 2247; Re Winston-Jones (a child) (Medical treatment: parents' consent) [2004] All ER (D) 313,* later reported as *Re L (A Child) (Medical Treatment: Benefit) [2005] 1 FLR 491; Portsmouth Hospitals NHS Trust v Wyatt and another [2005] EWHC Civ 1181; An NHS Trust v MB [2006] EWHC 507.* The child in the *Winston-Jones* case was 9 months old and suffered from an incurable genetic condition resulting in severe cardio-respiratory dysfunction. In *Wyatt* the child was 11 months old, had been born very prematurely and suffered from severe and repeated respiratory failure associated with heart and renal failure. She was blind, deaf, and could not move voluntarily. A declaration was sought that it would not be unlawful to withhold ventilation in circumstances where ventilation would be required to ensure survival. The parents in each case opposed the hospital authorities' request for a declaration that it would not be in the children's' *'best interests'* to be mechanically ventilated.
In the Winston-Jones case Butler-Sloss J granted the declaration. The judge at first instance in the Wyatt case declared the proposed action to be lawful. On appeal, the submission on behalf of the parents that the proper test should be one of *'intolerability'* was rejected on the grounds that *'intolerability'* was but one of a number of potentially valuable guides in the determination of *'best interests'*. In a reprise of the views expressed by Thorpe LJ in in *Re A (Medical Treatment) (Male Sterilisation) [2000] 1 FCR 193, CA,* the court opined, that *'best interest'* should be considered broadly and should encompass, but also go beyond, medical interests and include emotional and other welfare issues: *"any criteria which seek to circumscribe the best interests tests are, we think, to be avoided."* The Court of Appeal advocated the use of a balance sheet to weigh up the benefits and burdens associated with continued medical intervention.
In *NHS Trust v MB [2006] 2 FLR 319* Holman J held that it was not in the *'best interests'* of a child suffering from muscular atrophy to have a ventilator removed notwithstanding the fact the schedule of burdens attaching to continued treatment was far more extensive than the benefits accruing from a removal of ventilation. It was acknowledged that the child, in any event, was unlikely to live more than a year. Having reviewed previous cases the judge, following the advice given in *Portsmouth NHS Trust v Wyatt*, listed ten propositions which would be likely to be of benefit in arriving at a determination in cases where the lawfulness of a proposed medical procedure was in issue. In applying the balance sheet the benefits or advantages of treatment on one side, and the burdens or disadvantages or continuing or discontinuing treatment on the other, Holman J found that because the child's life did still contain benefits such as a capacity to gain pleasure from DVDs and CDs, and more importantly, from his relationship with his parents and family, it should be enabled to continue, despite the discomfort, distress and pain to which he was routinely subjected.
In *Re OT [2009] EWHC 633 (Fam),* a Hospital Trust sought emergency declarations that it was no longer under a legal duty to continue to treat a severely ill child who was suffering repeated collapses and

The human rights aspects of a decision to withhold medical treatment from a seriously disabled child were alluded to in *A National Health Service Trust v D.*[116] The case concerned an application for a declaration that it would be lawful not to resuscitate the child in the event of a further cardio-respiratory arrest. The Trust argued that treatment which would let the child end his life peacefully and with dignity was in order. This was opposed by the parents on the grounds that the medical proposal was premature. Once again the judge in the case, Cazalet J, emphasised that the factor governing any decision was the child's *'best interests'*: *"the court's prime and paramount consideration must be the best interests of the child. This of course involves.....consideration of the views of the parents concerned...However....those views cannot themselves override the court's view of the ward's best interests,"* reaffirming yet again that it is the courts, and the courts only, that are the ultimate arbiters in these cases. In his finding, Cazalet J confirmed that Article 2 of the European Convention on Human Rights was not infringed as a result of the granting of the declaration on the basis that the order was made in the child's *'best interests'*. He also confirmed that Article 3 of the Convention encompasses the right to die with dignity.

Before concluding this review of the application of the *'best interests'* test in cases where the lawfulness of the non-treatment of children with disabilities, particularly the withholding or the withdrawal of mechanical means to oxygenate the tissues, was in question, and which, it is contended, foreshadowed its invocation and application, contingent on a prognosis of medical futility, as a legal mechanism which allows for the unilateral determination by judges as to who should be allowed to continue living, it is necessary to consider a recent case involving conjoined twins, *Re A (children) (conjoined twins: surgical separation),*[117] where the defence of necessity was allowed in order to enable the life of one twin to be extinguished for the benefit of the other.

While the case is multi-faceted[118] and the essential facts have been traversed repeatedly nonetheless the salient features merit a reprise. One of the twins, Mary, was so disabled as to

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whose medical condition was deemed by all the medical parties involved to be futile. The parents, however, wanted everything to be done to prolong the child's life. They argued that the Trust's attempt to seek emergency declarations breached their human rights and those of their child. The court applied the *'best interests'* test and granted the declarations sought. It found that emergency declarations were not, in and of themselves, a breach of human rights; the parents had had plenty of time to prepare a case as the dispute with the Trust unfolded. The balance of benefits and burdens supported the declarations granted.

[116] *[2000] 2 FLR 677.*

[117] *[2001] Fam 147.*

[118] *An entire issue of the Medical Law Review (2001) 9, no 3 was devoted to the case. There is also an enormous bibliography. See, for example, Sheldon & Wilkinson, 'On the Sharpest Horns of a Dilemma: Re A (Conjoined Twins)', Medical Law Review, 9, Autumn, 2001, at 201; Bainham, A, 'Resolving the Unresolvable: The Case of Conjoined Twins', (2001) 60 Cambridge Law Journal 49; Holm & Erin,*

be incapable of an independent existence. She had no functioning heart and her lungs did not operate. Her tissues were oxygenated only because she shared a common aorta and venous return with her sister Jodie. On separation, Mary would die immediately; Jodie, however, would survive and be able to live a normal life. If no action was taken both would die within months. At first instance Johnson J attempted to justify an operation to separate as an '*omission*' on the basis that it would interrupt or withdraw the blood supply which Mary was receiving from Jodie. The Court of Appeal rejected this argument and averred that invasive surgery is unquestionably an *'action'*. Consequently, the doctors who carried out such an operation would be guilty of causing the death of Mary, and would face prosecution for murder.

The Court was faced with an unenviable conundrum. Should the operation be permitted notwithstanding the parents' objection or should the hospital do nothing and allow nature to take its course? The application of a *'best interests'* or '*welfare*' test gave rise to difficulties because there were two conjoined children whose individual *'best interests'* could not be reconciled. Looked at from an objective and dispassionate viewpoint the operation was clearly in Jodie's *'best interests'*. She would survive. But as both Ward and Brooke LJJ pointed out it was patently not in Mary's *'best interests'*. She would die.

The judicial reasoning followed in the case is, at times, confusing and inherently contradictory. Walker LJ made a vain attempt at arguing that the operation would be in Mary's *'best interests'* on the grounds that it would restore her bodily integrity and, as a separated individual, would allow her to die with dignity. Both Ward LJ and Brooke LJ argued that Jodie's '*interests*' should take priority on the grounds that Mary *"was destined for*

'Deciding on Life: An Ethical Analysis of the Manchester Conjoined Twins Case', 6 Jahrbuch fur Wissenschaft und Ethik; Appel, J, 'English High Court orders Separation of Conjoined Twins', (Fall 2000) 28 Journal of Law. Medicine & Ethics 312; Burrows, L, 'A Dilemma of Biblical Proportions', (Winter 2001) 27 Human Life Review 31; Gillon, R, 'Imposed Separation of Conjoined Twins: Moral Hubris by the English Courts?' (2001) 27 Journal of Medical Ethics 3; Harris, J, 'Human beings, persons and conjoined twins: An ethical analysis of the judgment in Re A', (2001) 9 Med L Rev 221; Hewson B, 'Killing off Mary: Was the Court of Appeal Right?', (2001) 9 Med L Rev 281; Knowles, L, 'Hubris in the Court', 31 Hastings Centre Report 50 (January-February 2001); London, A, 'The Maltese Conjoined Twins', 31 Hastings Centre Report 48 (January-February 2001); Mason, JK, 'Conjoined Twins: A Diagnostic Conundrum', (2001) 5 Edin LR 226; McEwan, J, 'Murder by design: The 'feel-good factor' and the criminal law', (2001) 9 Med L Rev 246. McCall, A, Smith, 'The Separating of Conjoined Twins (2000) 321 BMJ 782; Pearn, J, 'Bio-ethical Issues in Caring for Conjoined Twins and their Parents', (2001) 357 Lancet 1968; Ratiu & Singer, 'The Ethics and Economics of Heroic Surgery', 31 Hastings Centre Report 47 (March-April 2001); Radcliffe-Richards, J, 'The Wrong Moral Autopilot', New Statesman, 20 November 2000; Huxtable, R, 'The Court of Appeal and Conjoined Twins: Condemning the Unworthy Life?' (2000) 162 Bulletin of Medical Ethics 13; Munro, V, 'Square Pegs and Round Holes: the Dilemma of Conjoined Twins and Individual Rights', (2001) 10 Social & Legal Studies 4. See also Elias-Jones, 'Do we murder Mary to save Jodie? An Ethical Analysis of the separation of the Manchester conjoined twins', Post Grad Med. Journal, Vol.77, Issue 911, http://www.pmj.bmj.com, accessed 21 October, 2012; Dyer, C, 'Conjoined Twins Separated after long battle', BMJ 2000, vol.11, 321 (7270) 1175.

death". None of this, however, resolved the over-hanging issue of the unlawful killing of Mary.

In an attempt to address this Ward LJ said that Mary was effectively killing Jodie by *"draining her life-blood."* The operation could be justified therefore as *"quasi self-defence"*. Brooke LJ invoked the defence of necessity. The doctors would be entitled to operate because it was the lesser of two evils. He was emphatic that the doctrine of *double effect* was not applicable.[119] However, Walker LJ appeared to justify the operation on the basis of *double effect*: Mary's death was a foreseen but unintended consequence of saving Jodie's life.

In the event, the Court of Appeal allowed the use of the defence of *'necessity'* notwithstanding repeated findings that *'necessity'* is unavailable as a defence to murder. The *locus classicus* is *Dudley and Stephens*.[120] In *Howe*[121]the choice made by the defendants to prefer their own lives over those of their victims, whom they had killed in response to threats by another that if they did not do so, they themselves would be killed, was rejected.

Can *Re A* be distinguished from *Dudley and Stephens*? In the view of the Court of Appeal it apparently can be, based on the following reasoning: that the choice would not be one made by the person responsible for the killing but would be determined rather by the poor prognosis of one of the twins, nor would it be one between the life of the actor and that of the victim.[122] Without the operation to separate them, both infants would die within a few months. If the operation were performed, the weaker twin, Mary, would die immediately, but it was hoped that the stronger one, Jodie, would survive and be able to lead a *"relatively normal life."* In allowing the operation to proceed Brooke LJ invoked the formulation of

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[119] *"[The doctrine] can have no possible application in this case because by no stretch of the imagination could it be said that the surgeons would be acting in good faith in Mary's best interests when they prepared an operation which would benefit Jodie but would kill Mary...It follows from this analysis that the proposed operation would involve the murder of Mary unless some way can be found of determining what was being proposed would not be unlawful."*

[120] *(1884) 14 QBD 273.* Two sailors who had been shipwrecked were convicted of the murder of a cabin boy whom they had killed and eaten.

[121] *[1987] AC 417 (HL).*

[122] *Re A (Children) (Conjoined Twins: Surgical Separation) [2001] Fam 147, 239* (per Brooke LJ) (describing the weaker twin as *"self-designated for a very early death").* An argument could be made that the victim in *Dudley and Stephens* was also *'self-designated for death'* as he had drunk salt-water and was, according to the defendants, extremely unwell at the time that they decided to kill him [*Dudley and Stephens (19884) 14 QBD 273, 274].* See Lewis, P, *'England and Wales'* in Griffiths *'Euthanasia and Law in Europe'*, Hart Publishing, Oxford, 2008, fn. 36 supra, p. 362, footnote no. 98. Chand & Simister identify another distinction between *Dudley and Stephens* and *Re A*: *'In Dudley and Stephens, the cabin boy's death was directly intended: the defendants aimed to kill him, in order then to eat him. In Re A, [the weaker twin's] death was no part of the doctors' aim or purpose, although it was an inevitable consequence of what they sought to achieve'*. See Chand & Simister *'Duress, Necessity: How Many Defences?'*, King's College Law Journal 16: 121-32, 2005.This distinction was not one relied upon by the court in *Re A.* As death is directly intended in cases of euthanasia, such a limitation on the defence of *'necessity'* would prevent the application of the defence in such cases.

'necessity' attributed to Sir James Stephens: *"there are three necessary requirements for the application of the doctrine of necessity: (i) the act is needed to avoid inevitable and irreparable evil; (ii) no more should be done than is reasonably necessary for the purpose to be achieved; (iii) the evil inflicted must not be disproportionate to the evil avoided."*

Ward LJ specifically excluded the possibility that the defence of *'necessity'* could be used to justify or excuse euthanasia[123] and Brooke LJ stated that *"[s]uccessive governments, and Parliaments, have set their face against euthanasia."*[124] However, as Lewis points out, *"if the 'inevitable and irreparable evil' is the unbearable suffering of the patient which cannot be assuaged by other means than euthanasia, then Stephen's formulation could in theory allow for euthanasia provided it is seen as proportionate to the avoidance of unbearable suffering."*[125] However, she quickly provides re-assurance that fears of such an implication are unconvincing because they fail to acknowledge the reality of the choice faced by the judges in *Re A*.[126] A penultimate point regarding the judicial reasoning applied in *Re A* was the willingness of Johnson J, at first instance, and Walker LJ in the Court of Appeal, to entertain the notion that it was not in Mary's *'best interests'* to be maintained alive, based on the *'quality of life'* she could anticipate. The other members of the Court of Appeal, however, were not prepared to accept the argument of Walker LJ. Ward LJ in particular adverted to the fact that Mary's separation from Jodie would bring her life to a close before it had run its natural course without providing any countervailing advantage.

The Court concluded that the operation to separate the twins would be an assault on Mary. It was a positive action and would result in her death. Consequently, it came close to an act of euthanasia. The Court, other than Walker LJ, who was prepared to hold that Mary's death could be seen as an unintentional outcome of Jodie's survival, was not prepared to condone such a crossing of the Rubicon. It allowed the operation on the grounds of *'necessity'*, with the proviso that the authority of the case was confined by its unique circumstances. However, *"in strict utilitarian terms, this has to be seen as correct; one cannot be so certain, however, when speaking deontologically."*[127]

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[123] *Re A [2001] Fam 147, 204-5.*

[124] Ibid, at 293.

[125] Lewis, P, *op.cit., fn.36 supra, at 362-3.*

[126] *"Either both twins would die in a few months, or the stronger twin might be saved if the weaker twin were sacrificed by the operation to separate them. In other words, the choice was between saving one twin and saving neither. This is not the choice faced by the doctor in a euthanasia case. The choice is between the duty to preserve life and the duty to relieve suffering," Ibid, at 363.*

[127] Mason & McCall Smith, *op.cit., fn.15 supra, at 490.*

The totality of the findings in the cases reviewed above illustrates, it is suggested, the gradual but clearly discernible recalibration of the conditions which render non-treatment lawful, based largely on the application of a *'best interests'* test. The courts have reserved to themselves the unilateral right, based on inherent jurisdiction,[128] to make determinations as to when, and how, incompetent children are to have life-sustaining medical treatment denied to them, notwithstanding the expressed contrary wishes of parents and guardians. It has been established irrevocably that parents and guardians have no legal right to insist on treatment which doctors regard as unwarranted or inappropriate. That such a development entails an erosion of the principle of the *'sanctity of life'* would appear to be incontestable.

5. The *'Best Interests'* Test in the context of incompetent adults

Having demonstrated that a *'best interest'* criterion has displaced that of the *'sanctity of life'* in cases of children with disabilities, it is necessary to illustrate the impact which the same jurisprudential mechanism has had in the case of non-competent adults. While the decision by the House of Lords in *Airedale NHS Trust v Bland*[129] is still the leading authority on the withdrawal of treatment from an incompetent patient there have been statutory developments in the interim which impact on the treatment decisions that can now be made by others on behalf of an incompetent individual.[130] In *Bland* the House of Lords, among other considerations, had to base their decision on an assessment of what was in Mr Bland's *'best interests'*.

It was decided that continued life in a permanent vegetative state was not in his *'best interests'* and that it would be preferable, and lawful, to cease medical treatment, notwithstanding the fact that he was not terminally ill and could breathe independently. Other than having infections treated with antibiotics, he was not under specific therapeutic management. He was fed and hydrated intravenously. This artificial nutrition and hydration was deemed to be medical treatment and its withdrawal, in the overt knowledge that such action would accelerate death, was endorsed.[131]

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[128] See fn.26 supra.

[129] *[1993] AC 789.*For a jurisprudential critique of both *Airedale NHS Trust v Bland* and the *Irish case Re a Ward of Court (withholding medical treatment)(No.2) 2 IR 79,* see Chapter IX of Ireland.

[130] *Mental Capacity Act, 2005*, which came into effect in 2007.

[131]The legal position regarding the medical treatment of incompetent persons arising from the enactment of the Mental Capacity Act, 2005, is that such decisions can be made by proxy or surrogate. It is immaterial whether the proxy was appointed by the individual when still competent or judicially appointed. Previously, and unless a court intervention was sought, medical decisions on behalf of an incompetent person who had not indicated prior to the onset of incompetency what his wishes in respect of treatment might be, were made by the patient's doctor. Now, if no proxy has been

appointed, or the proxy does not have the authority to make the particular decision, the patient's doctor will decide unless the Court of Protection is invoked. The interests of incompetent adults are represented in legal proceedings by the Official Solicitor.

The governing principle underpinning statute law in the matter of medical decision-making for incompetent persons is that of *'best interests'*. Section 4 (6) of the Mental Capacity Act 2005 provides that the decision-maker of what is in an incompetent person's best interests *"must consider, so far as is reasonably ascertainable: (a) the person's past and present wishes and feeling; (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so."*

Similarly, the decision-maker must take account of the views of anyone named by the patient as a consultee, anyone engaged in caring for him or interested in his welfare, and any proxy decision-maker.

Notwithstanding traces of its influence in a number of cases in which the lawfulness of non-continuance of medical treatment of a disabled child was in question, especially those presided over by the Master of the Rolls, Lord Donaldson, English courts have rejected adamantly what is known as the *'substituted'* judgement test as an alternative to that of *'best interests'*. Taylor LJ in Re J did adopt a test which displayed the indicia of the *'substituted'* judgement approach but both Lord Goff and Lord Mustill in *Airedale NHS Trust v Bland* rejected its applicability at English law. See also O'Flaherty J in *Re a Ward of Court (Withholding medical treatment)(No 2)2 IR 79* in Chapter IX on Ireland.

The question of the withholding or the withdrawing of artificial nutrition and hydration, which lay at the core of the finding in *Bland*, has been the subject of guidance by both the British Medical Council and the General Medical Council.

This guidance was challenged *in R (on the application of Burke) v The General Medical Council.* A patient argued that the withdrawal, against his wishes, of artificial nutrition and hydration, in circumstances where he had become incompetent, was breach of his rights under the Human Rights Act, 1998. The decision at first instance was that the GMC guidance note was incompatible with Mr.Burke's right under Article 3 not to be subjected to inhuman and degrading treatment, and with his right under Article 8, not to have his physical and psychological integrity and dignity infringed.

Of greater significance, however, was the suggestion by Munby J that patients might have the right, in certain circumstances, to insist on a treatment which was not approved of by doctors exercising their clinical judgment. The Court of Appeal overturned his judgment and did so in a blunt and unequivocal fashion: *"The proposition that the patient has a paramount right to refuse treatment is amply demonstrated by the authorities cited by Munby J. The corollary does not, however, follow, at least as a general proposition. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. Insofar as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it."*

The judges then went on to address the issue of artificial nutrition and hydration*: "We have indicated that, where a competent patient indicates his or her wish to be kept alive by the provision of ANH any doctor who deliberately brings that patient's life to an end by discontinuing the supply of ANH will not merely be in breach of duty but guilty of murder. Where life depends upon the continued provision of ANH there can be no question of the supply of ANH not being clinically indicated unless a clinical decision has been taken that the life in question should come to an end. That is not a decision that can lawfully be taken in the case of a competent patient who expresses the wish to remain alive."*

The judicial reasoning in *Bland* is marked by significant differences of approach, the most notable being that of Lord Mustill who described the law which he was called upon to apply as being *"morally and intellectually misshapen"*. Notwithstanding these differences, however, it is possible to summarise those areas on which their Lordships actually agreed:[132]

- The principle of the *'sanctity of life'*, while important, was not absolute. This was a unanimous view;
- Artificial nutrition and hydration was deemed to be *"medical treatment and not basic care"*;
- With notable reservations it was accepted that withdrawing artificial nutrition and hydration was an omission rather than an act; a majority of the judges explicitly accepted that the doctors' intention in withdrawing ANH was to *"bring about the death of Anthony Bland"* (*per Lord Browne-Wilkinson*; *Lord Lowry* stated: *"the intention to bring about the patient's death is there"*; *Lord Mustill* said: *"the proposed conduct has the aim.....of terminating the life of Anthony Bland"*); had withdrawing the nasogastric tube been an act rather than an omission, this would have been a case of murder. Therefore, given that the doctors' intention was to cause death, it was of critical importance that the withdrawal of the tube be characterised as an omission.
- Prolonging Anthony Bland's life had ceased to be in his *'best interests'*; it is interesting to note that the application of *'best interests'* implies an acceptance of the notion of good medical practice. The Law Lords decided that the *Bolam* test, whereby the doctor's decision is judged against one which would be taken by a responsible and competent body of relevant professional opinion, was applicable in the management of the permanent vegetative state. The application of *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582* in subsequent cases, such as *Re G and Swindon & Marlborough NHS Trust v S*[133] is strongly indicative that good medical practice is being seen as a test of lawfulness.

It will be recalled that the Mental Capacity Act 2005 requires doctors to take account of a patient's previous values and beliefs. This means that a patient's desire, for whatever reason, to have life-prolonging measures continued at all costs, even in circumstances where the medical view is that such treatment is futile, must be accorded due weight, although, unlike a valid and applicable advance refusal of treatment, it is not determinative. In its guidance note the British Medical Council states that "if, for example, the patient is known to have held the view that there is intrinsic value in being alive, then life-prolonging treatment would, in virtually all cases, provide a net benefit for that particular individual."

[132] I am grateful to Jackson, *op.cit., fn. 49 supra, at 939*, for this summary.
[133] *[1995] 3 Med LR 84.*

- Since treatment was no longer in his *'best interests'*, the doctor is no longer under a duty to prolong his life, and treatment withdrawal could not constitute the *actus reus* of murder. Lords Browne-Wilkinson and Lowry suggested that if continued treatment was not in Anthony Bland's *'best interests'*, the doctor might actually be under a *"duty"* to cease treatment.

The finding has been the subject of extensive jurisprudential examination, much of which is not relevant here. Suffice it to say that the decision that artificial nutrition and hydration be categorised as medical treatment,[134] and that their withdrawal be deemed an omission rather than an act has drawn most of the critical fire.

The greater part of the opinions in *Bland* was concerned with the possible criminal implications for the doctors involved in the case. Consequently, it was of major importance to avoid any possibility that the removal of the nasogastric tube might lead to a charge of murder. To avoid such an outcome the removal was described as an omission. The philosophical ground on which the distinction between an act and an omission was arrived at was that it was impossible to distinguish between withdrawal of, and not starting, tube feeding, the latter being clearly an omission.

It is clear that the Law Lords strove valiantly to accommodate the request of the doctors treating Anthony Bland, and that of his parents, to cease the provision of artificial nutrition and hydration on the basis that further treatment was futile and that his dignity would be best upheld by letting him die. The doctor's duty did not require the provision of treatment that was not in the patient's *'best interests'*,[135] notwithstanding the fact, according to Lord Mustill, that Bland may not have had any interest at all.[136]

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[134] John Keown forthrightly states that categorising ANH as treatment was specifically arrived at so that it could legitimately be withdrawn. See Keown, J, *'Restoring Moral and Intellectual Shape to the Law after Bland'* (1997) 113 Law Quarterly Review 482-503. See also Chapter IX on Ireland.

[135] *[1993] AC 789 at 867-9 (Lord Goff), at 883-4 (Lord Browne-Wilkinson) and at 897 (Lord Mustill* who held that *"the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind"*). It would appear unlikely that the withdrawal of ANH will be found to be in the *'best interests'* if the patient is not in a permanent vegetative state or in the dying phase of life – see *W Healthcare NHS Trust v H and others [2005] 1 WLR 834, [20], [27] –[32] (CA)*. Dyer has described a case in which a doctor was found guilty of serious professional misconduct and suspended from practice for 6 months for authorising the withdrawal of artificial nutrition from an incompetent stroke patient who subsequently died. See Dyer, C, *'Withdrawal of Food Supplement Judged as Misconduct'*, British Medical Journal, 1999,318 : 895.

[136] *"The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interest of any kind....Thus, although the termination of his life is not in the best interests of Anthony Bland, his best interests in being kept alive have also disappeared."*

Unquestionably, however, through the invocation of the legal mechanisms of a differentiation between acts and omissions, and by describing artificial nutrition and hydration as medical treatment and not basic care - and hence capable of removal without fear of criminal sanction - the Law Lords decided that on the basis of the futility of continued treatment, and the quality of life which such treatment would entail, it was not in Anthony Bland's *'best interests'* to continue living. Apart from the application of the mechanisms alluded to there is no discernible difference in approach in this case than was evident in *Re J.*[137] It will be recalled that in that case Lord Donaldson made a number of observations which resonate throughout the reasoning applied in *Bland*. He stressed first, as did the Law Lords in *Bland,* that while there was a strong presumption in favour of a course of action which will prolong life, nevertheless, those making the decision must look at it from the assumed view of the patient.[138] Second, any decision made must be in the patient's *'best interests'*, and these are not dictated solely by medical considerations. Third, the debate was not about terminating life but solely about whether to withhold treatment designed to prevent death from natural causes.

All the opinions in *Bland* stressed that it was not a matter of it being in the *'best interests'* of the patient to die but, rather, that it was not in his *'best interests'* to treat him so as to prolong his life in circumstances where *"no affirmative benefit"* [139]could be derived from the treatment.[140]

In pursuance of the contention that a *'best interests'* paradigm dominates English jurisprudence where medical decisions on behalf of incompetent adults is concerned, it is not sufficient to advert solely to *Airedale NHS Trust v Bland.* It is also necessary to examine those cases which immediately followed it, together with those that have arisen subsequent to the enactment of the Mental Capacity Act, 2005.

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[137] *[1990] 3 All ER 930.*

[138] It was pointed out earlier that Lord Donaldson evinced some sympathy for the *'substituted judgment'* test in a number of cases over which he presided as Master of the Rolls. This is one of them. See *fn.106 supra.*

[139] Per Lord Browne Wilkinson, at 883.

[140] Lord Goff held that judicial approval should be sought in all PVS cases in which the patient's medical team believe it is in his/her *'best interests'* for artificial nutrition and hydration to be withdrawn. *Ibid, at 873-4.* This practice is reflected in cases subsequent to *Bland*. See *NHS Trust Av M; NHS Trust B v H [2001] 2 WLR 942; Swindon & Marlborough MHS Trust v S (1995) 3Med L Rev 84 (HC); Frenchay Health Care NHS Trust v S [1994] 1 WLR 601 (HC); Re D (Medical Treatment) [1998] FLR 411 (HC); NHS Trust A v H [2001] 2 FLR 501 (HC); An NHS Trust v J [2006] EWHC 3152 (Fam).* The Code of Practice issued under the Mental Capacity Act, 2005, contains a similar provision. The Department of Constitutional Affairs has made it clear that the approval of the Court of Protection must be sought prior to the implementation of a decision even in cases when a patient-appointed lasting power of attorney or a court-appointed deputy consents to the withdrawal of artificial nutrition and hydration from a PVS patient. See *Department of Constitutional Affairs 2007: [6.1].[8.18].[8.19].*

In *Frenchay Healthcare NHS Trust v S*[141] the central issue was whether it would be lawful for a hospital to refrain from renewing or continuing artificial feeding, via a gastrostomy tube, and any other life-sustaining measures in circumstances where the tube became detached. A declaration was sought which would allow medical treatment to be restricted to that which would allow the patient to die peacefully and with dignity. On the basis of the patient's *'best interests'* the declaration was granted and the decision was upheld on appeal.[142]

While spasmodic, and with the proviso that each case must be judged on its own facts, the reportage of cases subsequent to *Airedale NHS Trust v Bland* and *Frenchay v S* provide ample evidence to substantiate the contention in respect of the role now played by the *'best interests'* test at English law.[143]

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[141] *[1994] All ER 403.*

[142] This case gave rise to a number of concerns not least of which was that it might represent a *'slippery slope' "on which we could descend from PVS to little more than mental or physical disability when assuming that the patient's best interests lie in non-treatment"* See Mason & McCall, *op. cit., fn.15 supra, at 508.* Alternatively, *"it is a judicial effort to homogenise non-treatment decisions - during which process, PVS becomes merely the end-point for decision making rather than a condition to be considered on its own."* Ibid. These are questions which cannot be answered here but they do, nonetheless, indicate a pervasive unease among both the medical profession and lawyers as to the ultimate reach of the *'best interests'* test.

[143] In *Re G [1995] 3 Med L Rev 80* the presiding judge concluded that the dissenting views of the patient's mother should not act as a veto when his *'best interests'* favoured the removal of nutrition. The young man has suffered brain damage in a motor-cycle accident which was compounded by an anoxic episode. Lord Goff's comments in *Bland* to the effect that the attitude of relatives, in the event of conflict as to the course to be followed, should not be determinative were invoked and applied. The court also followed *Bolam* v Friern *Hospital Management Committee [1957] 1 WLR 582* as the benchmark of good medical practice.

Swindon & Marlborough NHS Trust v S [1995] 3 Med L Rev 84 concerned a patient who was being nursed at home. A blockage of the patient's gastrostomy tube occurred and further treatment would have involved hospitalisation. The medical evidence was that the patient was in a permanent vegetative state. An application that to discontinue life-sustaining measures in such circumstances would be in accordance with good medical practice as recognised and approved within the medical profession – the *Bolam* benchmark – and would be in the patient's *'best interests'*, was granted.

Re D (1997) 38 BMLR 1 concerned a 28-year-old-woman who had sustained very severe brain damage following a head injury some six years prior to the case coming before the court. An emergency arose when the gastrostomy tube through which she was being fed became dislodged. The medical evidence was that while unaware of anything or anyone she did not satisfy fully the conditions laid down by the Royal College of Physicians for the diagnosis of a persistent vegetative state.[143] Her condition was judged to be functionally indistinguishable from PVS albeit that one paragraph of the Royal College of Physicians' guidelines was not fulfilled. Notwithstanding the medical evidence that she did not fulfil one of the diagnostic criteria the judge in the case was unwilling to accept that *D* was not in a permanent vegetative state. He described her condition as *'a living death'*. He granted the declaration sought that it would be lawful and in her best interests that artificial feeding and hydration be withdrawn.

A number of issues have arisen in the context of the withholding and withdrawal of artificial nutrition and hydration in the light of the Human Rights Act, 1998. Could, for example, the withdrawal of ANH violate a patient's right to life under *Article 2*? Or, could the withholding or withdrawal of ANH amount to inhuman and degrading treatment prohibited by *Article 3*? In *NHS Trust A v Mrs M, NHS Trust B v Mrs H*[144] it was proposed to withdraw ANH from two patients in PVS. Following the precedent in *Bland* the declarations sought were granted. In addition, however, the High Court tested whether the application of the *Bland* precedent could offend Article 2 *(right to life),* Article 3 (*prohibition of cruel and inhuman treatment*) and Article 8 (*right to respect for private life*).

Dame Elizabeth Butler-Sloss P concluded[145] that *'a reasonable clinical decision....to withhold treatment'* could not be interpreted as violating *Article 2*. She also held that *Article 3* did not apply.[146]

It is respectfully suggested that the interpretation that, because PVS patients are insensate and cannot appreciate their state of being, it is not cruel and degrading to subject them to the vagaries attaching to the withdrawal of nutrition and hydration is an extremely narrow one. In *Campbell and Cosans v United Kingdom*[147] it had been held only that a victim's own

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In the *Re H (Adult: incompetent)(1997) 38 BMLR 11* a woman who was in such a severely brain-damaged state, and had been for three years following a car accident, that she was completely unaware of her surroundings. Like in the case of *D* however she did not satisfy one of the College of Physicians' diagnostic criteria and could not be aid to be in a persistent vegetative state. The judge, Sir Stephen Brown P, averred that *"it may be that a precise label is not of significant importance"* and he granted the application that treatment be suspended. He was careful however to state that the court was not sanctioning a procedure which was aimed at terminating life: *"The sanctity of life is of vital importance. It is not, however, paramount and ....I am satisfied that it is in the best interests of this patient that the life-sustaining treatment....should be brought to a conclusion."*

[144] *[2001] 2 WLR 942.*

[145] An insightful analysis of particularised reasoning adopted and applied by Butler-Sloss P in this case is provided by MacLean, A R, in *'Crossing the Rubicon on the human rights ferry'*, (2001) 64 MLR 775.

[146] *"Article 2 ...imposes a positive obligation to give life-sustaining treatment in circumstances where, according to responsible medical opinion"* – again an invocation of the Bolam test – *"such treatment is in the best interests of the patient but does not impose an absolute obligation to treat if such treatment would be futile. This approach is entirely in accord with the principles laid down in Airedale NHS Trust v Bland....In a case where a responsible clinical decision is made to withhold treatment, on the grounds that it is not in the patient's 'best interest', and that clinical decisions is made in accordance with a responsible body of medical opinion"* – again the Bolam test – *"the state's positive obligation under Article 2 is, in my view, discharged."* With regard to Article 3 Butler-Sloss stated: *"I am, moreover, satisfied that Article 3 requires the victim to be aware of the inhuman and degrading treatment which he or she is experiencing or at least to be in a state of physical or mental suffering. An insensate patient suffering from permanent vegetative state has no feelings and no comprehension of the treatment accorded to him or her. Article 3 does not in my judgment apply to these two cases."*

[147] *(1983) 7 EHRR 165, para 28.*

subjective reactions to treatment can impact on the question of whether violation has occurred.

In his judgment in *Bland* Lord Mustill expressed fears that the precedent established might be extended in the future to other, non-PVS cases. His fears were not unfounded. The finding in *G (Adult incompetent: withdrawal of treatment),*[148] where it was declared lawful to withdraw artificial sustenance from a woman who had suffered serious anoxic brain damage after inhaling her own vomitus following surgery, raised some concerns within medico-legal circles. The woman had been kept alive for months by means of artificial nutrition and hydration. The NHS Trust responsible for her care sought a declaration of legality as to the withdrawal of the artificial sustenance, an application that was supported by the woman's family. An expert witness stated that there was no reasonable prospect of her ever recovering. She should be allowed to die with dignity. Notwithstanding the fact that she was unable to give a valid consent to the withdrawal, the procedure was held not to be inconsistent with her human right to life. The cause of specific concern, however, was that the granting of the declaration was virtually tantamount to the acceptance that an assessment of futility leading to the withdrawal of nutrition and hydration may be appropriate for patients with dementia or for those who have suffered serious stroke.[149] A reasonable interpretation of the British Medical Association's guidelines *'Withholding and Withdrawing Life-prolonging Medical Treatment'*[150]might lead to the conclusion that the medical authorities were endorsing such a policy.

6. House of Lords Select Committee

In 1993, in the wake if the controversy generated by the decision in *Airedale NHS Trust v Bland,* the House of Lords appointed a Select Committee to address issues raised by the case. In its Report, published in 1994, the Committee unanimously recommended that the law should not be relaxed to permit either voluntary active euthanasia or physician-assisted suicide.[151]

In its deliberations in respect of euthanasia the Committee defined voluntary euthanasia, at the request of the individual concerned, as being a deliberate intervention undertaken with

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[148] *(2002) 65 BMLR 6.*

[149] In this regard see the arguments of Laurie, GT and Mason, JK, in their *'Negative treatment of vulnerable patients: Euthanasia by any other name?',* [2000] JR 159.

[150] 3rd ed., 2007.

[151] *Report of the Select Committee on Medical Ethics, 1994.* See fn.4 supra. The Committee's recommendation was accepted by the government. See *Government Response to the Report of the Select Committee on Medical Ethics, (Cm 2553, 1994).*

the intention of ending life so as to relieve intractable suffering, and act which must inevitably terminate life. The members[152]were unanimous in concluding that the right to refuse medical treatment was far removed from the right to request assistance in dying. Arguments in favour of voluntary active euthanasia and physician-assisted suicide were insufficient to justify weakening society's prohibition of intentional killing *"which is the cornerstone of law and social relationships."*[153]

One compelling reason underlying this conclusion was that the Committee did not think it possible to set secure limits on voluntary euthanasia.[154]

To create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion either by design, by inadvertence, or by the human tendency to test the limits of any regulation.[155]

The Committee was concerned that vulnerable people – *"the elderly, lonely, sick or distressed"* – would feel pressure, whether real or imagined, to request early death."[156]

While the Committee rejected the legalisation of *euthanasia,* it was nevertheless wholly supportive of the principle of *double effect* [157]

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[152] The Select Committee comprised fourteen members and was chaired by Lord Walton of Detchant. The membership included Lord Mustill, one of the Law Lords in the *Airedale NHS Trust v Bland [1993] AC 789*; Lady Warnock, a liberal philosopher who had chaired a government committee which had recommended the destructive research on human embryos in vitro; Lord Rawlinson, former Attorney General and Lord Habgood, the then Archbishop of York.

[153] *"Individual cases cannot reasonably establish the foundations of a policy which would have such serious and widespread repercussions. The issue of euthanasia is one in which the interests of the individual cannot be separated from those of society as a whole"*, at para. 237.

[154] *"Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But....issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused."* Ibid.

[155] *"These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address. Fear of what some witnesses referred to as a 'slippery slope' could in itself be damaging."* Ibid.

[156] *At para 239*: *"[T]he message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."*

[157] *"The essential question here is one of motive. If the motive is to relieve pain and distress with no intention to kill, we regard this as being wholly acceptable, both in terms of medical practice and under the current law."*

The notion that the use of *'double effect'* by the medical profession was tantamount to the widespread practice of euthanasia was dismissed: *"Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while acknowledging that the doctor's intention, and evaluation of the pain an distress suffered by the patient, are of crucial significance in judging 'double effect'. If this intention is the relief of severe pain*

The Committee was particularly concerned with the case of Anthony Bland and the subsequent decisions made by the High Court, the Court of Appeal and the Appellate Committee of the House of Lords. It could not reach agreement as to whether, in such a case, it ever be proper to withdraw food and fluid, however administered.[158]

Considerable attention was devoted to the issue as to whether a new offence of *'mercy killing'* should be introduced into the criminal law. The members concluded, however, that to distinguish between murder and *'mercy killing'* would be to cross the line which prohibits any intentional killing, a line which they thought it essential to preserve. Nonetheless, they were of the view that the mandatory life sentence for murder should be abolished.[159]

In 2003,[160] 2004[161] and 2005,[162]Lord Joffe introduced Bills in the House of Lords to legalise not only *"medical assistance with suicide"* but also, in cases where self-administration of lethal medication was not possible, "*voluntary euthanasia*". All three were unsuccessful. The 2004 Bill was considered by a Select Committee of the House of Lords under the chairmanship of Lord Mackay of Clashfern, which reported on 4 April, 2005.[163]

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and distress, and the treatment given is appropriate to that end, then the possible 'double effect' should be no obstacle to such treatment being given," at para 243. The Committee added: *"Some may suggest that intention is not readily ascertainable. But juries are asked every-day to assess intention in all sorts of cases, and could do so in respect of 'double effect' if in a particular instance there was any reason to suspect that the doctor's primary intention was to kill the patient rather than to relieve pain and suffering. They would no doubt consider the actions of the doctor, how they compared with usual medical practice directed towards the relief of pain and distress, and all the circumstances of the case."* Ibid.

[158] In the event it concluded *"that the question...was one which need not, and indeed, should not, usually be asked...Alternatively, it would be better to ask whether certain treatments could be judged inappropriate, in that they added nothing to the well-being of the individual as a person....In the Bland case, for example, our view was that, if antibiotics had been withdrawn earlier, the outcome would have been that which eventually occurred after his feeding tube was withdrawn. We concluded that recovery from the complicating infections which would be inevitable in such a case could have added nothing to his well-being."* Ibid.

[159] In its response the government did not accept this recommendation. However, it did accept that there be no change in the law relating to assisted suicide.

[160] *HL Bill 37, The Patient (Assisted Dying) Bill [HL] (2003) 53/2 http://www.publications.parliament.uk/pa/ld200203/ldbills/037/2003037.pdf. accessed 10 October2102 (HL Bill 37).*

[161] *HL Bill 17, Assisted Dying for the Terminally Ill Bill (2004) 53/3 http://www.publications.par;liament.uk/pa/ld200304/ldbills/017/20004017.pdf accessed 10 October 2012 (HL Bill 17).* For a critical analysis of the Bill see Keown, J, *'Physician-assisted suicide: Lord Joffe's slippery Bill'*, (2007) 15 Med L Rev 126.

[162] *Assisted Dying for the Terminally Ill Bill (2005) 54/1.*

[163] *Select Committee on the Assisted Dying for the Terminally Ill Bill – First Report (2005).* The proposed legislative measure was designed to provide legal authority for a terminally ill and mentally competent adult to request, and be provided with, physician-assisted suicide. The qualifying criteria for assistance with suicide included *'unbearable suffering'* – defined as *"suffering whether by reason of pain or otherwise which the patient finds so severe as to be unacceptable and results from the patient's terminal illness"*; the provision of adequate information and counselling (including the offer of

However, the Bill fell with the dissolution of Parliament prior to the general election in May, 2005, and the *Select Committee* recommended that an early opportunity be taken to debate the report in the House of Lords in the new parliamentary session.[164] In November 2005, a bill proposing physician-assisted suicide only for the terminally ill was introduced.[165] However, it was defeated on Second Reading on 12 May, 2006, by 142 votes to 100.[166]

During the passage of the *Coroners and Justice Act, 2009,* Lord Falconer moved an amendment in the House of Lords which would have created an exception to s.*2 of the* Suicide Act, 1961, in the case of acts done for the purpose of enabling or assisting a person to travel to a country in which assisted suicide is lawful, subject to certain conditions. The amendment was defeated.[167]

On 27 March, 2012, a debate was held in the House of Commons on the subject of *'assisted dying'.* The House passed a motion welcoming the Director of Public Prosecution's Policy Statement (2010) in the matter of factors which would be taken into consideration in deciding whether to instigate a prosecution in an instance of assisted suicide. It also encouraged further development of specialist palliative care and hospice provision. However, it rejected an amendment calling on the Government to carry out a consultation about whether to put the DPP's guidance on a statutory basis.[168]

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palliative care, where appropriate); repeated informed requests to die from the patient; a written declaration to this effect from the patient before two witnesses; a 14-day waiting period; and a final verification of consent. A conscience clause for professional staff was also included with an attendant obligation to refer the patient to another colleague in the event of its being invoked. While the primary aim of the Bill was to legalise physician-assisted suicide, it also sought to provide for active euthanasia in cases where the person – such as an individual in the circumstances of Diane Pretty – is not physically able to take their own life.

[164] *Hansard HL Deb 6 June 2003, vol 648. Cols 1585-1690; Select Committee on Assisted Dying for the Terminally Ill Bill [HL] Vol. 1: Report (London: The Stationary Office, 2005).*

[165] HL Bill 36, Assisted Dying for the Terminally Ill Bill (2005) 54/1 http://www.publications.parliament.uk/pa/ld200506/ld036/06036.i.html *accessed 10 October 2012 (HL Bill 36).*

[166] *House of Lords, House of Lords Annual Report 2006/7 (HL Paper 162, 2007)1.* http://www.publications.parliament.uk/pa/ld200607/ldbrief/162/162.pdf accessed 10 October 2012. The Select Committee recommended that any future Bill should consider, inter alia, (i) a clear distinction between assisted suicide and active euthanasia; (ii) a better articulation of a doctor's powers and responsibility under the legislation: (iii) the need for concepts such as *'terminal illness'* and *'competence'* to reflect current clinical practice; (iv) consideration of replacement of the criterion of *'unbearable suffering'* with notions of *'unrelievable'* or *'intractable'* suffering; and (v) the abandonment of an obligation on the conscientious objector to refer a patient to a willing colleague.

[167] Interestingly, the decision in *Purdy* was delivered three weeks later.

[168] While not germane to the consideration of the law on assisted suicide in England and Wales it is nonetheless of interest to note that in 2005, a member of the Scottish Parliament, Jeremy Purvis, introduced a consultation document in which, in essence, it was proposed that Scotland should adopt the terms of Oregon's *Death with Dignity Act*. See Chapter VII on America. This proposal never attained

7. The *Pretty* Case

In *Pretty v Director of Public Prosecutions and Secretary of State for the Home Department*[169] Lord Steyn stated that the logic of the European Convention on Human Rights *"does not justify that the House must rule that a state is obliged to legalise assisted suicide."*[170]

The applicant suffered from motor neurone disease and was terminally ill. She sought assistance from her husband to help her end her life, but only of there could be an assurance that he would not be prosecuted for assisting her in doing so. In the House of Lords Lord Bingham described the distinction between suicide on the one hand and assisting another to commit suicide as one which was *"deeply embedded"* in the fabric of English law. He also stressed the fundamental difference between the cessation of medical treatment on the one hand and active assistance to end life on the other. He concluded that *Article 8(1)* and *(2)* of the European Convention – the right to respect for private and family life – was not engaged by the prohibition on assisted suicide contained in section 2 (1) of the Suicide Act, 1961, but if it was, the section was not compatible with it. Counsel for *Pretty* had submitted that this article conferred a right to self-determination and cited *X and Y v Netherlands*,[171] *Rodriguez v Attorney General of Canada*[172] and *In re A (Children) (Conjoined twins: Surgical Separation)*[173] in support.

It was contended that this right embraced a right to choose when and how to die so that suffering and indignity could be avoided. Section 2 (1) of the Suicide Act, 1961, interfered with this right and it was for the United Kingdom, therefore, to show that the interference met the convention tests of *"legality, necessity, responsiveness to pressing social need* and *proportionality."*[174] Where the interference was with an intimate part of an individual's private life, there must be particularly serious reasons to justify the interference.[175]

The plaintiff claimed that the court was obliged to rule whether it could be other than disproportionate for the Director of Public Prosecutions to refuse to give the undertaking

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the status of a Bill. The *End of Life Assistance (Scotland) Bill* which was presented to the Scottish Parliament in 2010 has not progressed further.

[169] *[2001] UKHL 61.*

[170] Ibid., at para. 68: *"It does not require the state to repeal a provision such as section 2 (1) of the Suicide Act, 1961. On the other hand, it is open to a democratic legislature to introduce such a measure. Our Parliament, if so minded, may therefore repeal section 2 (1) and put in its place a regulated system for assisted suicide (presumably doctor assisted) with appropriate safeguards."*

[171] *(1985) 8 EHRR 235.*

[172] *[1994] 2 LRC 136.*

[173] *[2001] Fam 147.*

[174] See *R v A (No 2) [2001] 2 WLR 1546; Johansen v Norway (1996) 23 WHRR 33; R(P) v Secretary of State for the Home Department [2001] WLR 2002.*

[175] See *Smith and Grady v United Kingdom (1999) 29 EHRR 493 at p. 530.*

sought and, in the case of the Secretary of State, whether the interference with Ms Pretty's right to self-determination was proportionate to whatever legitimate aim the prohibition on assisted suicide pursues.[176]

It is unnecessary to reprise in detail the judicial reasoning adopted and followed by the five Lords who sat in the appeal. It is sufficient to note that Lord Bingham was of the view that the most detailed and erudite discussion known to him of the issues in the appeal was to be found in the judgments of the Supreme Court of Canada in *Rodriguez v Attorney General of Canada.*[177]

Having failed in her claim, Ms Pretty brought the matter before the *European Court of Human Rights*.[178] The European Court disagreed – or at least, seems to have disagreed[179] – with the House of Lords' opinion that *Article 8* was not engaged.[180] Critically, however, it did agree that *Article 8* was not breached.

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[176] Counsel on behalf of the plaintiff placed particular reliance on certain features his client's case, namely (i) her mental competence; (ii) the frightening prospect which faced her; (iii) her willingness to commit suicide if she were able; (iv) the imminence of death; (v) the absence of harm to anyone else, and (vi) the absence of far-reaching implications if her application were granted. He suggested that the blanket prohibition in section 2 (1) of the Suicide Act, 1961, (a) applied without taking account of particular cases; (b) was wholly disproportionate, and (c) the materials relied on did not justify it. Reference was made to *R v United Kingdom (1983) 33 DR 270 and Sanles v Spain [2001] EHRLR 348.*

[177] *[1994] 2 LRC 136*; see Chapter VIII on Canada for a detailed analysis of this case.

[178] *Pretty v United Kingdom (2002) 35 EHRR 1.*

[179] Lord Hope addressed this matter in the House of Lords decision in *Purdy v Director of Public Prosecutions [2009] UKHL 45, at paras. 35-39: "The difference between the House and the Strasbourg Court on the application of Article 8 (1) to Ms. Pretty's case was on a narrow but very important point. Lord Steyn expressed the view of the majority most clearly when he said that the guarantee under Article 8 prohibits interference with the way in which an individual leads his life and it does not relate to the manner in which he wishes to die: [2002] 1 AC 800, para.61. It is clear from Lord Bingham's opinion, at paras. 19 to 23, that he was strongly influenced by the fact that the right to liberty and security in section 7 of the Canadian Charter of Rights and Freedoms which was held by the majority in the Supreme Court of Canada in Rodriguez v Attorney General of Canada [1994] 2 LRC 136, to confer a right to personal autonomy extending even to decisions on life and death had no close analogy in the European Convention, and by the absence of Strasbourg jurisprudence on this point, when he said at para. 23 that there was nothing in Article 8 to suggest that it had reference to the choice to live no longer.....I would...depart from the decision in R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department Intervening) [2002] 1 AC 800 and hold that the right to respect for private life in Article 8 (1) is engaged in this case."*

[180] *Pretty v UK [2002] 35 EHRR 1, at para. 67: "The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right for private life as guaranteed under Article 8 (1) of the Convention."*

In the matter of the claim that the ban on assistance with suicide contained in the Suicide Act, 1961, did not comply with the provisions of *Article 8 (2)*[181] the Court did not consider the blanket nature of the ban on assisted suicide to be disproportionate.[182]

The decision in *Pretty v United Kingdom* provides the requisite contextualisation for the subsequent decision by the House of Lords in *Purdy v Director of Public Prosecutions.*[183]

8. The *Purdy* case[184]

The jurisprudential relevance of the *Purdy* case lies in the finding that it was incumbent on the Director of Public Prosecutions *"to clarify what his position is as to the factors that he*

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[181] *"Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from in lawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."*

[182] *"The Government has stated that flexibility is provided for in individual cases by the fact that consent is needed form the DPP to bring a prosecution and by the fact that a maximum sentence is provided, allowing lesser penalties to be imposed has appropriate...It does not appear arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence", at para 67.*

[183] *[2009] UKHL 45.* In the court of first instance – Divisional Court, *R (on the application of Debbie Purdy) v DPP [2008] EWHC 2565 (Admin)* – it was held that, as per the decision in the House of Lords in *R (on the application of Pretty) v DPP [2001] UKHL 61*, the right to die did not engage *Article 8* of the *Human Rights Act, 1998*, and that the DPP has no duty to set out any policy on the exercise of discretion to prosecute beyond the statutory *Code for Crown Prosecutors*. The claimant, Debbie Purdy, suffered from multiple sclerosis. She anticipated that her condition would worsen to a point at which her continuing existence would become unbearable. She would then want to end her own life. However, to do so she would have to travel to a jurisdiction in which assisted suicide was lawful. She would be unable to do this without the assistance of her husband. In the event that he assisted her he would be liable, under the Suicide Act, 1961, to prosecution. Section 2(1) of the Suicide Act, 1961, provides that a person *"who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding 14 years."* The Act also provides, at s.2 (4), that no proceedings shall be instituted except by or with the consent of the DPP. The claimant and her husband wished to know if he was likely to be prosecuted under s.2 (1) of the Act. She brought a claim for judicial review, and under *s.7* of the *Human Rights Act, 1998*, to challenge the failure of the DPP to provide a policy as to the circumstances in which a prosecution would be brought where the assisted suicide takes place in a jurisdiction in which it was lawful. It was claimed that this was a breach of the *Human Rights Act, 1998, Schedule 1, Article 8*, which provides that: *(1) Everyone has the right to respect for his private and family life, his home and his correspondence; (2) there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.* The High Court dismissed the application as did the Court of Appeal in *R (on the application of Purdy) v DPP [2009] EWAC Civ 92.*

[184] *[2009] UKHL 45.*

[184] *[2009] UKHL 45.*

regards as relevant for and against prosecution" in cases of encouraging and assisting suicide.[185]

The applicant intended to travel to a private clinic in Switzerland to avail of the end-of-life services which are provided there. Her husband was willing to assist her to make the journey, but she was concerned that he would be prosecuted under the applicable legislation in the United Kingdom were this to occur.[186] In particular, she wished to know what factors the DPP would employ in determining whether or not her husband would be prosecuted

Lord Hope held that the European Court, in its judgment in *Pretty*, *"when read as a whole"*, had found that the right to respect for private life in *Article 8 (1)* was engaged by decisions of this kind. Similarly, he stressed that legal certainty was a core question to be addressed in considering whether any restrictions on the right to family life were proportionate and "*prescribed by law*" in the manner provided by *Article 8 (2).*[187]

He went on to express the opinion that the Code for Crown Prosecutors, which the Director of Public Prosecutions was required to issue pursuant to section 10 of the (UK) Prosecution of Offences Act, 1985, *"must be treated as the equivalent of a law for Article 8(2) purposes."*[188] Holding that the guidelines in existence were inadequate, he allowed the appeal and required the Director of Public Prosecutions to clarify those factors which he would take into consideration when deciding whether or not to prosecute in an assisted suicide case.[189]

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[185] The finding in *Purdy* that the UK Director of Public Prosecutions should clarify those factors that he regards as relevant for and against prosecution in a case of assisted suicide formed the basis of the claim by the plaintiff in *Fleming v Ireland [2113] IEHC 2.* See Chapter IX on Ireland.

[186] In his article *'Suicide in Switzerland: Complicity in England?',* [2009] Crim LR 335, Professor Michael Hirst suggested that it is not an offence for a person to do acts in England and Wales which aid or abet a suicide by someone else which subsequently takes place in a jurisdiction where suicide is lawful. He pointed out that no prosecution had ever been brought under section 2 (1) of the Suicide Act, 1961, in circumstances such as those which the appellant contemplated. He contended that no such prosecution could ever succeed, as her suicide would itself have to occur within the jurisdiction in order for any offence to be committed by the person who assisted her.

[187] In this respect, he stated: *"The requirement of foreseeability will be satisfied where the person concerned is able to foresee, if need be with appropriate legal advice, the consequences which a given action may entail. A law which confers a discretion is not in itself inconsistent with this requirement, provided the scope of the discretion and the manner of its exercise are indicated with sufficient clarity to give the individual protection against interference which is arbitrary...", at para 41.*

[188] *[2009] UK HL 45, at para.47.*

[189] The members of the Judicial Committee – the title given to the interim body prior to the metamorphosis of the judicial capacity of the House of Lords into the Supreme Court of England and Wales – held that the DPP had a duty to publish a policy on the decision to prosecute. While the five judges took different routes in arriving at their conclusions there was unanimity that the Committee would use the *Practice Statement (Judicial Precedent) [1966] 3 All ER 77* to depart from its decision in *Pretty* and follow the decision of the European Court on Human Rights. The Committee was of the view also that the DPP, in publishing the reason for his decision not to prosecute in a prior case, that of Daniel James – available at <http://www.cps.gov.uk/news/articles/death-by-suicide-fo-daniel-james/> -

Notwithstanding the importance of the decision in *Purdy* it should be noted, however, that it dealt only with the question of the exercise of prosecutorial discretion. It did not address the more far-reaching question of possible defences to assistance with suicide.

9. *DPP Guidelines*

Complying with the Court's request the Director of Public Prosecutions, in February 2010, published his *Policy for Prosecutors in Respect of Cases Encouraging or Assisting Suicide.*[190] The Policy applies *"when the act that constitutes the encouragement or assistance is committed in England and Wales; any suicide or attempted suicide as a result of that encouragement or assistance may take place anywhere in the world, including in England and Wales."*[191]

Sixteen public interest factors tending to favour prosecution, and six against, were listed.[192]

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which involved a young man being accompanied to the Swiss *Dignitas* clinic to end his life by his parents and a friend appeared, in the words of Lord Brown, at 81, *"to underline the essential unhelpfulness of the Code for Crown Prosecutors as any sort of guide to those attempting to ascertain the critical factors likely to determine how the Director will exercise his prosecutorial discretion in this class of case."* Lord Hope was even more dismissive: *"The Director's own analysis shows that, in a highly unusual and sensitive case of this kind, the Code offers almost no guidance at all. The question of whether a prosecution is in the public interest can only be answered by bringing into account factors that are not mentioned there," at 53.* Consequently, as stated by Lord Neuberger, *"it cannot be doubted that a sensible and clear policy document would be of great legal and practical value, as well as being, I suspect, of some moral and emotional comfort, to Ms Purdy and others in a similar tragic situation," at 101.*

[190] *http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html accessed 17 November 2012*. The Policy document was issued following the publication of an interim policy, which formed the basis for public consultation. See Crown Prosecution Service's *'Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide, Summary and Responses (February, 2010) http://www.cps.gov.uk/consultations/as_responses.pdf* accessed 17 November 2010. In January, 2012, the House of Commons rejected a motion proposing that the Crown Prosecution Service Policy be placed on a statutory footing. The statutory prohibition of assisted suicide remains unchanged, but those who consider acting in violation of the law can consult the guidelines to ascertain whether or not in their particular case a prosecution is likely to be in the public interest. For further discussion see, for example, *Lewis, P, 'Informal Legal Change on Assisted Suicide: the Policy for Prosecutors'*, (2011) 31 Legal Studies 119; *Greasley, K, 'R(Purdy) v DPP and the Case for Wilful Blindness'*, (2010) 30 Oxford Journal of Law Studies 301; *D, R & Solomon, AS, 'Assisted Suicide and Identifying the Public Interest in the Decision to Prosecute'*, (2010) Crim Law 737; *Rogers, J, 'Prosecutorial Policies, Prosecutorial Systems, and the Purdy Litigation', (2010) Crim Law 543; Williams, G, 'Assisting Suicide, the Code for Crown Prosecutors and the DPP's Discretion'*, (2010) 39 CLWR 181; *Mongomery, J, 'Guarding the Gates of St Peter: Life, Death and Law Making' (*2011) 31 Legal Studies 644; *Mullock, A, 'Overlooking the Criminally Compassionate: What are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide'*, (2010) 18 Med L 442.

[191] *Ibid. at para 8.*

[192] *Ibid. at para. 431.*

The 16 public interest factors tending to favour prosecutions are: (1) The victim was under 18 years of age. (2) The victim did not have the capacity (as defined by the Mental Capacity Act, 2005) to reach an informed decision to commit suicide. (3) The victim had not reached a voluntary, clear, settled, and

Since the promulgation of the Crown Prosecution's Policy there have been no prosecutions for the offence of assisted suicide.

The policy has been criticised as being indicative of a movement towards legalisation of assisted dying – the *'thin end of the wedge'* or *'slippery slope'* argument – and for establishing a template in respect of assisted suicide which differed significantly from those which had been adopted in other jurisdictions.[193]

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informed decision to commit suicide. (4) The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect. (5) The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative. (6) The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim. (7) The suspect pressured the victim to commit suicide. (8) The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide. (9) The suspect had a history of violence or abuse against the victim. (10) The victim was physically able to undertake the act that constituted the assistance him or herself. (11) The suspect was unknown to the victim and encouraged or assisted the victim to commit suicide by providing specific information via, for example, a website or publication. (12)The suspect gave encouragement or assistance to more than one victim who were not known to each other. (13) The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance. (14) The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care. (15) The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present. (16) The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

The 6 public interest factors tending against prosecution are:

(1) The victim had reached a voluntary, clear, settled, and informed decision to commit suicide. (2) The suspect as wholly motivated by compassion. (3) The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance. (4) The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide. (5) The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide. (6) The suspect reported the victim's suicide to the police and fully assisted then in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

[193] See Keown, J, *'Assisted suicide must not be legalised through the back door'*, The Daily Telegraph (London, 25 February, 2010).

10. The *Nicklinson* case

The case of *Nicklinson v Ministry of Justice*[194] is the most recent judicial exposition of the law on assisted suicide in the UK. Following as it does on the decisions in both *Pretty* and *Purdy*, the Report of the House of Lords on the *Joffe Bill* and the publication of the Crown Prosecution Service's *Policy for Prosecutors in Cases of Encouraging or Assisting Suicide*, a brief analysis of the judicial reasoning employed is warranted.[195]

The decision in the case highlights the vexed questions that can arise *"when an individual right to choose clashes with the public interest in respecting sanctity of life and consistency at law."*[196] This was the first occasion on which a case was brought not just to challenge the prohibition of assisted suicide, but also that of euthanasia, and where a partial legalisation of assisted dying was sought through a development of the common law.

The plaintiff suffered from locked in syndrome and wished to die *"with dignity and without further suffering."* In short he wanted to establish a right to die by means of active voluntary euthanasia or assisted suicide, and at a time of his own choosing.

A declaration was sought that it would not be unlawful, on the grounds of the common law defence of *'necessity'*,[197] for his doctor, or another doctor, to terminate or assist the

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[194] Neutral Citation: *[2012] EWHC 2381 (Admin): The Queen on the Application of Tony Nicklinson and Ministry of Justice (Interested Parties: Director of Public Prosecutions and Jane Nicklinson), and between The Queen on the Application of AM and (1) Director of Public Prosecutions; (2) The Solicitors Regulation Authority; (3) The General Medical Council (Interested Party: An NHS Primary Care Trust) (Interveners: The Attorney General; CNK Alliance Ltd [Care Not Killing]).* The relevant facts were: Tony Nicklinson suffered a catastrophic stroke in June 2006. He was paralysed below the neck and was unable to speak. His only method of communication was by an eye blink computer.

[195] I am grateful to Richards, B, for her valuable case note. See *'Making Decisions Who is to decide when a life can end: The Court, Parliament, or the Individual?', Bioethical Inquiry (2012) 9, 385, published online: 12 October, 2012.*

[196] *Ibid.*

[197] At English law, the *'necessity'* defence is available where *"(i) the act is needed to avoid inevitable and irreparable evil; (ii) no more should be done than is reasonably necessary for the purpose to be achieved and (iii) the evil inflicted must not be disproportionate to the evil avoided."* See *Re A (Conjoined Twins: Medical Treatment), per Brooke LJ, [2001] Fam 147.* Necessity, however, does not provide a defence against a charge of murder. See *R v Dudley(1884) 14 QBD 273; R v Howe [1987] AC 417, at 489 C per Lord Griffith, and at 453 D-E, per Lord Mackay.* As the leading cases on the issue deal with the situation where someone was killed in order to save the life of another, thus involving a choice between two lives it has been argued that these precedents leave *"open the possibility that a deliberate killing may be justified where individual rights are not sacrificed"* (See Wilson, W, *'Criminal Law,* 4th ed., Pearson, Harlow, 2011 at 259*)*, or where no arbitrary choice of one life over another was necessary (See Ashworth, A, *'Principles of Criminal Law'*, 6th ed., Oxford University Press, 2009, at 131*)*. See also Ormerod, *D, 'Smith & Hogan's Criminal Law'*, op.cit., fn.14 supra, at 370.
The *'necessity'* defence is usually conceptualised as allowing, under limited circumstances, violations of the law the victim did not consent to. See Ormerod, *op.cit. supra, at 644.* This is also true in the medical context. In *R F(Mental Patient: sterilisation) [1990] 2 AC 1 (HL)* it was held that in the absence of *parens patriae* jurisdiction and proxy-decision-making powers on behalf of incompetent adults,

termination of his life. The claim was that this defence was available to a charge of murder in the case of active voluntary euthanasia and/or to a charge under s.2 (1) of the Suicide Act, 1961. It was also contended that the criminalisation of assisted suicide was incompatible with Article 8 (the right to respect for private life) of the European Convention on Human Rights in that it prevented him from exercising a right to receive assistance in committing suicide.

Permission to apply for relief by way of judicial review was granted.[198]

In the High Court Toulson LJ identified the issues on which the Court had to deliberate:

"1. Is voluntary euthanasia a possible defence to murder?

2. Is the DPP under a legal duty to provide further clarification of his policy?

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doctors can administer treatment to them that is in their *'best interests'* to receive. See also *Re a Ward of Court (Withdrawal of medical treatment)(No.2) [1996] 2 IR 79.* In *Re F* the legal justification was found in the defence of necessity (*per Lord Brandon, at 55-56*), based on the doctor's conflicting duties towards the patient: the duty to respect the patient's right to bodily integrity and the duty to provide medical treatment that preserves the patient's life or health (*per Lord Bridge, at 52*). Consequently, the necessity defence and the doctors' conflicting duties towards the patient only become relevant where the patient him/herself cannot authorise the doctor's actions through consent(per Lord Goff, at 73-75). However, the inability to provide authorisation in such cases was caused by incapacity, not by the unlawfulness of the underlying behaviour *per se. See* Michalowski, S, *'Relying on Common Law Defences to Legalise Assisted Dying: Problems and Possibilities', Medical Law Review, 1st November, 2012, at 1.*

[198] *By Charles J (12 March, 2012) on the following grounds:*

"1. A declaration that it would not be unlawful, on the grounds of necessity, for Mr. Nicklinson's GP, or another doctor, to terminate or to assist termination of Mr Nicklinson's life."

By way of preliminary issue, the claimant had sought a declaration that the common law defence of '*necessity*' would be available to a charge of murder in a case of voluntary active euthanasia and/or to a charge under *section 2 (1) of the Suicide Act, 1961*, in the case of assisted suicide, provided:

(a) the Court had confirmed in advance that the defence of necessity would arise on the facts of the particular case;

(b) the Court was satisfied that the person was suffering from a medical condition that causes unbearable suffering; that there were no alternative means available by which his suffering may be relieved; and that he had made a voluntary, clear, settled and informed decision to end his life;

(c) the assistance was to be given by a medical doctor who was satisfied that his or her duty to respect autonomy and to ease the patient's suffering would outweighed his or her duty to preserve life.

"2. Further or alternatively, a declaration that the current law of murder and/or assisted suicide was incompatible with Mr Nicklinson's right to respect for private life under Article 8, contrary to sections 1 and 6 of the Human Rights Act, 1998, in so far as it criminalises voluntary active euthanasia and/or assisted suicide."

3. Alternatively, is section 2 of the Suicide Act incompatible with Article 8 of the European Convention on Human Rights in obstructing the plaintiffs from exercising a right in their circumstances to receive assistance to commit suicide?

4. Are the General Medical Council and the Solicitors Regulation Authority under a legal duty to clarify their positions?

5. Is the mandatory life sentence for murder incompatible with the European Convention on Human Rights in a case of genuine voluntary euthanasia?"

Each of these issues was traversed in great detail. Toulson LJ began with an outline of the common law with respect to suicide and euthanasia:

"it would be wrong for the court to depart from the long established position that voluntary euthanasia is murder, however understandable the motives may be, unless the court is required to do so by Article 8 of the European Convention in Human Rights."[199]

Interestingly, he also averred that *"as to the control of the consequences, it is hard to imagine that Parliament would legalise any form of euthanasia without a surrounding framework regarding end of life care and without procedural safeguards"* – the implication being that a cautious, conservative traditional path in such an ethically highly charged area of policy was preferable to the any radical solution devised by the courts.[200]

Counsel for Nicklinson submitted that Lord Goff's averment in *Airedale NHS Trust v Bland*[201] that the crossing of the Rubicon entailed by a doctor who, for humanitarian reasons, administered a drug to his patient to bring about his death, had actually been endorsed by the finding in *Re A (Children) (Conjoined Twins: Surgical Separation).*[202] The finding *"shows*

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[199] *At para. 87."...the law of England and Wales does not recognise either a tailor-made offence of 'mercy' killing or a tailor made defence, full or partial, of 'mercy' killing, regardless of the compassionate motives of the mercy killer." See R v Inglis [2010] EWCA Crim 2637, [2010] All ER (D) 140(Nov)).* In addition, Toulson LJ cited Lord Judge CJ's dicta in *Inglis* that the issues of *'mercy'* killing, euthanasia, and assisting suicide could only be decided by Parliament, not the courts. Any proposed changes in the law should be *"reflective of the conscience of the nation"*. See also Lord Reid in *Shaw v DPP [1962] AC 220, at 275: "...where Parliament fears to tread it is not for the courts to rush in."* The re-assertion of the traditionally acknowledged role of judges as declarers of the law, rather than makers of law, was also endorsed in *Airedale NHS Trust v Bland [1993] AC 789.* This, however, did not stop the Law Lords in that case deciding that it was lawful to withdraw life-sustaining treatment from a patient in order that he might die – something which could not be regarded as anything other than new law, and without democratic input.

[200] See Burns, S, *'The Death of Humanity', New Law Journal, Issue 7529, 14 September, 2012* www.newlawjournal.co.uk/nlj/content/death-humanity accessed 10 January, 2013.

[201] *[1993] 1 AC 789, at 865.*

[202] *[2001] Fam 147.*

that the court is able to fashion means of permitting doctors to act in a way which accords with the demands of humanity."[203]

In the Court's view, however, the unusual features which were critical in *Re A*[204] were absent from the facts in *Nicklinson*. If a doctor were to administer a lethal drug to the claimant there could be no defence to a charge of murder based on lack of causation, lack of intent or quasi self-defence. Nonetheless, counsel for the claimant relied on the case for the broader argument that the court was willing to apply the doctrine of *'necessity'* in a new situation and, in doing so, was prepared to consider which was the lesser of two evils.

The Court was not persuaded by counsel's arguments.

The claimant argued that Article 8 of the European Convention on Human Rights protects two values which are regarded as the birth-right of each individual – the right to personal autonomy, or self-determination, and a right to dignity.[205] It was submitted that autonomy and dignity, humanity and justice required that the plaintiff should be permitted to end his life and *Article 8* of the Convention gave him the right to do so.

Toulson LJ concluded, however, that there was no jurisprudence to support the assertion that a *"blanket ban on voluntary euthanasia is incompatible with Article 8."* Of significance, in his

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[203] At para. 63.

[204] Lord Toulson said that the Court in *Re A* had considered three possible defences: lack of causation, lack of intent and *'necessity'*, overshadowed by a concept of *'quasi self-defence.'* The Court had concluded that the operation would be lawful, but the three members of the court expressed their reasoning in different ways. *See pp.210-214 supra.* Ward LJ concluded that where a doctor was faced with conflicting duties towards two patients whose lives were at risk, it was lawful for him to adopt the course which would be the lesser of two evils. He did not use the language of *'necessity'*, but his reasoning could be said to fall within that concept. Brooke LJ conducted a lengthy and comprehensive analysis of the principle of *'necessity'* and he concluded that it applied on the unusual facts of the case. Robert Walker LJ concluded that whereas it would be unlawful to kill Mary intentionally, that is, to undertake an operation with the primary purpose of killing her, Mary's death would not be the purpose of the operation. Although Mary's death would be foreseen as an inevitable consequence of an operation which was intended, and necessary, to save Jodie's life, Mary's death would not be the intention of the surgery. She would die *"because tragically her body, on its own, is not and never has been viable"*. His judgment, therefore, combined all three strands of necessity, lack of intent and lack of causation.

[205] In *Omega Spielhallen-und Automatenaufstellungs-GmbH v Oberburgermeisterin der Bundessadt Bonn [2005] 1 CMLR 5* the European Court of Justice recognised that the Community legal order strives to ensure respect for human dignity as a general principle of law and it referred with approval to the opinion of the Advocate General on the matter in *AG82-AG91*. In her opinion the Advocate General observed that the concept of human dignity is a generic concept, for which there is not a traditional legal definition, but that respect for human dignity is an integral part of the general legal tenets of Community law. The right to dignity was given particular emphasis by Denham J, as she then was, in *Re a Ward of Court (No.2) [1996] 2 IR 73, at 163*.

view, was the fact that the aim of *Article 8* was to protect the vulnerable and the aim of *"the current state of the law with respect to euthanasia"* was also to protect the vulnerable. With the aims of both components of the law being consistent with each other, it was impossible to find that they were incompatible. In any event, it was up to Parliament and not the courts to make law in this area.

The matter as to whether the DPP was under a legal duty to provide further clarification of his 2010 policy[206] in respect of those factors which he would consider in deciding whether or not to prosecute in a case of assisted death was considered at some length.

The Court noted that objective of the policy was to *"identify fact and circumstances in deciding whether to prosecute"* and referred to the sixteen factors in favour of prosecution for assisting another person's suicide and the six against contained in the policy.[207]

The Court also availed of the opportunity to reprise the reasoning underpinning the factors which he would take into consideration in deciding whether to prosecute, or not, in a case of assisted suicide, provided by the DPP in person before the Falconer Commission.[208]

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[206] Published following the judgment in *Purdy*. See fn.185 supra.

[207] *See fn.192 supra.*

[208] The *Falconer Commission on Assisted Dying* – which was not officially favoured and was boycotted by many end-of-life organisations on the basis that it had a pre-ordained objective, namely the legalisation of assisted dying – published its report in January, 2012. It expressed the view that a choice to end their own lives could be safely offered to some people with terminal illnesses, provided stringent safeguards were observed. The current law on assisted dying was described as *"inadequate and incoherent."* The Commission was funded by the author Terry Pratchett and by Bernard Lewis, a businessman, and sponsored by *Dignity in Dying*, formerly known as the *Voluntary Euthanasia Society*. The Commission demanded that Parliament investigate the circumstances under which it would be possible for people to be assisted to die. It outlined a legal framework that would permit only those who had been diagnosed with less than a year to live to seek an assisted suicide, and then only if the met strict eligibility criteria, including (i) two independent doctors were satisfied with the diagnosis; (ii) the person was aware of all the social and medical help available; (iii) they were making the decision voluntarily and with no sense of being pressurised by other or feeling *"a burden"*; (iv) they were not acting under the influence of a mental illness, and were capable of taking the medication themselves, without help. In March, 2013, Lord Falconer announced that he would seek to introduce another assisted suicide Bill in the House of Lords in May, 2013. The DPP, in his evidence to the Commission, had stated:

"...the law makes it an offence to assist suicide. It gives the prosecutor discretion. We thought that if the law remains un-amended and in that form, it was important to distinguish between as it were one off acts of support or compassion and those that were engaged in the delivery of professional services or a business that would routinely....bring them into conflict with the law, because of the broad prohibition on assisted suicide. I mean, I appreciate not everyone would agree with that distinction but if you do have a broad based offence, it's one thing to say, 'this is as it were, a one-off compassionate act' compared with 'this is the provision of a service of a business' which inevitably involves a breach of

The DPP's explanation was found to be a constitutionally proper approach. It was consistent with the requirements of the order in *Purdy.*[209] For it to be any more detailed would be unduly prescriptive and would run the risk of a mechanistic approach to the decision as to whether or not prosecution was warranted.[210]

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the law and I think...if we didn't put that factor in, Parliament might say we are really undermining the prohibition on assisted suicide."

He demurred at the suggestion that his policy should be seen as in some way schematic:

"We want to be transparent about the factors, hence the policy, and apply it on a case by case basis. We want to avoid being too schematic because it's not for me or the Crown Prosecution Service to determine what the law should be. The law is clear and we're simply being given discretion in individual cases...What I think would be wrong, what I want to resist is saying: 'schematically this is what we're trying to achieve', because that is not for me."

When asked whether setting out factors for and factors against prosecution was any different from setting out rules, he replied:

"I think it is, because ultimately it's a discretion; this is simply saying what are the sort of factors we're likely to take into account. That is different from saying 'schematically there are the cases were are going to prosecute and these are the cases we're not going to prosecute'. I appreciate that the two are not at opposite ends of the continuum by any stretch of the imagination. But they are conceptually different and I have avoided any attempt I hope to be schematic about this and insisted that every case has to be decided on its own facts. These are factors to indicate to people what is likely to be taken into account one way or the other, with the overriding proviso that no one factor outweighs others. We don't simply weigh them all up and we will decide each case on a case-by-case basis. We're trying to avoid....the schematic approach does risk, unless it's very carefully constructed, undermining Parliament's intention that this should be an offence."

[209] Notwithstanding the assurances provided by the DPP, however, concern was expressed that the effect, although not the intention, of the Crown Prosecution Services policy was to dispense with the law in a category of cases. The *Falconer Commission*, in particular, expressed strong criticism of the guidelines on the grounds that they provide the circumstances in which the public interest test will be used, not with a view to deal with the exceptional or unexpected case, but in order to deal with the most common manifestation of the conduct that is criminalised by section 2(1) of the Suicide Act, 1961: *"These guidelines are exceptional as they provide the circumstances in which the public interest test will be used, not with a view to deal with the exceptional or unexpected case, but in order to deal with the most common manifestation of the conduct that is criminalised by* section 2(1) of the Suicide Act, 1961. *There is no doubt that the DPP has a public – interest discretion not to bring a prosecution even if he is satisfied that the evidential test is satisfied. But the public interest test is normally used to deal with the exceptional individual case. By contrast, the guidelines provide a reason not to prosecute that applies equally to all. Or, to put it another way, they take a whole identifiable category of case out of the ambit of the criminal justice process."*

It is interesting to note that the critique of the guidelines by the *Falconer Commission* was not alluded to by the Irish High Court in *Fleming v Ireland [2012] IEHC 2* in which it was suggested that the Irish Director of Public Prosecutions might take account of them in arriving at a decision whether to prosecute a case of assisted suicide. See Chapter IX on Ireland.

[210] *At para. 138.* He gave three reasons why he thought such a formulation of policy would be wrong: ***First,*** it would go beyond the Convention jurisprudence about the meaning of "law" in the context of

Likewise, it would be clear to a person who, in the course of his profession, agreed to provide assistance to another with the intention of encouraging or assisting that person to commit suicide that such conduct would carry with it a real risk of prosecution. Whether the risk would amount to a probability would depend on all the circumstances, *"but I do not believe that it would be right to require the DPP to formulate his policy in such a way as to meet the foreseeability test advocated."*[211]

However, as the *Falconer Commission's* comments tended to indicate, together with the remarks of the Solicitor-General in the debate in the House of Commons some months earlier,[212] the submission by counsel for the DPP that it had always been made clear that a final decision as to prosecution, or not, involves *"an exercise of judgment based on all the*

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the rule of law. Even when considering the meaning of "law" in the strict sense of that which may be enforced by the courts, the jurisprudence allowed a degree of flexibility in the way it was formulated as, for example, in *Sunday Times v UK.*

"This must apply even more in relation to 'law' in the extended sense of meaning the law as it is liable in practice to be enforced (Purdy paragraph 112), because flexibility is inherent in a discretion. It is enough that the citizen should know the consequences which may well result from a particular course of action."

Second, *it would be impractical, is not impossible, for the DPP to lay down guidelines which could satisfactorily embrace every person in the 'Class 2' category described by counsel for the claimant, so as to enable that person to be able to tell as a matter of probability whether he or she would be prosecuted in a particular case.*

The judge could envisage a scenario in which the DPP would be expected to lay down a scheme by which a person would be able to tell in advance in any given case whether a particular factor or combination of factors on one side would be outweighed by a particular factor or combination of factors on the other side.

"The DPP is not like an examiner, giving or subtracting marks in order to decide whether a candidate has achieved a pass mark."

Third, *it would require the DPP to cross a constitutional boundary which he should not cross. For the DPP to lay down a scheme by which it could be determined in advance as a matter if probability whether an individual would or would not be prosecuted would be to do that which he had no power to do, i.e. to adopt a policy on non-prosecution in identified classes of case, rather than setting out factors which would guide the exercise of his discretion", at paras 140-143.*

[211] *At para. 140.*

[212] *524 Official Report HC, No 287, Col 1380. "There is a growing confusion – perhaps it was there already – between the guidelines which are the DPP's policy statement on when it is and is not thought appropriate to prosecute and the factors that he will consider, and the substantive law that is set out in section 2 of the Suicide Act. The two are quite different."*

relevant considerations",[213] while indisputably correct legally, might not accord fully with public perception.

In conclusion, the question whether the mandatory sentence of life imprisonment for murder was incompatible with the European Convention on Human Rights in cases of genuine voluntary euthanasia, was addressed.

It was acknowledged by the court that there was strong evidence – considered by the Law Commission in its review of the law of murder – that the public did not regard the mandatory sentence of life imprisonment as appropriate in cases of "*genuine*" voluntary euthanasia. Toulson LJ, however, refrained from explaining what he meant by "*genuine*" and provided no indication as to the criteria that might be applied to elicit whether an act of euthanasia was either genuine or not.

It was unnecessary to decide on the matter of incompatibility in the case before the court on the basis that a determination could not realistically affect the claimant's position, whether a doctor, or other person, who carried out an act of *voluntary euthanasia* would be exposed to such a grave penalty or lesser punishment.[214]

Therefore, a decision to allow the plaintiffs'[215] claims would have consequences far beyond their cases. To do as they wanted, the court would be making a major change in the law and would be compelling the DPP to go beyond his established legal role.

"*These are not things which the court should do.*"[216]

The application was refused.[217]

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[213] *<http//www.cps.gov.uk/publications/prosecutions/assisted_suicide-policy.html> "The list of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits. If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim, the public interest factors tending in favour of or against prosecutions may have to be evaluated differently in the light of the overall criminal conduct."*

[214] *"On any view, the risk of conviction for homicide is likely to be a strong deterrent for any person, especially a professional person"*, at para 149.

[215] The second claimant wished to remain anonymous. He is referred to as 'Martin' in the case text.

[216] *It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. Under our system of government these are matters for Parliament to decide, representing society as a whole, after Parliamentary scrutiny, and not for the court on the facts of an individual case or cases*", at para 150.

[217] Lord Toulson's colleague judges, Mr Justice Royce and Mrs Justice Macur agreed with his analysis, reasoning and conclusions. Interestingly, however, Mrs Justice Macur added:

It is to be observed that notwithstanding the strength of the view express by Lord Toulson that it is for Parliament to change the law, not the courts, it is unquestionable that "*the courts have taken up the challenge posed by changes in medical realities and social attitudes in end-of-life issues without waiting for legislators to react.*[218]

11. Conclusion

The contention at the outset was that the common law as practiced, while not overtly disavowing traditionally endorsed paradigms, particularly that of the sanctity/inviolability of life, has repeatedly demonstrated an innate ability to accommodate alternative criteria in

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"Superfluous as it may therefore appear I nevertheless feel compelled to comment that the dire physical and emotional predicament facing Tony and Martin and their families may intensify any tribunal's unease identified by Lord Mustill in Bland (at 887) in the distinction drawn between 'mercy killing' and the withdrawal of life sustaining treatment or necessities of life. Judges of the Family Division sitting in the Court of Protection adjudicate upon applications for declarations in relation to the latter and have become well accustomed to the 'balance sheet of best interests' which informs the decision of the Court. However, Mr Bowen QC (counsel for Tony Nicklinson) does not succeed in persuading me that this process may reassure society that the development of the common law for which he contends is merited by separate consideration of individual circumstances by individual tribunals of whatever stature and experience. The issues raised by Tony and Martin's case are conspicuously matters which must be adjudicated upon by Parliament and not Judges or the DPP as unelected officers of state," at para 152.

It would appear that Mrs Justice Macur was undisturbed by the application of a *'best interest'* test by judges in circumstances where incompetency obtained. She was not satisfied, however, that the voluntary expression of a wish to die was one which could be accommodated within the jurisprudential purview of the principles of autonomy and self-determination.

[218] See Michalowski, *op.cit., fn.197 supra, at 28.* When the Law Lords decided the landmark case of *Airedale NHS Trust v Bland [1993] AC 789,* the withdrawal of life-sustaining medical treatment from a patient in a persistent vegetative state was an unresolved legal problem which was resolved by the Court via a novel and controversial interpretation of existing legal principles. See Keown, J, *'Restoring Moral and Intellectual Shape to the Law after Bland',* (1997) 113 Law Quarterly Review 481. Likewise, it was novel to hold that refusal of life-sustaining medical treatment by competent adults needs to be respected on the basis that patient autonomy trumps the interest in the preservation of life, per Lord Goff in *Bland, at 864.* See also Lord Donaldson MR in *Re T (Adult: Refusal of Treatment)[1993] Fam 95 (CA), at 103.* In cases of assisted dying, however, the Law Lords, in *Bland* (per Lord Mustill, *at 892-3*) and *Pretty* (per Lord Bingham, *at paras 26-30,* Lord Steyn, *at para 62,* and Lord Hope, *at para 102*) held that the balance falls in the other direction, that is in favour of preserving life. Does the decision in *Purdy* indicate the beginnings of a change in the Law Lords' position in this matter and is it something upon which future courts could build? Lord Brown and Baroness Hale suggested in *Purdy* that the exercise of the DPP's discretion in cases of assisted suicide not only had to be foreseeable, but also needed to take into account that *Article 8* right of the person who wished to die. In *Nicklinson,* however, Toulson LJ adopted what might be regarded as a restrictive reading of *Purdy* according to which the binding reasoning of *Purdy* was limited to a requirement that the application of the relevant law needed to be clarified.

order to resolve intractable human problems, including decisions as to when and how human life is brought to an end.[219]

It has been shown that in the case of those who either never possessed the capacity to decide whether they wished to continue to live, or to die, or of those who no longer possess such capacity, that judicial determinations in respect of life and death are contingent on an estimation of future life quality, based on a *'best interests'* test which, in turn, relies on a medical prognosis of futility. While it is true that this test has received a broad measure of medico-legal support in the context of the continued treatment, or not, of those who no longer possess capacity to decide such matters for themselves, and particularly those who are in a persistent vegetative state, nonetheless its invocation in respect of the removal of artificial nutrition and hydration continues to attract criticism from both legal and medical practitioners.

The *'best interest'* test is, at its core, an interpretative one.[220] After years of endorsing medical opinion, the courts, beginning in the late 1980s and early 1990s – some ten to fifteen years before the passage of the Mental Capacity Act, 2005 - adopted a much more proactive approach to *'best interests'.*

Prior to the Mental Capacity Act, the law left patients lacking mental capacity and their doctors in something of a legal limbo.[221] No one had legal authority to act as a proxy or give consent on behalf of the patient. Even if a patient was compulsorily detained under the Mental Health Act, 1983, section 63 of that Act, which allowed doctors to dispense with the patient's consent, applied only to treatment for mental disorder.[222]

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[219] In *Nicklinson*, Toulson LJ averred, at para 79, that the courts can develop the common law *"incrementally in order to keep up with the requirements of justice in a changing society..."*

[220] In *Bland* Lord Goff posed the question thus: *"...[It] is not whether the doctor should take a course which will kill his patient, or even take a course which has the effect of accelerating death", [1993] 1 All ER 821, at 869.* In his view the more appropriate question was whether *"the doctor should or should not continue to provide his patient with medical treatment or care which, if continued, will prolong his patient's life...[T]he question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care."* Ibid. In the same case, albeit contingent on an estimation of invasiveness, Lord Browne-Wilkinson stated, *"...unless the doctor has reached the affirmative conclusion that it is the patient's best interest to continue the invasive care, such care must cease", at 883.*

[221] See *T v T [1988] 1 All ER 613.*

[222] See *B v Croydon Health Authority [1995] 1 All ER 683; Riverside Mental NHS Trust v Fox [1994] 1 FLR 762.* In *R V Collins and Ashworth Health Authority, ex p Brady [2000] Lloyd's Rep Med 355,* forcible feeding to prevent Ian Brady starving himself to death was held to constitute treatment for his mental disorder.

The impetus for judicial action to clarify the legality of treatment of mentally-disabled patients was provided by the issue of sterilisation of women over 18 who had learning disabilities.[223] If the girl was under 18, she could be made a ward of court, and the court, if it agreed with her parents and her doctors that sterilisation was in her *'best interests'*, could authorise the requisite surgery.[224] In *T v T* Wood J granted a declaration that terminating *T's* pregnancy and sterilising her would not be unlawful. Where a patient was suffering from such mental abnormality as never to be able to consent to proposed treatment a doctor was justified in *"taking such steps as good medical practice demands."*[225]

The *Bolam* test[226] had been criticised by the Law Commission. It stated that it should be made clear *"beyond any shadow of a doubt that acting in a person's 'best interests' amounts to more than not treating a person in a negligent manner."*[227] The Commission proposed that a *'best interests'* test should be retained to assess the lawfulness of treatment of mentally-disabled people, but verifiable criteria to determine a person's *'best interests'* needed to be clarified.

The courts got the message and in *Re A.*[228]Thorpe LJ emphasised that the decision to refuse a vasectomy on a mentally-disabled man was one which encompassed *"medial, emotional and other issues."*[229] The decision could only be made by a judge. In assessing the pros and cons of treatment, the judge should embark on a balancing exercise. Before authorising major and invasive procedures, the judge must be satisfied that the case for such treatment will be significantly in credit. In *Re S*[230] Butler-Sloss P stated that *"the Bolam test [is] irrelevant to the judicial decision, once the judge [is] satisfied that the range of options was within the range of acceptable opinion among competent and reasonable practitioners."*[231] Thorpe LJ emphasised that what the medical expert witnesses offered was expert advice on the options for

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[223] See Brazier & Cave, *op.cit.., fn.99 supra, at 131.*

[224] *See B (A Minor)(Wardship: Sterilisdation) [1987] 2 All ER 206, HL.*

[225] *T v T [1988] 1 All ER 613, at 625.* In 1989, a similar case, *F v West Berkshire Health Authority [1989] 2 All ER 545,* reached the House of Lords. The Law Lords granted a declaration that F might lawfully be sterilised. Lord Brandon stated: *"...a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the 'best interests' of the patient", at 551.*

[226] Established in *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.* It was held that a doctor would not be guilty of negligence if he acted *"in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area....a man not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view"*, at 587-588

[227] Law Commission Report No 231, Mental Incapacity, para 3.27.

[228] *(Medical Treatment)(Male Sterilisation)[2000] 1 FCR 139, CA.*

[229] Ibid, at 200.

[230] *(Adult Patient: Sterilisation) [2000] 3 WLR 1288.*

[231] Ibid, at 1299.

treatment. The court must then exercise the choice the patient was unable to make. The patient's *'welfare'* in its broadest sense must be the paramount consideration.[232] In *R (on the application of N) v Doctor M*[233] there was a body of expert opinion testifying that a particular treatment was not in the patient's best interests. It was held that expert opinion was relevant, but not conclusive.[234]

The *'best interest'* criterion, therefore, is something of a flexible entity and is one which depends wholly on the judicial interpretative approach taken in particular cases. When applied in circumstances, for example, where the decision to be made relates to the withdrawal of artificial nutrition it is difficult not to conclude that the argument that it is in the *'best interests'* of a patient to be starved – which, in effect, is what the withdrawal of nutrition amounts to - is nothing more, or less, than a statement to the effect that it is in the patient's *'best interest'* to die. In such a context Lord Goff's statement in *Bland* that *"we are not saying that it is your best interests to die, just that it is in your best interests not to receive essential physiological support"*[235]is inherently contradictory. The two cannot be separated.[236] Lord Lowry, in the same case, appeared to share these reservations.[237]

It has been asked recently, with no small degree of justification, whether it would not be more honest to admit that the deliberate removal of sustenance from a vegetative patient is indistinguishable from euthanasia[238]

While this would remove a great deal of what must be regarded as *"paralogical"* argument, it would *"also involve a complete change of direction in the current jurisprudence – a change on which the courts would be reluctant to embark without the support of the legislature",*[239] as was evident in *Airedale NHS Trust v Bland*[240] in the UK, and in *Re a Ward of Court (No. 2)* in Ireland.[241]

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[232] See also *Simms v Simms [2003] 1 All ER 669; A v A Health Authority [2002] 1 FCR 481.*
[233] *[2003] 1 FLR 667.*
[234] See Brazier & Cave, *op.cit., fn.99 supra, at 133.*
[235] *[1993] 1 All ER 821 at 896.*
[236] See *Mason and McCall Smith, op.cit., fn.15 supra.*
[237] *[1993] 1 All ER 821 at 887.*
[238] *Mason & McCall Smith, op.cit. fn.15 supra, at 517.*
[239] *Ibid.*
[240] *[1993] AC 789.*
[241] The authors suggest that there is one step on the path to honesty that could be taken without giving offence. *"In their anxiety to avoid conflating the final management of PVS with euthanasia, the courts in England, Scotland and Ireland have been at pains to emphasise that the cause of death in persistent vegetative state cases is the original injury. But, while it is true to say that this was the ultimate cause of death, the proximate cause, given that the patient has survived for a minimum of a year, must be the result of starvation – otherwise, there would be no death and, hence, no cause of death. There would be no difficulty in certifying death as being due to : (i) inanition due to lawful*

However, an essential ingredient in such a change of direction would be an acceptance of the concept of the *'substituted'* judgment test, rather than that of *'best interests'*. If this were to eventuate the removal of sustenance from persistent vegetative patients would equate, at most, to *'passive, voluntary euthanasia', "which is already practiced widely under one name or another."*[242]

The thrust of the argument is that persistent vegetative cases occupy something of a unique niche in the spectrum of euthanasia. All higher brain function has been permanently lost and there is neither awareness nor sensation. There is no alternative of palliative care because there are no senses to palliate. Only the vestiges of the person remain as the breathing body.

Certainty of definition and diagnosis, however, are of crucial importance. While, in many instances, such as *Bland*[243] and *Re a Ward of Court (No.2)*[244] the medical condition was unequivocal, there is an acute danger that the reasoning adopted and followed in such cases could be extended to include less clear-cut circumstances.

The House of Lords did distinguish *Bland* from other *'quality of life'* cases, such a *Re J.*[245] In the former, a wholly insensate patient was deemed to have no interests in continued treatment which could, as was decided, be discontinued on the basis of futility. In the latter it was accepted that some benefit could be derived from treatment of a patient who was not insensate, but it was held nonetheless that non-treatment was to be preferred when any supposed benefit was weighed against other considerations such as pain and suffering.

However, Mason and McCall Smith argue – and, frankly, it is difficult not to empathise with their view - that *S*[246]*, Re D,*[247] *Re H,*[248] *Re G*[249] and *NHS Trust v X*[250] in particular, demonstrate a *"shift in thinking from that accepted in Bland towards that involved in Re J"*[251] and wonder *"if this is not something of a move towards acceptance of active euthanasia."*[252] In their view

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removal of life support to (ii) severe brain damage due to (iii) cerebral hypoxia. This concession to transparency would, we feel, actually help to defuse the emotionalism that surrounds the ultimate management of PVS. A further purely practical advantage would be that the mortality statistics would be maintained correctly – and it would be possible to discover how often such decisions are made." Op. cit., at 519-20.

[242] *Op.cit., fn. 15 supra, at 517-8.*

[243] *[1993] AC 789.*

[244] *[1996] 2 IR 79.*

[245] *[1990] 3 All ER 930.*

[246] *Swindon and Marlborough NHS Trust v S [1995] 3 Med LR 84.*

[247] *(1997) 38 BMLR 1.*

[248] *(1997) BMLR 11.*

[249] *(2001) 65 BMLR 6.*

[250] *[2006] Lloyd's Rep Med 29.*

[251] *[2006] EWHC 3152 (Fam).* To be distinguished from *Re J [1990] 3 All ER 930.*

[252] *Op.cit, fn.15 supra, at p.518.*

these cases provide the most impressive example to date of the *"willingness of the British courts to take 'quality of life' decisions and represent a significant step in this area of law."*[253]

They point to the finding in another *Re J*[254] which, when stripped to its essentials, seems, in their view, to have been based on the ground that the treatment option proposed should do *J* no harm: *"It has been suggested that the 'best interest' test was converted to a 'not against the interests' test*[255] *and it seems to us that this might well be a helpful approach in appropriate cases."*[256]

It would appear, therefore, that the time when *'best interests'* is deemed to encompass assistance with death for a competent adult patient who has expressed a voluntary wish to die but is incapable of doing so by his or her own hand may not be as far distant as the ethical community might envisage.

The recent decision in *Carter v Canada*,[257] albeit on appeal, is indicative of a jurisprudential willingness to extend traditional boundaries to allow for an acceptance of the right of an individual who is terminally ill, and who wishes to avoid further pain and suffering, to avail of assistance with death from a third party in the knowledge that criminal proceedings against the person who helps with the act are unlikely ever to occur. The disavowal of the possibility of such a development, in the absence of legislative underpinning, within the parameters of English law, evidenced in the decisions in *Pretty, Purdy* and *Nicklinson,* should not blind the dispassionate observer, however, to the historical reality that while the *'best interests'* test received statutory endorsement in the Mental Capacity Act, 2005, it first saw the light of day in the courts some twenty-five years earlier. Therefore, any suggestion that an expansion of the test will not involve future curial initiative would not only be foolhardy but would also be a denial of previous, empirically probative judicial activism in the matter.

In summary, and paradoxically, at English common law, if you are incompetent and the medical prognosis is negative you can be killed, in your best interests, by judicial authority; if, on the other hand, you are terminally ill and you express a voluntary and settled wish to die by suicide, albeit your physical condition does not allow you to do so, you cannot legally receive assistance to achieve your objective.

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[253] Ibid.
[254] *[2006] EWHC 3152 (Fam).*
[255] Lewis, P, *'Withdrawal of treatment from a patient in a permanent vegetative state: Judicial involvement and "innovative treatment"', (2007) 15 Med L Rev 392.*
[256] Ibid.
[257] *[2012] BCSC 886.*

It would appear, therefore, that in the UK the only legal method by which those who wish to commit suicide in order to avoid further unbearable pain and suffering, but cannot do so without the assistance of another, can overcome this dilemma is to seek a declaration of incompetence and, having obtained it, submit to the judicial *'best interests'* criteria which will result in an earlier than natural death.

While at first sight this suggestion might appear to be outlandishly *outré,* and one incapable of implementation, nonetheless it does highlight the apparent lack of logic which applies to the jurisprudential approach to the totality of third party assistance with death at English common law.

The suggestion as to the solution for those wishing to commit suicide, but who are unable to do so unaided, is posited solely for the purposes of focussing attention on what is admittedly a trans-jurisdictional legal conundrum and one which, realistically, is not going to disappear because superior courts repeatedly refuse to recognise that the principles of autonomy and self-determination are sufficiently elastic to encompass the right of an individual to decide when and how he or she may choose die.

Inevitably, however, as more and more cases arise due to the spectacular achievements of modern medicine, leading to an increase in human longevity, the courts will orchestrate judgments – as they did in *Bland,*[258] *Pretty,*[259] *Purdy,*[260] *Nicklinson,*[261] *Rodriguez,*[262] *Carter,*[263] *Washington v Glucksberg,*[264], *Re a Ward of Court*[265] *and Fleming*[266] - in language which legislatures will be increasingly obliged to heed and, as with the issue of foetal death, will eventuate ultimately in an amelioration of the law of murder in order to allow for instances in which assisted dying is recognised as lawful.

The predictions of Cassandra ought not always be discounted!

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[258] *[1996] AC 789.*
[259] *[2001] UKHL 61.*
[260] *[2009] UKHL 45.*
[261] *[2012] EXHC 2381(Admin).*
[262] *[19934] 3 SCR 519.*
[263] *[2012] BCSC 886.*
[264] *521 US 702 (1997).*
[265] *[1996] 2 IR 79.*
[266] *[2013] IEHC 2.*

Chapter VII - Assisted Death in America

The progression from eugenics to rights

1. Introduction

Euthanasia is prohibited in all of America's fifty states.[1] Third party assistance with suicide is proscribed in all but four.[2] However, the approach taken to both issues since independence is uniquely redolent, on the one hand, of some of the less attractive features which the general debate on assisted dying can evoke, irrespective of jurisdictional boundaries, and, on the other, of a strategically choreographed invocation of more palatable principles - those of individual autonomy and personal rights - aimed at having assistance with suicide recognised as a constitutional prerogative.

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[1] The practice of euthanasia is illegal and is classified as murder/manslaughter. *State v Fuller, 278 NW 2nd 756, 761 (Neb. 1979) – "murder is no less murder because the homicide is committed at the desire of the victim"; Turner v State, 108 SW 1139, 1141 (Tenn.1908); Martin v Commonwealth, 37 SE 2nd.43 (Va, 1946); NY Penal Law, 125.25 (McKinney, 1987)* – euthanasia is encompassed within the definition of second degree murder. See *American Model Penal Code, 210.5.*

[2] **38** of the **50** states currently have statutes prohibiting physician-assisted suicide (see **Appendix A**). **3** states – Alabama, Massachusetts and West Virginia - and the District of Columbia, prohibit assisted suicide by common law. **4** states – Nevada, North Carolina, Utah and Wyoming – have no specific laws regarding assisted suicide, may not recognise common law, or are otherwise unclear on the legality of assisted suicide. *Oregon, Washington* and *Vermont* are the **only** states that have enacted legislation, in 1994, 2008 and 2013 respectively, permitting such assistance. In *Oregon* and *Washington* the legislation resulted from ballot initiatives. In *Vermont* the *'End of Life Choices' Act,* which permits physicians to administer a fatal overdose to terminally ill patients who wish to commit suicide, was signed into law in May, 2013. In *Baxter v Montana 2009 MT449; 354 Mont 234; 224 P.3d 1211*, the state Supreme Court held that consent by a terminally ill patient to physician aid in dying can constitute a defence to a charge of homicide. Notwithstanding this finding, however, assisted suicide has not been legalised formally in Montana.
There are no specific criminal statutory prohibitions in respect of aiding, abetting, assisting or counselling suicide in the states of Alabama, Idaho, Massachusetts, Nevada, North Carolina, Ohio, Utah, Vermont, Virginia, West Virginia and Wyoming. The penal codes of the following states specify that their medical directive statutes *"shall not be construed to condone assisted suicide"*: Alabama, Idaho, Massachusetts, Nevada, Ohio, Utah and West Virginia. The Virginia Code *[Va. Code Ann.S.8.01 - 622.1(Lexus 2000)]* enacts a civil statute providing that a person may be enjoined from assisting suicide or may be liable for monetary damages by assisting or attempting to assist suicide. Some states classify aiding or causing suicide as a separate and discrete offence while others consider such an act a type of homicide or manslaughter. The states of Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Iowa, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, North Dakota, New York, Oklahoma, Pennsylvania, South Dakota and Wisconsin, criminalise aiding, abetting and/or assisting suicide, exemplified by that of North Dakota [*Cent. Code S.12.1-16-04]:"Any person who intentionally in any manner advises, encourages, abets, or assists another person in taking or in attempting to take his or her own life is guilty of a felony."* In eleven states - Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maryland, New Jersey, Rhode Island, South Carolina and Tennessee – statute law specifies that aiding or assisting suicide means providing the physical means or participating in a physical act resulting in suicide or causing suicide.

As was outlined in the introductory chapter[3] an examination of the jurisprudential, philosophical and ethical dispositions on these deeply emotive issues in the United States over the course of almost two and a half centuries exemplifies the ease with which a number of seminal sociological theories, particularly those of social-Darwinism and eugenics, influenced – and infected - the national approach to non-natural death, particularly in the period between the publication of Darwin's *Origin of the Species* in 1857 and the early years of World War II. This approach was only finally dissipated as reportage of atrocities committed by the Nazi regime against both the institutionalised mentally ill and handicapped children began to impact on the national mood.

Such an historical examination also provides ample empirical evidence to support the contention that those whose ultimate objective it is to legalise euthanasia deliberately tailor their endeavours in a manner calculated to elicit maximum sympathy for the emotive and putatively inequitable plight of those who, notwithstanding a wish to do so, are physically incapable of committing suicide, while simultaneously relegating the ethical and moral implications which assistance with earlier than natural death encompass - irrespective of characterisation as voluntary, non-voluntary or involuntary - to the allegedly arcane arena of religious doctrine.

In the second half of the twentieth century, for example, American euthanasia advocates began to recalibrate their endeavours in order to take advantage of the increasing scepticism of authority, the rise of the legal right to privacy and the revivified debate as to the appropriate balance between collective and individual rights, including those of marriage, education and procreation. In short, as has been pithily stated by Gorsuch, American advocates of third party assistance with death began *"to argue their position less in terms of social or biological progression, as they had done previously, and more in terms of individual autonomy and privacy."*[4]

Unlikely as it might now appear, the history of assistance with death in America is one which manifests a clearly delineable progression from a pervasive and unapologetic eugenic orientation[5] to one in which endeavours to have assistance with suicide declared constitutional under the *Due Process* and *Equal Protection* doctrines of the *Fourteenth Amendment* are predicated exclusively on a rights-based philosophy.

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[3] See Chapter 1: Introduction supra.

[4] Gorsuch, N, *'The Future of Assisted Suicide and Euthanasia'* Princeton University Press, Princeton and Oxford, 2006, at 38.

[5] See Dowbiggin, I, *'A Merciful End: The Euthanasia Movement in Modern America'*, Oxford University Press, 2003; *"In the period between the publication of Darwin's 'Origin of the Species' (1857) and the early 1920s the United States had become perhaps the world's most eugenic nation," at 15,*

This latter approach was clearly in evidence in the legal arguments which were made on behalf of the plaintiffs in the Courts of Appeal of the Second and Ninth Districts in *Vacco v Quill*[6] and *Compassion in Dying v Washington,*[7] respectively. It was also reflected in the *Philosophers' Brief*[8]– the *amicus curiae* submissions on behalf of the plaintiffs by a number of leading jurists in the consolidated review of both cases in *Washington v Glucksberg.*[9] Both Courts of Appeal, invoking previous Supreme Court reasoning employed in the identification of constitutionally protected personal rights, found in favour of recognising a right, under the *Fourteenth Amendment*, to physician-assisted suicide for terminally ill competent patients who wish to avail of an earlier than natural death.[10]

However, in *Washington v Glucksberg*[11] - examined in greater detail below - the Supreme Court declined to endorse such a right. In the case of *Vacco v Quill* the Court rejected the argument that because New York permitted competent persons to refuse life-saving medical

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[6] *Quill v Koppell, 870 F.Supp.78 (S.D.N.Y 1994), rev'd sub nom. Quill v Vacco, 80 F.3d 716 (2d Cir.1996), rev'd Quill v Vacco, 521 US 793 (1997) (Vacco v Quill).*

[7] *Compassion in Dying Washington, 850 F.Supp.1454 (W.D. Wash. 1994), rev'd 49 F.3d 586 (9th Cir.1995), aff'd, 79 F.3d 790 (9th Cir, reh'g denied, 85 F.3d 1440 (9th Cir. 1996) rev'd sub nom. Washington v Glucksberg, 521 US 702 (1997) (Washington v Glucksberg).*

[8] Six prominent philosophers - Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson submitted what became known as the *'Philosophers' Brief'* in support of the Ninth and Second Courts' holdings of unconstitutionality in both *Compassion in Dying v Washington* and *Vacco v Quill.* See Dworkin's *'Introduction to Assisted Suicide: The Philosophers' Brief', New York Review of Books,* vol. XLIV, No 5, March 27, 1997, at 41-45: *"[I] know of no other occasion on which a group has intervened in Supreme Court litigation solely as general moral philosophers", at 41. See also his exchange of views with Yale Kanisar: Dworkin, 'What the Court Really Said', New York Review of Books, vol. XLIV, No 14, 25 September, 1997, at 40-44; Kamisar, 'Assisted Suicide and Euthanasia: An Exchange ', New York Review of Books,* vol. XLIV, No 17, 6 November, 1997, at 68-70.

[9] *Washington v Glucksberg, 521 US 702(1997).*

[10] The 9th Circuit Court's majority decision rested solely on the constitutionally protected liberty interest contained in the Fourteenth Amendment's *due process* clause. The court's reasoning relied heavily on Supreme Court abortion cases, particularly *Planned Parenthood v Casey, 505 US 833 (1992),* which it found to have *"compelling similarities,"* see *Compassion in Dying v Washington, 79 F.3d.790, at 800-01.* It noted the Supreme Court's decisions recognising the right of individuals to be free from government interference in deciding matters as personal as whether to bear or beget a child and whether to continue an unwanted pregnancy to term, *ibid, at 838.* The 2nd Circuit court rejected this interpretation and instead upheld the constitutional challenge to the New York law criminalising assisted suicide based on the Fourteenth Amendment's *equal protection* doctrine. The appellate court held that New York state law did not treat equally all competent persons who were in the final stages of fatal illness and wished to hasten their deaths, and that distinctions made in the law did not further any legitimate state purpose. See *Quill v Vacco, 80 F.3d 716, at 725-27.*For further discussion see Otlowski, M , *'Voluntary Euthanasia and the Common Law',* Oxford University Press, 1997, at 114 *et seq;* Pratt, C, *'Efforts to Legalise Physician-Assisted Suicide in New York, Washington and Oregon: A Contrast Between Judicial and Initiative Approaches – Who Should Decide?'* (1998) 77 Oregon Law Review 1027, at 1029-32: Gorsuch , *N,* op.cit., fn.4 supra, 12-13, 48-49, *52 (Quill v Vacco)* and 8-9 *(Compassion in Dying v Washington); Darr, K, 'Physician-Assisted Suicide: Legal and Ethical Considerations',* Journal of Health Law, Vol.40 No.1, 2007.

[11] *Washington v Glucksberg, 521 US 702 (1997).* The Court declined to review the companion case, *Lee v Harcleroad, 107 F.3d 1382 (9th Cir.1997),* in which the 9th Circuit held that a group of terminally ill persons and their physicians had no standing to challenge the constitutionality of Oregon's PAS law because the law posed no personal danger to them. See *Lee v Harcleroad, 107 F.3d., at 1388, 1391.*

treatment, but prohibited competent persons not on life support from doing *"essentially the same thing"*, the state's assisted suicide prohibition violated the right of equal protection. The notion that the due process clause created a constitutional guarantee of *"self-sovereignty"*, embracing all *"basic and intimate exercises of personal autonomy,"*[12] was similarly rejected.

The Supreme Court was not amenable either to a claimed reliance on the putatively prescriptive language employed in *Planned Parenthood v Casey*.[13] *"That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and Casey did not suggest otherwise."*[14]

As stated earlier,[15] it would be impossible to achieve an understanding of the turmoil which accompanied the various cultural, social, political and jurisprudential stances adopted in respect of non-natural death throughout the nineteenth and twentieth centuries in the United States without recognising the impact which positivist, evolutionist and the eugenicist theories, together with Progressivism, had on the development of the totality of the national psyche up to an including the early years of World War II.[16]

The truth is that the genesis of the latter-day rights-based philosophy in the matter is traceable to the uncomfortable comparisons which began to be made between the practice of state-sponsored involuntary sterilisation of institutionalised mentally ill patients and empirical reports of the assiduous implementation of the eugenic recommendations of *Hoche*

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[12] *See* Otlowski, M, *op.cit,* fn.10 supra, at 38; Gorsuch, N, op.cit. fn. 4 supra, *(Vacco v Quill)* at 3, 14-18, 216; *act-omission distinctions in,* 49; *intent-based distinctions in,* 53-54, 72, 170*; natural–unnatural distinctions in, 15, 51-52, 191; utilitarian arguments in,* 102-3 *and (Washington v Glucksberg)* at 3, 14-18, 20-21, 49, 142, 216, 219-20*; amicus briefs in*, 133*; history test in,* 81*; intent-based distinctions in,* 73*; "reasoned judgment test" in, 76-77; utilitarian arguments in,* 102-3.

[13] *505 US 833 (1992).* See fn.10 supra. *Casey* held that *"at the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion if the state,"* at 852. From this principle the Court concluded that an abortion right necessarily followed. It was on the basis of *"the mystery of life passage"* that the 9th Circuit *en banc* panel and Justice Stephens concluded (*Compassion in Dying v Washington, 79 F.3d, at 813*) that Casey provides an *"almost prescriptive"* mandate requiring recognition of a fundamental liberty interest in the receipt of assistance in committing suicide.

[14] Per Rehnquist CJ.

[15] See Chapter 1: Introduction supra.

[16] The impact of the works of Charles Darwin, for example, on both American public policy and on the nation's consciousness was immense. They called into question *"the most fundamental beliefs of Americans, almost all of which derive from the Judaeo-Christian tradition."* See Dewey, J, *'The Influence of Darwin on Philosophy'*, in Appleman, P, ed., *'Darwin: A Norton Critical Edition, Norton, New York, 1979, at 305.* Darwin's theories had introduced a mode of thinking that *"in the end was bound to transform the logic of knowledge, and hence the treatment of morals, politics and religion."* Ibid.

and Binding by the authorities in Nazi Germany.[17] While the news of the deliberate killing of 200,000 disabled and elderly persons in Germany aroused genuine horror in America, nonetheless the fact that a well-established and determined campaign to have euthanasia legalised had been in train for some time could not be gainsaid.

It might be argued in mitigation that the proponents of such legalisation were confined to a societal elite, including at least one member of the US Supreme Court, and were not accurately reflective of the prevailing national mood. However, the overt advocacy of *"legalised, safeguarded, and [state-] supervised"* mercy killing for suffering patients in the final stages of life by the Euthanasia Society of America, which had been founded in 1938, could not have gone unnoticed in a society which had already accepted, without any appreciable protest, the demonstrably eugenic sentiment that *"three generations of imbeciles are enough."* [18]

For some considerable time prior to the outbreak of war in Europe in 1939, however, euthanasia in America was viewed and endorsed officially as a convenient tool for ridding society of disabled infants, the incurably insane, and the mentally retarded. One of the founders of the Euthanasia Society, Charles Francis Potter, proposed that the mentally disabled be "*mercifully executed*" by what was referred to as *"[the] lethal chamber*" while another, Ann Mitchell, welcomed the outbreak of the Second World War as an opportunity for a *"biological house cleaning."*[19] Mitchell was unequivocal about the eugenic dimensions of euthanasia - *"we must breed human beings as carefully as we do animals"* - and she advocated "*euthanasia as a war measure, including euthanasia for insane, feeble-minded monstrosities."* She argued that such tactics were necessary if established democracies wished to defeat Nazi Germany. *"She believed wholeheartedly that the war was a life-or-*

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[17] See fn.8, Chapter 1: Introduction supra..

[18] The dictum of Justice Oliver Wendell Holmes in *Buck v Bell, Superintendent of the Virginia Colony for Epileptics and Feeble Minded, 274 US 200 (1927), 207.* The Court held that the *Eugenical Sterilisation Act* of the State of Virginia passed constitutional muster. This Act permitted the sterilisation of inmates of state institutions who were found to suffer from hereditary insanity or imbecility. Carrie Buck, a teenager, was selected by the state to be the first person sterilised under the new law. Buck had already given birth to one child, and her mother was institutionalised. Officials at her mother's asylum claimed that mother and daughter shared hereditary traits of feeblemindedness and sexual promiscuity. In upholding the constitutionality of the new law, Justice Holmes proclaimed *"[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind,,..,three generations of imbeciles are enough."* These sentiments are to be contrasted with those in *Meyer v Nebraska, 262 US 390 (1923), at 402,* some years earlier, that *"putting away....the offspring of the inferior, or of the better when they chance to be deformed [would] do....violence to both the letter and spirit of the Constitution."*

[19] See Kuepper, S.L., *'Euthanasia in America, 1890-1960: The Controversy, the Movement and the Law, PhD diss., Rutgers University, 1981, at 38-39,* citing Robinson, W.J., *'Euthanasia, Medico-Pharmaceutical, 16 Critic and Guide (1913), at 85-90.*

death contest for biological supremacy that would be decided by those nations most willing to put euthanasia and eugenics into practice."[20]

The President of the Euthanasia Society, Foster Kennedy, a neurologist by profession, stated publicly, in 1939 – and without the slightest hint of embarrassment - that there was an urgent need to legalise euthanasia for the severely mentally retarded – what he referred to as *"nature's mistakes."* It was *"absurd and misplaced sentimental kindness"* only that kept society for mercy killing *"a person who is not a person."*[21]

In short, the eugenic contention that society had a duty to end the lives of those with defects because they unnecessarily drained community resources had not been uncommon since the early 1900s. In 1913 William J. Robinson, a leading member of the *Progressive* movement[22] had argued that euthanasia was simply evolution in action.[23] Two years later Charles Darrow, of Scopes Monkey trial[24] fame, had advocated that what he referred to as *"unfit children"* be chloroformed. *"Show them the same mercy that is shown beasts that are no longer fit to live,"*[25]he declared unapologetically. Robinson rejected the notion of individual liberty in cases of hereditary defectives or deformed infants. *"Such individuals have no rights. They have no right in the first instance to be born, but having been born, they have no right to propagate their kind."*[26] By the end of the 1930s these sentiments were concretised in the statutory prohibition of marriage of the mentally ill and the mentally retarded in forty-one states. In the same period thirty states had passed eugenic sterilisation legislation.[27]

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[20] Dowbiggan, op.cit., fn.5 supra, at 55.

[21] See *'Mercy Death Law Ready for Albany'*, New York Times. 14th February, 1939, at 2. See also his letter to the editor of the New York Times, 22 February, 1939, at 20; *'Doctor's Defence of Euthanasia'*, Daily Telegraph, London, 15 February, 1939, cited in *Dowbiggin,* op.cit., fn.5 supra, at 60.

[22] See fn.7, Chapter 1: Introduction.

[23] See fn.21 supra.

[24] Scopes, a high school biology teacher was charged with violating a 1925 Tennessee statute prohibiting the teaching of evolution theory in public schools. Charles Darrow's defence of Scopes, over William Jennings Bryan's defence of biblical fundamentalism, did not prevail and Scopes was convicted and fined. By 1929 six other states had passed anti-evolution laws and Tennessee's own statute would not be repealed until 1967. For further discussion of the Scopes trial see Larson, E.J, *'Summer for the Gods: The Scopes Trial and America's Continuing Debate over Science and Religion,* Basic Books, New York, 1997. See also Numbers, R.L., *'Darwinism Comes to America',* Harvard University Press, 1998.

[25] Philadelphia Inquirer, 18 November, 1915, at 7. Cited in *Kuepper,* op.cit., fn.19 supra.

[26] Robinson, W.J., *'Eugenics, Marriage, and Birth Control', 2nd ed., New York, 1922, at 74-76.* Cited in Kelves, D.J., *'In the name of Eugenics: Genetics and the uses of Human Heredity',* Knopf, New York, 1985, at 93-94.

[27] See Haller, M, *'Eugenics: Hereditarian Attitudes in American Thought, 2nd ed.* edition, New Brunswick, N.J., Rutgers University Press, 1984, at 137. See also Pickins, D, *'Eugenics and the Progressives',* Nashville: Vanderbilt University Press, 1969; Ludmerer, K, *'Genetics and American Society: A Historical Appraisal',* Baltimore: John Hopkins University Press, 1972; Kevles, D, *'In the Name of Eugenics: Genetics and the Uses of Human Heredity',* New York, Knopf, 1985; Reilly, P, *'The Surgical Solution: A*

In the latter part of the nineteenth and the early part of the twentieth centuries there was a widely held fear in America that the country was careering towards degeneracy and that social undesirables were reproducing in Malthusian numbers[28] - a situation which constituted nothing less than a public health crisis.[29] Leading members of the American intellectual community, including social scientists, geneticists an medical personnel had enthusiastically bought into Francis Galton's new science *"of improving stock"* and of using *"agencies of social control"* to *"improve ...the racial qualities of future generations."*[30] The prevalence of eugenic views was epitomised not alone in Oliver Wendell Holmes's obiter comments in *Buck v Bell*,[31] but in the founding, in 1923, of the American Eugenics Society.[32] It was also exemplified by the enactment by Congress in 1921 and 1924 of nationality quotas for people wishing to enter the United States.[33]

The arguments deployed in defence of sterilisation were also invoked in favour of euthanasia. The terms became virtually synonymous. In 1931 the Illinois Homeopathic Medical Association approved of euthanasia for *"imbeciles and sufferers from incurable disease."*[34] The Harvard-based social Darwinist Earnest Hooton argued that euthanasia for *"the hopelessly diseased and the congenitally deformed and deficient"* was necessary if America

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History of Involuntary Sterilisation in the United States, Baltimore: John Hopkins University Press, 1991; *Larson, E, 'Sex, Race, and Science: Eugenics in the Deep South',* Baltimore: John Hopkins University Press, 1995.

[28] In 1915 when a Chicago surgeon refused to operate on a deformed baby who subsequently died, it emerged from the ensuing public debate that there was a growing minority of Americans, some of them Progressives (*see fn.19 supra*) - convinced of the need to apply scientific theory to social problems and conventional values - who were of the view that Malthusian fears of an uncontrolled increase in population could be dissipated humanely by letting defective infants die without treatment. This policy had the added advantage of reducing the number of unfit individuals in society. See Pernick, MS, *'The Black Swan: Eugenics and the Death of 'Defective' Babies in American Medicine and Motion Pictures since 1915',* Oxford University Press, New York, 1996.

[29] See Gorsuch, *op.cit., fn.4 supra, at 33*, referring to Darwin's *'Descent of Man and Selection in Relation to Sex (2d ed. 1882).* In such an atmosphere, euthanasia came to be regarded as a method of social control and one which would be instrumental in achieving the dual objective of alleviating Malthusian fears of unmanageable population control and minimising the public cost of maintaining those in society less capable of looking after themselves. With the arrival of Darwinism, the belief that there were no immutable laws governing ethical behaviour became prevalent. In many American minds science displaced religion as the arbiter of both social policy and ethical conduct. See *Russett, C, 'Darwin in America: The Intellectual Response, 1865-1912',* WH Freeman, San Francisco, 1976.

[30] Galton, Francis, op.cit., fn 6, Chapter 1:Introduction supra, at 24*, quoted in Paul, D, 'Controlling Heredity: 1865 to the Present',* Atlantic Highlands, N.J., Humanities Press, 1995, at 3.

[31] See fn.18 supra.

[32] See Mehler, B, *'A History of the American Eugenics Society, 1921-1940'*, Ph.D diss., University of Illinois, Urbana-Champaign, 1988.

[33] See Dowbiggin, I, *'Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940',* Ithaca, N.Y., Cornell University Press, at 191 et seq.

[34] See *'Death for Insane and Incurable Urged by Illinois Homeopaths', New York Times, 9 May, 1931, at 4.*

was to reverse what he regarded as its biological decline.[35] Euthanasia was likewise endorsed for "*unproductive members*" of society.[36]

Notwithstanding the prevalence of such views, however, the first formal attempt at legalising euthanasia – via a bill in the State of Ohio in 1906 – failed, and it was not until 1937, a mere five years before America entered World War II, that a second effort was made, this time in Nebraska. A doctor, Inez Celia Philbrick, who supported eugenic sterilization, endeavoured to have such a bill introduced in the unicameral state legislature.[37] The proposal allowed for adults of "*sound mind*" and suffering from an "*incurable and fatal*" illness to apply to a district judge for a merciful death.[38] The bill, however, also included provisions for the killing, without their consent, of mental incompetents and minors suffering from incurable and fatal diseases. In the event, the draft bill was never considered by the state legislature.[39]

In early 1939 the *Euthanasia Society* published a template '*Euthanasia Bill*' for use by those states that might be disposed to changing the law in the matter of non-natural death. However, no state availed of the heavily conditioned model.

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[35] See Hooton, E, '*The Future Quality of the American People*', 154 The Churchman 11-12 (1940).

[36] Lennox, W, '*Should They Live? Certain Economic Aspects of Medicine,* 7 The American Scholar, 454-66 (1938). The Euthanasia Society of America conducted a determined, if occasionally chaotic, campaign to nudge public opinion towards an acceptance of active euthanasia. Strange as it might now appear, leading members of the Society believed that a number of concomitant factors would assist in the endeavour to have assistance with death legalised. In their view, not least of these factors were female enfranchisement, the enactment of eugenic sterilisation and what it viewed, as early as 1938, as the imminent decriminalisation of birth control. "*They tended to believe that death would be the last taboo to fall in the struggle to free Americans from what had been described as 'biological slavery'*". See *Dowbiggin*, op.cit., fn 5 supra, at xv.

[37] See Nebraska Legislature, 52nd Session, Legislative Bill No.135.

[38] The application would be forwarded to a committee of two doctors and one lawyer, and if all requirements had been met and the judge and committee approved the attending doctor could administer a lethal dose to the patient.

[39] The Committee on Public Health and Miscellaneous Subjects of the Nebraska State Legislature did hold public hearings on the proposed bill. However, a motion by the only medical member of the legislature that the bill be postponed indefinitely was carried without dissent. Philbrick also advocated that statutes similar to those permitting eugenic sterilisation be enacted legalising euthanasia for institutionalised mental patients and the mentally retarded. In correspondence with Charles Potter, one of the founders of the Euthanasia Society of America, she expressed the view that a comprehensive euthanasia bill ought to be "*mandatory in the case of idiots*" – *whom she described as "living beings with whom communication is impossible*" – "*monstrosities, the insane, suffering from certain types of insanity, in which incurability has been established after a term of years during which there has been expert supervision and study.*" In similar vein she averred that the "*criminal insane should always be put to death humanely,*" and "*in its social application the purpose of euthanasia [was] to remove from society living creatures so monstrous, so deficient, so hopelessly insane that continued existence [has] for them no satisfactions and entails a heavy burden on society.*" Cf. *Correspondence between Philbrick and Potter, 20 December,* 1937 Partnership for Caring, Inc., Records, Lewis Associates, Baltimore, Md.

[40] The date of the publication of Darwin's '*Origin of the Species*'. See fn.5, Chapter 1: Introduction supra.

Euthanasia *per se,* therefore, was not an unknown concept to the American public at the time of their country's entry into World War II. Between 1857[40] and 1939, Francis Galton's *"science of improving stock,"*[41] via the use of involuntary sterilisation, had become widespread. It was looked upon as a public health measure designed to minimise the costs of supporting disadvantaged groups, improve the welfare of future generations and reconstitute the basis for an enduring social order. *"The eugenics movement's most successful initial inroads into American society involved the forced sterilization of the mentally ill."*[42]

Reportage of the treatment of mental patients and handicapped children in Germany, however, impelled those who supported the legalisation of euthanasia to address the unpalatable association which many Americans had begun to make between the campaign for legalisation of third party assistance with death and Nazi murders. Increasingly, empirical confirmation of such atrocities placed euthanasia advocates on the defensive and in 1942, the Euthanasia Society found it expedient to publicly condemn the Nazi *"wholesale slaughter of innocents."* In order to avoid *"any possible misunderstanding"* of its agenda it stressed that it supported *voluntary euthanasia* only.[43] In private, however, the attitude of some of its leading members was not always as definitively condemnatory.[44]

In 1950 the World Medical Association, of which the American Medical Association was a member, had recommended to all national medical associations that euthanasia be condemned *"under any circumstances"*[45] and in 1952 the *Euthanasia Society of America*

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[40] The date of the publication of Darwin's *'Origin of the Species'*. See fn.5, Chapter 1: Introduction supra.

[41] See fn.6, Chapter 1: Introduction supra.

[42] See Gorsuch, *op. cit., fn.4 supra, at 34.*

[43] The momentum of the pro-euthanasia movement which had been building since the turn of the century began to slow down. In 1939, a public opinion poll indicated that as many as **46%** of Americans were in favour of some form of legal euthanasia. See Williams, Glanville, *'The Sanctity of Life and the Criminal Law', Knopf, New York, 1958, at 296.* By 1950 the approval rating for allowing physicians by law to end incurably ill patients' lives by painless means if they and their families requested it had fallen to **36%.** See Gallup, G.H., *'The Gallup Poll: Public Opinion, 1935-1971,* 3 vols., Random House, New York, 1972, vol 2, at 887. Cf. also Gittleman, D.K., *'Euthanasia and Assisted Suicide',* 92 Southern Med. Jour. 370 (April, 1999).

[44] Ann Mitchell, who had welcomed the outbreak of war as an opportunity for a *"biological house cleaning"* (*see fns.21 &.22 supra*), while expressing unhappiness with Nazi methods in public, did not disagree with the results in private. In correspondence with the secretary of the British Voluntary Euthanasia Legalisation Society in 1941 she expressed the hope that the war would usher in a new *"biological age"* and revolutionise thinking so that mass sterilisation and euthanasia would become acceptable. Mitchell was not alone in this view. The fact that as late as 1943 the Euthanasia Society thought it appropriate to establishing a committee to draft a bill legalising involuntary euthanasia for *"idiots, imbeciles, and congenital monstrosities"* is indicative of an absence of any qualms about euthanasia for the non-consenting handicapped on the part of the founding members of the Society. In the event nothing came of this proposal.

[45] See *'World Medical Unit to Admit Doctors from Germany and Japan'*, New York Times, 18 October, 1950, at 22, cited in Gittleman, op.cit., fn.45 supra.

petitioned the *Human Rights Commission of the United Nations* to declare the right to die a basic human right for people dying of incurable disease. The fact that the Commission did not oblige is probably reflective of the fact that in the immediate post World War II years Americans, not unlike many other nationalities, had set their face determinedly against the legalisation of euthanasia.[46]

An exception to the newly minted antipathy to assisted death, however, was the noted British criminal jurist, Glanville Williams – a member of both the *Euthanasia Society of America* and its English counterpart, the *British Voluntary Euthanasia Legalisation Society* - who, in his seminal work, *'The Sanctity of Life and the Criminal Law',*[47] unabashedly advocated euthanasia. In his view people were *"entitled to demand the release of death from hopeless and helpless pain"*[48] and there should be immunity from prosecution for doctors who helped willing individuals to die.

In a foretaste of the invocation of constitutional personal rights some forty years later, the central issue, according to Williams, was *"personal liberty."*[49]The prohibition against euthanasia was defensible only on religious grounds. Consequently, it did not apply to those who did not share such beliefs. He also argued that, contingent on parental consent, killing

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[46] See Larson, EJ & Amundsen, DW, *'A Different Death: Euthanasia and the Christian Tradition'*, Inter-Varsity Press, Downers Grove, Illinois, 1998, at 165.

[47] *Knopf, New York, 1958.* See also his, *'Euthanasia and Abortion', 38 Col. L.Rev.178201(1966).* Glanville Llewelyn Williams (1911-1997). He was the only foreign Specialist Consultant for the American Law Institute's project for a Model Penal Code. He was a Fellow and Director of Studies in Law at Jesus College Cambridge. Previous to these appointments he held the senior law chair at the London School of Economics and was Quain Professor of Jurisprudence at University College London. He was described by Sir Rupert Cross, Vinerian Professor at Oxford as *"without doubt the greatest English criminal lawyer since Stephen."* See *'The Reports of the Criminal Law Commissioners (1833-1949) and the Abortive Bills of 1853'*, in Glazebrook, P.R., *'Reshaping the Criminal Law', London, Sweet & Maxwell, 1978, at 5, 20.* The reference is to Sir James Fitzjames Stephen (1829 -1894), author of *'A General View of the Criminal Law of England, London, Macmillan, 1863*; *'History of the Criminal Law', 3 vols.(1883)* and *'A Digest of the Criminal Law, London, Macmillan, 1877.* Stephen drafted a Criminal Code which, although it received the blessing of a Royal Commission, was not enacted in England, but was adopted elsewhere in what was then known as the British Empire.
Williams was in favour of eugenic sterilisation in cases of *"incapacitating but non-painful affliction, such as paralysis."* He also supported the sterilisation of *"hopelessly defective infants"* and of people *"suffering from dementia."*
The first advocate of a right to die for the chronically ill, Felix Adler, the founder of a movement known as *Ethical Culture* – a new form of Judaism – argued in 1891 that chronic invalids should hold out as long as possible but when their pain and unhappiness became overwhelming they deserved the right to die peacefully. The process whereby this was to be achieved should be voluntary and rigorously safeguarded and the physician should be permitted to administer what was referred to as a *"cup of relief"*. See Chicago Tribune, 6 August, 1891, at 1, cited in *Kuepper,* op.cit., fn 19 supra, at 31-32.

[48] Ibid, at ix-x.

[49] See *'Euthanasia and Abortion'*, op.cit., fn. 47 supra, at 179.

defective infants could be justified on eugenic and humanitarian grounds. On the basis that juries usually acquitted parents who had killed their handicapped children out of mercy Williams claimed that the legalisation of euthanasia in such instances *"would simply bring the law into closer relation to its practical administration."*[50]

A not unimpressive rebuttal of Williams' contention that euthanasia was defensible only on religious grounds - and one which has not lost any of its pertinency with the passage of time - was issued by the jurist Yale Kamisar.[51] He argued that *"abstract propositions and carefully formed hypotheticals are one thing; specific proposals designed to cover everyday situations are something else again."* They acted as a powerful bulwark against an increasingly agnostic view of both involuntary as well as voluntary euthanasia. While he did not compare the pro-euthanasia lobby with Nazi atrocities, he did allude to the internment of Japanese-Americans during World War II as evidence of what might happen if deliberate steps were not taken to swiftly snuff out *"what are or might be small beginnings."*[52] He stated:

"Miss Voluntary Euthanasia is not likely to be going it alone for very long. Many of her admirers..... would be neither surprised nor distressed to see her joined by Miss Euthanatise the Congenital Idiots and Miss Euthanatise the Permanently Insane and Miss Euthanatise the Senile Dementia."[53]

Kamisar has been a persistent opponent of the legalisation of euthanasia. He subscribes to the slippery slope theory and has argued that the *"legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others."*[54] After first writing about the matter in response to Williams's *demarche* he concluded almost forty years later, in 1995, and with no small degree of prescience, that by the start of the millennium it was strongly probable that at least several states would decriminalise active voluntary euthanasia – albeit under the characterisation of *'aid-in-dying'* - and that there was a distinct possibility that at least several appellate courts would announce a state or federal constitutional right to active voluntary euthanasia. While he believed that the U.S. Supreme Court would not discover or recognise such a right *"the*

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[50] Op.cit., fn.47 supra, at 346-50. See also his *'Euthanasia and Abortion'*, op.cit., fn. 49 supra, at 181.
[51] Kamisar,Y, *'Some Non-Religious Views Against Proposed Mercy-killing Legislation'*, Minnesota Law Review 42, 1958, 969-1042
[52] Ibid, at 976, 1032, 1038.
[53] Ibid at 1031.
[54] Ibid at 1011. For William's response to Kamisar see "'*Mercy-killing' Legislation – A Rejoiner,*" Minnesota Law Review 43 (1958): 1-12.

possibility that it may can no longer be disregarded."[55] It could not be said that he was inaccurate in the thrust of his prediction, even if he may have erred in some of the detail.[56]

The late 1950s and early 1960s in America witnessed a flourishing of interest in the concepts of patient autonomy and individual rights. Euthanasia ceased to be contextualised exclusively within social and biological parameters and began to be regarded more in the context of civil liberties, particularly that of privacy. The terminology also changed and the word euthanasia was replaced by the phrase the right to die.[57] Eugenic justifications for mercy killing were finally put aside, as were recommendations for state run euthanasia programmes. Developments in modern medicine, especially the increased ability of doctors to delay death arising from use of technology, gave rise to apprehensions that the prolongation of life could entail, in certain instances, virtual total dependency on medical machinery for indefinite periods.

Similarly, the second half of the 20th century saw the development of what came to be known as *'situational ethics'* – the principal tenet of which was that there were no absolute moral standards to guide medical treatment; the solution to any health-related dilemma depended solely on the particular circumstances surrounding the patient's condition.[58] Its founder, Joseph Fletcher, supported assisted suicide and voluntary euthanasia. *"Death control, like birth control, is a matter of human dignity. Without it persons become puppets."*[59] While Fletcher's rationale for voluntary euthanasia was based on patient autonomy, nonetheless he robustly defended eugenic sterilisation in his hugely influential book *'Morals and Medicine'*[60] published in 1954.

In 1975, the Malthusian concerns of social Darwinists and the views of Glanville Williams were re-echoed in Olive Ruth Russell's *'Freedom to Die: Moral and Legal Aspects of*

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[55] Kamisar *'Physician-Assisted Suicide: the last bridge to active voluntary euthanasia', in Keown, J, ed., 'Euthanasia Examined: Ethical, Clinical and Legal Perspectives',* Cambridge University Press, 1995, pp.225-260.

[56] See fn.8 supra.

[57] In 1974 the *Euthanasia Society of America* was renamed as the *Society for the Right to Die* and in 1977 the *Euthanasia Educational Fund* became *Concern for Dying*. These organisations underwent various upheavals and further name changes in the years that followed. In 1980, the *Hemlock Society of Los Angeles* was founded by Derek Humphry who became one of the most influential advocates of euthanasia, and remains so to this day. Not unlike others who continue to present their pro-euthanasia message in emollient terms of personal autonomy and the right of the individual to choose, Humphry, while careful not to do so overtly, has intimated on occasion that a *'right to die'* might also entail a duty to do so in certain circumstances. See Humphry & Clement, *'Freedom to Die: People Politics and the Right to Die Movement',* 2000, at 339-40, 342, 347, 348.

[58] See Fletcher, J, *'Situation Ethics: The New Morality',* Westminster Press, Philadelphia, 1966.

[59] See Fletcher, J, *'The Patient's Right to Die',* Harper's Magazine 221 (October 1960), at 143.

[60] *Morals and Medicine: 'The Moral Problems of the patient's Right to Know the Truth: Contraception, Artificial Insemination, Sterilisation, Euthanasia',* 2nd ed., Princeton University Press, 1979.

Euthanasia' which advocated the acceptance of euthanasia as a way of halting what it referred to as the *"surging rise in the number of physically and mentally crippled children."*[61] Other contributors to the debate in support of the right to assistance with death, including voluntary euthanasia, in the period from the mid-1950s to the present day, included Ronald Dworkin,[62] Dan Brock,[63] Margaret Battin[64] and Norman Cantor.[65] These jurists were enormously influential in providing intellectual credibility to the various endeavours to have assisted suicide recognised as a constitutional right. However, even among those most associated with arguments based on autonomy and choice *"the right to die sometimes appears to morph into a duty to do so"*[66] - Ronald Dworkin's hypothetical illustration involving an elderly woman suffering from Alzheimer's disease being a case in point.[67]

From the 1960s onwards the debate in America about euthanasia took place against a new backdrop - that of countercultural ferment, not least of which related to prohibition of contraception and abortion. In 1965 in *Griswold v Connecticut*[68] the Supreme Court called in aid the *Third, Fourth* and *Fifth Amendments* to the Constitution to enable it to reverse an

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[61] See *Olive Ruth Russell, 'Freedom to Choose Death: A Discussion of Euthanasia',* (lecture given at the Chevy Chase Presbyterian Church, 29 May, 1973).Russell was a prominent psychologist in the United States at the time her book was published.

[62] Dworkin, R, *'Life's Dominion; An Argument about Abortion , Euthanasia and Individual Freedom',* Vintage Books, New York, 1993.

[63] Brock, D, *'Life and Death: Philosophical Essays in Biomedical Ethics', 1993*; *'Voluntary Active Euthanasia',* Hastings Centre Report 22, no.2, 1992. Brock argues that the rights of those suffering severely from Alzheimer's disease *"approach more closely the condition of animals"* and therefore *"lack personhood".*

[64] Battin, Margaret P, *'Euthanasia: The Fundamental Issues'* in *'The Least Worst Death: Essays in Bioethics on the End of Life,* 1994 at 120; also *'Should We Copy the Dutch? The Netherlands' Practice of Voluntary Euthanasia as a Model for the United States' in 'Euthanasia: The Good of the Patient, The Good of Society 95,* ed. Bisbin, R, 1992. While supporting a right to assisted suicide on mercy and autonomy grounds Battin also argues that principles of distributive justice require legalisation of non-voluntary euthanasia for those who do not have a *"realistic desire"* for continued care. See *'The Least Worst Death',* op.cit., at 121. In Battin's estimation it is an act of injustice to allow certain persons to live if they fail to enjoy a certain quality of life, including those who are *"permanently comatose, decerebrate, profoundly brain damaged, and other who lack cognitive function".* Such people must be killed. *Ibid.* Battin has been a witness for plaintiffs in cases where the ban on assisted suicide is claimed to be either disproportionate or unconstitutional, or both. See, for example, *Fleming Ireland [2013] IEHC 2.*

[65] Cantor, N, *'On Kamisar, Killing, and the Future of Physician-Assisted Death',* 102 Mich.L.Rev., 2004, at 1793.

[66] Gorsuch, op.cit. fn. 4 supra, at 40.

[67] While still competent an elderly expresses a desire to be killed when dementia sets in. However, after the condition has taken hold she displays a willingness to enjoy life and, contrary to her previously expressed wishes, now says that she wants to live. Dworkin asks which of the two requests commands respect: the earlier, rational choice, or that of a woman affected by dementia? While stopping short of expressly advocating compliance with the first option Dworkin appears to enjoin society to ignore the pleas for life of the demented aged person in favour of some previously signed document or comment that she – or he, as the case may be - would rather die than become demented. See *Dworkin,* op.cit., fn.62 supra, Ch.7.

[68] *381 US 479 (1965).*

anti-contraception law and legalise the sale of contraceptives – something which might come as a surprise to other jurisdictions who, prior to that date, might have looked to the United States as the embodiment of progress and enlightenment in sexual matters. The apogee of a widespread campaign to have the constitutional underpinning of individual personal rights judicially endorsed was reached in the Supreme Court decision to recognise a right to abortion in *Roe v Wade*[69]in 1973. The finding was based on a woman's constitutional right to privacy and choice.

Interest in death and dying led to the establishment in 1969 of the *Hastings Centre*, headed by Daniel Callaghan.[70] The *"silence about death"* began to end.[71] The notion that the individual had a right to die with dignity began to flourish and in 1972 the *Church Senate Special Commission's* hearings on aging[72] indicated that Americans had become increasingly unhappy about the *"brutal irony of medical miracles"* which, while capable of extending the dying process, served also to diminish patient dignity and quality of life.[73] In truth, it had become increasingly difficult to distinguish death with dignity from aid in dying.[74]

Another significant development occurred in this period was the introduction of the living will. The concept of the living will suited the shifting cultural climate in America in the 1960s and 70s with the growing emphasis on the right to privacy and *"the emancipation of patients from impersonal, alienating and technocratic professions and institutions."*[75] This allowed for a patient to request voluntarily in advance that treatment that simply prolonged his or her

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[69] *410 US 113 (1973)*

[70] In addition, universities and medical schools taught courses and held seminars on death and dying – in effect the discipline of bio-ethics. From 1970 onwards, books on death began to appear regularly. See Steinfels & Veatch (eds), *'Death Inside Out'*, The Hastings Centre Report, Harper & Row, New York, 1975, at 1.

[71] See Goleman, D, *'We are Breaking the Silence about Death'*. Psychology Today 10 (1976), 44; Garrett, V, *'The Last Civil Right? Euthanasia Policy& Politics in the United States, 1938-1991', Ph.D diss., University of California, Santa Barbara, 1998.* In evidence before the 1972 Special Senate Committee on Aging (see fn.74 post) Elizabeth Kubler-Ross, author of *'On Death and Dying, Collier Books, New York,1969*, stated: *"We live in a very peculiar, death-denying society...We isolate both the dying and the old, and it serves a purpose, I guess. They are reminders of our own mortality."* See also Dempsey, D, *'The Way we Die: An Investigation of Death and Dying in America Today'*, Macmillan, New York, 1975; *'Dying is Worked to Death'* (Editorial), Journal of the American Medical Association 229 (1974), 1909-1910; Cohen, EJ, *'Is Dying Being worked to death?'*, American Journal of Psychiatry 133 (1976), at 575-77.

[72] *Death with Dignity: An Inquiry into Related Public Issues, Proceedings before the Special Committee on Aging,* U.S. Senate, 92nd Congress, 2nd. Session, 7-9 August, 1972, Parts 1-3 (Washington, DC: Government Printing Office, 1972). The Special Committee was chaired by Senator Frank Church. Notwithstanding insistence to the contrary the Committee found it impossible to prevent the issue of euthanasia being raised at the hearings.

[73] See *Garrett,* op.cit, fn 71 supra, at 113.

[74] See *Death with Dignity*: An Inquiry into Related Public Issues, op.cit., fn.72 supra, Part 1, 1; Part 2, 68-69. *In re Quinlan, 70 NJ 10, 355 A.2d 647 (1976)* was the first case in America to explicitly distinguish between letting die and both direct killing and assistance with suicide.

[75] Dowbiggin, op.cit, fn.5 supra, at 121.

life could be discontinued in the event that the patient became unable to express such a request at the time such a decision was required. By 1978 some three million living wills had been distributed by the *Euthanasia Educational Fund*.[76] In 1976 California became the first state to recognise the living will and by 1986 all but eleven states had done so.

The case *In re Quinlan*[77] is of particular significance to an understanding of the changing perception in American society in respect of euthanasia from the 1970s onwards. *Quinlan* did not establish an absolute or general right to die – a right to end one's life in any manner one sees fit. The only right or liberty that it established – and one which *Cruzan v Director v Director, Missouri Department of Health*[78] later recognised – was the right under certain circumstances to refuse or to reject life-sustaining medical treatment.[79] The case explicitly distinguished between letting die and both direct killing and assisted suicide. The specific right established was the right to end artificial life support.[80] This decision marked a ground-breaking, legal first step for right-to-die advocates. In terms of its impact it approximated to the decision which *Brown v Board of Education* had for the de-segregation of educational facilities.[81] It followed the decisions in respect of the right to privacy in *Griswold v Connecticut*[82] and *Roe v Wade*[83] and held that this right could be exercised when a terminally ill patient wishes to withhold or withdraw life-sustaining support.

2. The Law

The formal federal law in the United States of America in the matter of voluntary, consensual euthanasia has never been anything other than unequivocally prohibitive. At both common law and by statute euthanasia is classified as murder.[84] As is the case in other jurisdictions within the Western jurisprudential tradition neither victim consent nor the perpetrator's

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[76] Following a promotion from 1973 onwards by the syndicated columnist, Abby van Buren. Van Buren urged her readers to write to the Euthanasia Educational Council for a copy of the living will. See *'Dear Abby, Some Thoughts on a Good Death', Universal Press Syndicate. 1 April, 1973*, reproduced in Zucker, M, ed., *'The Right to Die Debate: A Documentary History, Greenwood Press, Westport, Connecticut, 1999, at 75-76.*[77] *In re Quinlan, 70 NJ 10, 355 A 2d 647 (1976)*

[77] *In re Quinlan, 70 NJ 10, 355 A 2d 647 (1976)*

[78] *497 US 261 (1990).*

[79] *In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), at 665, 670.*

[80] The state court permitted an unconscious patient to be removed from a respirator, as her family wished. In *Cruzan v Director, Missouri Department of Health, 497 US 261 (1990)* the Supreme Court upheld the state's power to keep an unconscious patient on a feeding tube, over her family's objections, because they patient had not left clear instructions for ending life-sustaining treatment.

[81] *347 US 483 (1954).* See Filene, P, *'In the Arms of Others: A Cultural History of the Right-to-Die in America'*, Ivan Dee, Chicago, 1998, at 22-25.

[82] *381 US 479 (1965).*

[83] *410 US 113 (1973).*

[84] See fn.1 supra.

motivation are admissible defences to intentional homicide.[85] It is irrelevant for the purposes of determining criminal responsibility that the person killed requested or consented to his or her own death[86] and American law does not permit of a defence to a charge of murder that death was imminent by virtue of a patient's terminal condition.[87] While the issue of intention is paramount to the requirement of *mens rea*, both at common law and in those jurisdictions where the law has been codified, motive is of no relevance whatever for the purposes of establishing criminal liability.

In short, neither euthanasia nor mercy-killing are regarded as special categories of homicide within the generality of American jurisprudence. Liability is determined solely on the basis of ordinary criminal law principles and the relevant applicable law is that pertaining to murder.

Doctors – albeit few in number – have been prosecuted in the United States for the unlawful killing of patients but determination of guilt does not appear to attract the imposition of those penalties which normally accompany convictions for murder.[88] The case of Dr Jack Kevorkian would appear to be the exception.[89]

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[85] While courts, on occasion, have regarded both victim consent and the killer's motive as mitigating factors in determining sentence (*See Model Penal Code, 210.5, commentary at 106; NY Penal Law 125.20(2), 125.25 (1)(a)*), any claim that a jury should be instructed on the basis of assisted suicide, where homicide would be a more appropriate charge, especially in circumstances where the defendant *"was an active participant"* in the overt act of causing death, has been firmly rejected. See *State v Cobb, 625 P.2nd1133 (Kan.1981), at 1136.* See also *LaFave and Scott, 'Criminal Law',* 2nd. ed., Minnesota, 1984, at 475.

[86] Under the *American Model Penal Code*, drafted by the *American Law Institute* and traditionally invoked as the basis for criminal law revision by many states, helping another to commit suicide is a criminal act. See *Article 210.5.* In 1980 the *American Law Institute*, having reviewed state laws on assisted suicide, acknowledged that its criminalisation was widely supported. *See Model Penal Code, cmt.5, at 101, n.23* (*discussing state statutes*). It endorsed two criminal provisions of its own: (1) *'Causing Suicide as Criminal Homicide'*: *"A person may be convicted of criminal homicide for causing another to commit suicide only if he purposely causes such suicide by force, duress, or deception"*; (2) *'Aiding or soliciting suicide as an Independent Offence'*: *"A person whom purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanour."*

[87] See Devlin, P, *'Samples of Law-making', London, 1962, at 94-95: "The deliberate acceleration of death must prima facie be murder and I do not see how under any system of law it can logically be otherwise. The certainty of death in the immediate future cannot of itself be a defence any more than the certainty in the remote future."* The statutory position in the United States regarding the condition of the patient, and the acceleration of an imminent death is the same as at the common law.

[88] The first recorder prosecution of a doctor for the unlawful killing of a patient occurred in the state of New Hampshire in 1950. See *People v Sander (unreported)* NY Times, 10 March 1950. An analysis of the case is contained in Sachs, T, *'Criminal Law: Humanitarian Motive as a Defence to Homicide' (1950) 48 Mich.LRev.1199.* Dr.Sander was accused of the murder of a patient suffering from cancer by injecting air into one of her veins. At his trial the doctor did not deny that he had administered air intravenously. His defence was that there was no evidence to support the charge that he had caused the patient's death. As it could not be proved beyond reasonable doubt that his actions were the proximate cause of death he was acquitted. In *People v Montemarano (unreported) (1974) Nassau County Court (NY)* a doctor was charged with the murder of a 59 year-old-patient suffering from terminal cancer of the throat. At his jury trial it was alleged that the patient had died shortly after a

The law in America in the matter of assisted suicide is equally clear. However, it does exhibit some jurisdictional variation. With the exception of the states of Oregon and Washington, where physician-facilitated procedures for persons intent on committing suicide have been legalised, albeit within precise parameters and subject to specific protocols,[90] the provision of such assistance is either specifically criminalised or is impermissible under medical directive statutes in every state of the Union.[91]

The proscription of third party assistance with suicidal death under American law is not of recent origin. Its genesis can be traced to that jurisdiction's pre-revolutionary embodiment of prevailing English common law which treated all intentional acts of suicide as inherently wrongful, that is *malum in se*.[92] In its turn, English common law had been indebted to the

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fatal dose of potassium chloride had been administered. The defence argued that the patient had died either before the potassium chloride was administered or that had died from other unspecified causes. The doctor was acquitted. See also *People v Hassman (unreported)* NY Times, 20 Dec. 1986; *People v Rosier (unreported)* Washington Post, 2 Dec. 1988.

[89] In 1999, in the state of Michigan Dr Kevorkian was convicted of the second-degree murder of a fifty-two-year-old patient suffering from amyotrophic lateral sclerosis, also known as Lou Gehrig's disease. He was sentenced to jail for ten to twenty-five years. Throughout the previous decade Kevorkian had maintained publicly – including on national television – that not only did the individual have the right to receive assistance with suicide but that a right to be killed by another person, as long as the act was performed with the consent of the victim and the perpetrator was motivated by compassion or mercy, was constitutionally permissible.

[90] The state of Oregon enacted a physician-assisted suicide law in 1994. The *Death with Dignity Act* came into effect in 1997. The *Washington Death with Dignity Act, Initiative 1000*, codified as *RCW 70.245*, which was enacted on 4th November, 2008, allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have less than six months to live. In 2009 the Montana Supreme Court ruled in a 4-2 decision in *Baxter v Montana, 2009 MT 449; 354 Mont.234; 224 P.3d 1211 (SC),* that there was no provision in its state laws preventing patients from seeking physician-assisted suicide. Because patients consent to their own deaths and administer the lethal medications themselves physicians would not be liable to prosecution under general homicide laws. However, unlike Washington and Oregon, Montana has not legalised physician-assisted suicide. *See fn. 2 supra.*

[91] See fn.2 supra. For further discussion see Lagay, F, *'Physician-assisted suicide: The Law and Professional Ethics'* (2003) 5 (1) The American Medical Journal of Ethics *<vitrtualmentor.ama-assn.org/2003/01/pfor1.html>* accessed 14 December 2012. Prior to the enactment, in 1994, of the *Death with Dignity Act* in Oregon, Texas was the only state where it had been argued successfully, albeit for a short time only, that because suicide and attempted suicide were no longer deemed to be criminal offences assistance with suicide should be similarly decriminalised. In a foretaste of the suggestion, per Lord Hoffman, *in Airedale NHS Trust v Bland [1993] AC 789, at 827,* that the removal of the taint of illegality from the act of suicide amounted to a recognition of a *de facto* right to commit the act, it was argued, persuasively, in *Grace v Stone, 60 SW 529 (Tex.Crim.App.1902), at 530,* that *"the party who furthers the means to the suicide must also be innocent of violating the law."* However, had such reasoning been adopted and followed within the totality of Texan jurisprudence both euthanasia and consensual homicide would have been deemed, logically, to be legally permissible. In the event, as demonstrated in *Aven v State, 277 SW 1080 (Tex. Crim. App.1925),* euthanasia continued to be regarded as an illegal act. The decision in *Grace* was effectively overruled by the subsequent criminalisation of assisted suicide under the Texas Penal Code.

[92] *Bracton* in his mid-thirteenth century work *'On the Laws and Customs of England'* – see Samuel E. Thorne edition, 1968 - set the course of English common law in the matter of the criminalisation of suicide. He condemned all acts of intentional self-destruction. Only suicides induced by insanity escaped punishment: *"that a madman is not liable is true."* See also *Edward Coke, Third Institute*

teachings of the early Christian church. In an evocation of the fear of a *slippery slope* St. Augustine had averred that if death was deemed to be an acceptable escape from temporal troubles suicide might come to be regarded as a permissible method of avoiding the possible risk of any future sin.[93] According to St. Thomas Aquinas, following Aristotle, it was contrary to nature and charity to damage intentionally human life which, he contended, was an immutable basic good deducible by practical reasoning.[94]

When the Fourteenth Amendment to the Constitution – encompassing as it does the doctrines of Due Process and Equal Protection - was ratified in 1868,[95] nine of the then thirty-seven states had enacted statutes which criminalised assisted suicide.[96] The prohibition against such action which was contained in the early nineteenth century *Field Code*[97] had been readily adopted by individual jurisdictions intent on legislative codification. Consequently, as statute law gradually replaced inherited precepts of the common law as the normative benchmark for the regulation and evaluation of human conduct, assisted suicide was deemed to be a criminal offence in many states.

On its face, therefore, the law in America could not be clearer. Both euthanasia - irrespective of any categorisation as voluntary, non-voluntary or involuntary – and assisted suicide, other than in those states where its provision has been legalised, are criminal offences and are punishable under general homicide laws.

54(1644); 4 William Blackstone, Commentaries on the Laws of England 189 (1769); 1 Matthew Hale, Pleas of the Crown 411 (1847).

[93] See St. Augustine, *'The City of God'*, bk.1, ch.27.

[94] *See Summa Theologiae, part 2 of the Second Part, Q.64, a.3.*

[95] The Fourteenth Amendment was added to the Constitution in the aftermath of the Civil War (1861-65). The section which refers to *Due Process* and *Equal Protection* reads: *"No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the law."* See *Fourteenth Amendment, Bill of Rights, Section 1.*

[96] Statistics provided in evidence in *State of Michigan v Kevorkian, 447 Mich.436, 527 N.W.2nd 714 (1994), at 731.*

[97] The *Field Code* was a reformist model code template which, during the nineteenth century, provided guidance to legislative codification efforts by individual states. Under the heading *'Aiding Suicide'* Article 231 of the Code stated that *"every person, who wilfully, in any manner, advises, encourages, abets or assists another person in taking his own life, is guilty of aiding suicide"*. There is distinct similarity between the language of the Field Code and that contained in the statutes prohibiting assistance with suicide in most states. Likewise, the similarity between the language of the *Field Code* and that used in the *Suicide Act of the United Kingdom* and that of *Ireland,* both enacted in *1961*, is to be noted.

A person accused of the unlawful termination of the life of another, contingent on the particular circumstances of the case, faces prosecution for either first or second degree murder.[98]

The laws in respect of both euthanasia and assisted suicide have been the subject matters of a number of commissions, inquiries and task forces, both at federal and state level, which, without exception, have recommended that the proscription of active killing should be maintained.

The *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research*,[99] albeit primarily concerned with the foregoing of life-sustaining treatment, acknowledged in its 1983 Report that a serious consequence of sustaining this prohibition could entail the prolongation of patient suffering, particularly of those who were terminally ill.

Such a consequence, however, did not justify a change in the law.[100]

In the matter of the possibility of doctors who effected an earlier than natural death of a patient being held liable under the criminal law the Commission was of the view that *"since neither wrongful shortening of life by physicians nor the failure to give appropriate medical treatment for fear of the criminal law appears to be prevalent, society seems to be well served by retaining its criminal prohibition on killing, as interpreted and applied by reasonable members of the community in the form or prosecutors, judges and jurors."* [101]

In 1985, a *Task Force* was established in the state of New York to make recommendations on public policy aspects of issues raised by medical advances.[102]In its Report, in 1994, it recommended unanimously that the existing state laws prohibiting assisted suicide and

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[98] American Model Penal Code, 210.5

[99] *'Deciding to Forgo Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions', Washington, 1983*

[100] "In the final stages of some disease, such as cancer, patients may undergo unbearable suffering that only *ends with death. Some have claimed that sometimes the only way to improve such patients' lot is to actively and intentionally end their lives. If such steps are forbidden, physicians and family might be forced to deny these patients the relief they seek and to prolong their agony pointlessly. If this were a common consequence of a policy prohibiting all active termination of human life, it should force a re-evaluation of maintain the prohibition. Rarely, however, does such suffering persist when there is adequate use of pain relieving drugs and procedures,"* at 73.

[101] Ibid.

[102] *'When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (Report of the New York State Task Force on Life and the Law,'* New York, 1994.

euthanasia should not be changed. Permitting voluntary active euthanasia and physician-assisted suicide would be an *"unwise and dangerous policy."*[103]

The *Task Force's* conclusions are epitomised in the unadorned comment that *"if assisted suicide and euthanasia are legalised, it will blunt our perception of what it means for one individual to assist another to commit suicide or to take another person's life. Over time, as the practices are incorporated into the standard arsenal of medical treatments, the sense of gravity about the practice would dissipate."*[104]

The *Task Force* was accused of proceeding from *"a fairly paternalistic stance"* and of providing *"little recognition of the interests of those individuals seeking assistance in dying from their doctors."*[105] Likewise, it was criticised on the basis that insufficient attention was given *"to the fact that many doctors are already involved in assisting the suicide of their patients and performing euthanasia."*[106] Nonetheless, it could not but be acknowledged that the Report contained *"a detailed and scholarly analysis of the issues and has thereby made a significant contribution to the debate."*[107]

Contrary to the view that little recognition was given to the interests of those seeking assistance with death the Report specifically concluded – and *"explicated their reasons for doing so in voluminous detail"*[108] - that the legalisation of assisted dying would *"pose profound risks to many patients"* and that those risks *"would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care."*[109]

The fact that the twenty-four member of the *Task Force*, representing as they did a wide variety of ethical, philosophical and religious views, was capable of arriving at a unanimous recommendation that the existing law be retained, of itself, is a matter of not inconsiderable achievement. Even those members who thought euthanasia was justified in some instances concluded that, weighing the costs and benefits, continued criminalisation would *"curtail the autonomy of patients in a very small number of cases when assisted suicide is a compelling and justifiable response, [but would] preserve the autonomy and well-being of many others. It*

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[103] *Ibid., xii-xiii.*
[104] Ibid., xii-xiv.
[105] See Ogden, R, *'The Power of Negative Thinking',* 13 Last Rights 69, 1994.
[106] Ibid.
[107] Ibid.
[108] New York state Report, xiii-x; Keown, J, *'Euthanasia, Ethics and Public Policy: An Argument against Legalisation',* Cambridge University Press, 2002 (Third printing 2005), at 187-190;
[109] Ibid., ix.

[would] also prevent the widespread abuses that would be likely to occur if assisted suicide were legalised."[110]

A Commission on Death and Dying in the state of Michigan examined the question of assisted suicide in the wake of the reported activities of Dr. Jack Kevorkian. Kevorkian sought to overturn the laws prohibiting active euthanasia and assisted suicide. He argued that not alone was there a right to receive assistance with suicide, but also that a right to be killed by another person, so long as the act was performed with the consent of the person being killed and the killer was motivated based by compassionate or mercy. The Michigan *Commission reported in 1994.*[111] While it failed to reach unanimity one of the three positions it adopted in respect of law reform options – albeit supported only by a minority of the twenty-two organisations from which the membership was drawn - did recommend that the ban on physician-assisted suicide be maintained and be made permanent.[112] The state legislature subsequently enacted a statute banning physician-assisted suicide and the courts have consistently found the practice to be in violation of the common law.[113]

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[110] Ibid, at 141.

[111] See Final Report of the Michigan Commission on Death and Dying, Michigan, 1994.

[112] The Commission comprised of representatives from medical and nursing organisations, hospice, hospital and nursing home organisations, right to life advocates, social workers, pro-euthanasia organisations, and legal representatives from the State Bar of Michigan and the Prosecuting Attorney's Association. In addition to a *Consensus Report* which made recommendations on a number of matters including improved access to palliative care and a greater focus on pain and symptom management, the Report contained three Position Reports which outlined a number of law reform options: *(a) decriminalisation and regulation of 'aid in dying', including both physician-assisted suicide and voluntary active euthanasia; (b) procedural safeguards to be established if the legislature decided to legalise physician-assisted suicide; and (c) the ban on physician-assisted suicide be maintained and made permanent.* Nine of the twenty-two members were in favour of the option of the decriminalisation and regulation of *'aid in dying'*; nine members also voted for the option of establishing safeguards for legalised physician-assisted suicide; only five members expressed support for the recommendation that the prohibition of physician-assisted suicide be maintained.

[113]Under Michigan law at the time Kevorkian began to assist patients to commit suicide providing assistance to a person intent on committing suicide was not a specific offence. The appropriate charge was that of murder. The prosecution however was unable to demonstrate conclusively that Kevorkian had activated the suicide device he employed. After legislation was introduced prohibiting assisted suicide Kevorkian was charged with participation in the deaths of other patients. In the event however he was acquitted. He was convicted of second-degree murder in 1999 after he had filmed himself administering a lethal injection to Thomas Youk who was suffering from amyothropic lateral sclerosis (Lou Gehrig's disease). In 1993 a County Circuit Court judge had ruled that the laws prohibiting assisted suicide had been improperly enacted and issued a permanent injunction against enforcement. See *Hobbins v Attorney General (Wayne Cty. Cir. Ct. Mich., 1993).* In a separate case it was found that the deemed due process interest in an individual's decision to end his/her life was impermissibly burdened by the law prohibiting assisted suicide. In *People v Kevorkian No. 93-11482 (Wayne Cty.Cir.Ct. Mich. 1993)* it was held that a person has a constitutionally protected right to commit suicide when his/her quality of life is significantly impaired by a medical condition and where the medical condition is unlikely to improve. Both these rulings were reversed by the Michigan Court of Appeals. Michigan law prohibiting assisted suicide was found not to violate the Constitution and the state was free to criminalise the provision of assistance with suicide. See *Hobbins v Attorney General 518 NW 2d 487*

3. Assisted Suicide: Efforts to Decriminalise

Since the first attempt to have assisted suicide decriminalised in Ohio in 1906, there have been numerous endeavours, either by way of voter initiative, legislative challenge or court action to have the law changed in order to facilitate physician-assisted death.[114]

(Mich.App.1994). In further appeals on specific issues in *People v Kevorkian, Hobbins v Attorney General 527 NW 2d 714 (1994*) the Michigan Supreme Court held that the decisions by the U.S. Supreme Court in the cases of *Cruzan v Director, Missouri Department of Health 111 LEd.2d 224 (1990)* and *Planned Parenthood v Casey 112 S.Ct.2791 (1992)* did not support the conclusion that any persons, including the terminally ill, have a liberty interest in suicide that is protected by the *Due Process* Clause of the *Fourteenth Amendment*. The judgment was emphatic *"those who assert such a right misapprehend the nature of the holdings in those cases."*

[114] In 1906 a bill was introduced in the state legislature of **Ohio** but it was rejected by **79** to **23** votes. See *Appel, JM, 'A Duty to Kill? A Duty to Die? Rethinking the Euthanasia Controversy of 1906',* Bulletin of the History of Medicine 78 (3): 610-34, 2004*; Emanuel, E, 'History of Euthanasia Debates in the United States and Britain',* Annals of Internal Medicine (1) 793-802, Nov. 1994. Beginning in the 1980s endeavours to have physician *'aid in dying'* legalised occurred in a number of states where citizens are allowed to introduce fully drafted legislation if a certain number of signatures on a petition, based on a percentage of the voter population, are obtained within a specified time period. The first such attempt was the **Humane and Dignified Death Act 1988** which sought, via an amendment to the **Californian Constitution**, to extend the right of privacy to include the right of the terminally ill to physician *'aid in dying'*. *'Aid in dying'* was defined as any medical procedure that would terminate the life of a qualified patient – that is, one that was fully competent - swiftly, painlessly and humanely. *'Terminal condition'* was defined under the legislation as one which, regardless of application of life-sustaining procedures, was incurable and, within reasonable medical judgement, would lead to death within six months. See *Risley, R and White,* M, *'Humane and Dignified Death Initiative for 1988'* (1986) 1 Euthanasia Rev. 226-37; *Clarke, D, 'Physician Assisted Aid in Dying: A California Proposal' (1988)* 2 Euthanasia Rev. 207; *Otlowski, M, 'Voluntary Euthanasia and the Common Law',* OUP, 1997 (reprinted 2004), at 365.The scope of the proposed legislation was potentially quite broad, permitting physician *'aid in dying'* at the request of a competent patient as well as providing a mechanism for the patient to appoint an agent to request *'aid in dying'* on his or her behalf in the event that he or she became incompetent. The endeavour was unsuccessful. A sufficient number of signatures could not be obtained within the specified time-frame to qualify the initiative for the ballot. See *Parachini, A, 'Bringing Euthanasia to the Ballot Box',* Los Angeles Times, 10 April, 1987, sec.5, at 1. A second attempt to have legislation enacted via voter initiative was made in **California** in 1992. However, having succeeded in qualifying for the ballot, the initiative, known as **Proposal 161**, was defeated by **52%** to **48%.** In 1990 the **'Death with Dignity Initiative'**, known as **Initiative 119**, collected some **223,000** signatures in support of a petition for the introduction of legislation permitting physician *'aid in dying'* in **Washington** state. The minimum number required for the referendum process was **150,001**. The initiative was defeated, **54%** to **46%**, in the referendum held on 5 November, 1991. In 2008 however **Initiative 1000** was passed, by **59%** to **41%**, making it legal for doctors to prescribe a lethal dose of medication for patients with less than six months to live. Specific conditions must be met before a person can qualify for *'aid in dying'*: the patient must make two separate requests, orally and in writing, more than two weeks apart; he or she must be of sound mind and not suffering from depression and must have their request approved by two separate doctors. Doctors are not allowed to administer the lethal dose. In 1994 the **Death with Dignity Act** was passed in the state of **Oregon** legalising the practice of physician-assisted suicide in certain circumstances. See section post on Oregon. In 1997 in ***Krischer v McIver*** the Florida Supreme Court upheld the constitutionality of Florida's law against assisted suicide. In 1999 in ***Sampson and Doe v State of Alaska*** the Alaskan Supreme Court ruled that the Alaskan Constitution's right to privacy and liberty does not allow terminally ill patients to be assisted by physicians in committing suicide. However, in the state of **Montana** physician *'aid in dying'* is deemed to be a legitimate defence to a charge of unlawful killing. This arose from a decision of the Montana Supreme Court in ***Baxter v Montana*** in 2009. See section post on Montana. In ***Final Exit Network, Inc.et al v State of Georgia, 290 Ga.508 (2012)*** it was found

In the period 1990-2012 alone, there were **91** proposals, including **4** ballot initiatives, in **25** states, to legalise assisted suicide.[115] Apart from *Oregon,* in 1994, and *Washington*, in 2008, none were successful. More recently, attempts at changing the jurisprudential landscape occurred in the states of Montana, Georgia and Massachusetts.

Before analysing the judicial reasoning adopted and followed in *Compassion in Dying v Washington*[116] and *Vacco v Quill*,[117] in which the criminal prohibition of assisted suicide in the states of Washington and New York were found to violate the *due process* and *equal protection* doctrines, respectively, of the Fourteenth Amendment, it is appropriate to review briefly the circumstances which eventuated in *Death with Dignity Acts* being enacted in Oregon and Washington, together with developments in Montana, Georgia and Massachusetts.

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that the state's statute which criminalises the activity of anyone who *"publicly advertises, offers or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose"* was a content-based restriction on speech that did not satisfy a strict level of constitutional scrutiny. The **Georgia** legislature immediately cured the constitutional defect by the insertion of a new provision in the *Official Code HB 1114 [16-5-5(b)]* which criminalises assistance with suicide but removed the previous reference to the actor's speech. Under some circumstances, however, a person who is not a health care provider may be permitted to assist in a suicide, including apparently that of a person who is not terminally ill, regardless of the person's motives. See *HB [16-5-5(c)].* There is a view that the Georgia legislature re-acted precipitately to the decision by the State's Supreme Court in ***Final Exit Network, Inc. v Georgia (2012)***. See *Vollmar, V, 'Georgia's Assisted Suicide Ban Lacks Patient Safeguards,' Jurist – Forum, 18 April, 2012, http://jurist.org/forum/2012/04/valerievollmar-assisted-suicide.php.*

[115] *Alaska (1996), Arizona (`1996, 1999, 3003, 2004, 2005, 2007, 2008), California (1992: Proposition 161 which was defeated 54% to 46%, 1995, 1999, 2005, 2006, 2007), Colorado (1995, 1996), Connecticut (1994, 1995, 1997, 2009, together with pending legislation, Proposed Bill 356, 2011), Hawaii (1997, 1998, 1999:3 attempts, 2001, 2002, 2003/04, 2005, 2006, 2007, 2009 and 2011 Bills 356, 1383 & 1165 currently pending), Illinois (1997), Iowa (2006), Louisiana (1999), Maine (1995, 1997, 1999, 2000: Question 1:Maine Death with Dignity Act, defeated 51% to 49%), Maryland (1995), Massachusetts (1995, 1997, 2009, 2011:H 2233, 2012: H3884, and the Death with Dignity proposal on general election ballot paper, November, 2012: defeated), Michigan (1992, 1994, 1995, 1997, 1998:Measure B, defeated 71% to 29%), Mississippi (1996), Montana 2009, 2011), Nebraska (1996, 1997, 1999), New Hampshire (1996, 1998, 1999, 2009, 2011), New Mexico (1995, 2009), New York (1995, 1999, 2001, 2012), Pennsylvania (2007, 2009, together with Senate Bill SB431 currently pending, 2013), Rhode Island (1995, 1998, 2002, 2006, 2007), Vermont (1995, 1997, 1999, 2003/04, 2005/06, 2007, 2009, 2011 and Bill H 274, S103, currently pending, 2103), Washington (1991: Ballot Initiative 119: Defeated 54% t0 46%, 1995, 1998, 2006, and the successful Initiative I-1000, 2008), Wisconsin (1995, 1997, 1999, 2001, 2003, 2005, 2007), Wyoming (2004).*

[116] *850 F.Supp.1454 (W.D. Wash.1994), rev'd 49 F.3d 586 (9th Cir.1995), aff'd, 79 F.3d 790 (9th.Cir reh'g denied, 85 F.3d 1440 (9th Cir.1996) rev'd sub nom. Washington v Glucksberg, 521 US 702 (1997)(Washington v Glucksberg).*

[117] *Quill v Koppell, 870 F.Supp.78 (S.D.N.Y.1994), rev'd sub nom. Quill v Vacco, 80 F.3d 716 (2d Cir.1996), rev'd Quill v Vacco, 521 US 793 (1997)(Vacco v Quill).*

(a) The Oregon Experience:

The 1994 *Oregon Death with Dignity Act,*[118] effective since 1997, allows doctors prescribe, but not administer, medications that can be used to end life, to state residents suffering from a terminal illness.[119] The Act is exclusively referable to physician-assisted suicide. It does not encompass euthanasia.[120] Life-sustaining medical practices, such as withholding or withdrawing treatment because of futility or as result of an expressly stated wish by a

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[118] *Oregon Death with Dignity Act, Oregon Revised Statute 127.800-127.897<public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>*accessed 14December 2012. The Act came into force in 1997.The law resulted from the success of *Ballot Measure 16*, the *Oregon Death with Dignity Act,* in November 1994. The genesis of the Ballot Measure lay in the assisted suicide of a woman suffering from chronic heart disease. Her husband assisted her to take her own life, but in order to protect himself legally, left her side immediately before her death. The husband, together with physicians and lawyers, drafted *Ballot Measure 16.* The margin if success was narrow – **51%** to **49%**. **627,980** voted in favour, **596,018** voted against. See *Oregon Blue Book, 'Initiative, Referendum and Recall: 1988-1995' <bluebook.stste.or.us/state/elections/elections21.htm>* See also Pratt, C.A., *'Efforts to Legalise Physician-assisted Suicide in New York, Washington and Oregon: A Contrast between Judicial and Initiative Approaches – Who Should Decide?' (1998) 77 Oregon Law Review 1027.* The implementation of the Act was delayed when, in *Lee v Oregon, 891 F.Supp 1429(D.Or.1995)* its constitutionality was challenged on the basis that it *inter alia* violated terminally ill patients' due process and equal protection rights under the 14th Amendment. The plaintiffs also argued that the Act violated their free exercise of religion and freedom of association rights under the First Amendment and their statutory rights under the Americans with *Disabilities Act, 1990*, the *Rehabilitation Act, 1973* and the *Religious Freedom and Restoration Act, 1993*. The plaintiffs obtained a permanent injunction from the US District Court of Oregon on the basis that the law lacked sufficient safeguards to prevent terminally-ill adults who are incompetent from committing suicide. The 9th Circuit Court of Appeals reversed and the injunction was lifted in October 1997. *Lee v Oregon 107 F.3d 1382 (9th Cir 1997).* Prior to this court resolution a referendum, *Ballot 51*, was ordered by the Oregon state legislature to repeal the 1994 law (*House Bill 2954-Referred to the Electorate of Oregon by the 1997 Legislature to be voted on at a special Election, November 4, 1997*). The reasons given for the referral related to the law's effectiveness and on-going concerns regarding the adequacy of safeguards including those related to counselling, residency and reporting requirements. See *State of Oregon Secretary of State, 'Voters' Pamphlet, State of Oregon Special Election, November 4, 1997 <library.stste.or.us/repositopry/2009/200912301518203/sp1997_11_4.pdf>* Notwithstanding statements in favour of repeal by the *Oregon Medical Association* and the *Oregon Association of Hospitals and Health Systems, Ballot 51* succeeded by a margin of **60%** to **40%**. See Ganzini, L, *'The Oregon Experience'* in Quill & Battin (eds) *'Physician-Assisted Dying: The case for palliative care and patient choice', John Hopkins University Press, 2004.* Opposition to the law did not cease with the passage of *Ballot 51*. Its nullification was sought under the (i) the Controlled Substances Act, 1970 and (ii) a directive from the Attorney General (the *'Ashcroft Directive'*)(*'Dispensing of Controlled Substances to Assist Suicide [Memorandum, 6 November, 2001]* which stated that assisted suicide was not a *"legitimate medical purpose"* within the meaning of the *Controlled Substances Act*. Under this Act physicians who prescribed medications that could be used to end life could be subjected to penalties including suspension and revocation of registration. The matter was resolved in *Gonzales v Oregon, 546 US 243 (2006)* where the Supreme Court upheld an injunction obtained by Oregon's Attorney General to prevent enforcement of the Ashcroft Directive.

[119] Or.rev.Stat 127.800-897, sec.2.01. The law nowhere conditions access to assisted suicide on the existence of pain of any kind, let alone pain that cannot be fully treated by readily available medicines.

[120] *Ibid at 3.14.*

patient, pain medication in doses that may have life-shortening effects and palliative sedation fall within the parameters of acceptable medical practice generally in America.[121]

The law requires that a person requesting a prescription for lethal medication: *(a) is an adult, 18 years or older; (b) is capable; (c) is a resident of Oregon;*[122] *(d) "has been determined by the attending physician and consulting physician to be suffering from a terminal disease";*[123] *(e)"has voluntarily expressed his or her wish to die"; and (f) "make[s] a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with [Oregon Revised Statutes Sections]127.800-127.897."*[124]

Once the threshold requirements are established, obtaining a prescription requires the following steps:

1. The patient must make two oral requests to his or her physician, separated by at least 15 days;[125]

2. The patient must provide a written request to his or her physician, signed in the presence of two witnesses;

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[121] These practices are governed by numerous professional regulatory protocols and statutory instruments. See, for example, *The Patient Self-Determination Act (PSDA), 1991*; *Decisions Near the End of Life (CEJA Report B-A-9, adopted June, 1991) 9-10*www.ama-assn.org/resources/doc/code-medicalethics/2211a/pdf accessed 15 December2012. The CEJA develops ethics policy for the American Medical Association (AMA). See also *Oregon Medical Board, Statement of Philosophy – Pain Management (adopted 16 April 1999); FAQs about the Death with Dignity Act (OHD, 19 November, 2010)4<public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/Death* withDignityAct/Document/faqs.pdf>accessed 15 December, 2012.

[122] There is no provision in the law to prevent an individual from moving to the State of Oregon to avail of physician-assisted suicide provided the person can demonstrate residency. Residency is determined by the provision of a driver's licence, voter registration, property lease or state tax return. See *<public.health.oregon.gov/ProviderPartnerResources/EvaluationReasearch/DeathwithDignityAct/Pages/faqs.aspx> accessed 15 December, 2012.*

[123] A "*terminal disease*" is defined as "*an incurable and irreversible disease that...will, within reasonable medical judgment, produce death within six months.*" Or.Rev.Stat.127800, sec.12. Initially, approximately **50%** of Oregon doctors acknowledged that they were not confident in their own ability to predict whether patients have more or less than six months to live. *See Lee, M, et al, 'Legalising Assisted Suicide – Views of Physicians in Oregon,* 334 New Eng. J. Med. 310 (1996). See also *Battin, et al 'Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on patients in "vulnerable" groups"',* Jour. Med. Ethics, Vol.33, No.10 (2007), at 591*;* Godlee. F, ed., 'Professionals' Opinions about Death with Dignity', BMJ, Vol.344, electronic pre-release, 4075, June 14, 2012; *Sullivan, et al, 'Legalised Physician-Assisted Suicide in Oregon, 1998-2000',* New Eng.J.Med, Vol.336, No.6 (2001), at 605*; Ganzini, L, et al, 'Oregon Physicians' Attitudes about and experiences with En-of-Life care since passage of Oregon Death with Dignity Act',* Jour.of Am.Med.Assoc., Vol. 285, No.18 (2001), at 2362.The law does not require that either the attending doctor or the consulting doctor have any special expertise

[124] Or.rev.Stat 127.805 sec 2.01.

[125] In addition, forty-eight hours must elapse between the patient's written request and the writing of the prescription. *Or.rev.Stat.127.850.* Doctors who write death inducing prescriptions in good-faith compliance with the Act's requirements are thereafter shielded from criminal, civil, and professional sanctions. Or.rev.Stat 127.855, sec.1

3. *The prescribing physician and a consulting physician must confirm the diagnosis and prognosis;*

4. *The prescribing physician and a consulting physician must determine whether the patient capable;*[126]

5. *If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination;*

6. *The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control;*

7. *The prescribing physician must request, but may not require, the patient to notify his or her next of kin of the prescription request.*[127]

The Oregon law allows the doctor to dispense the medications directly or, with the patient's written consent, the doctor may contact and inform the pharmacist of the prescription.[128] The doctor may attend the patient when the medication is taken, but is not required to do so.[129] Doctors must report all prescriptions for lethal medication to the Oregon Department

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[126] The term *'capable'* is defined to mean *"that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician or psychologist, a patient has the ability to make and communicate health care decisions to health care providers."* See Or.Rev.Stat.127.800, sec.3. The law does not require that either the attending doctor or the consulting doctor have any special expertise.

[127] 1994 Oregon Law, 127.810, 2.02. Office of Disease Prevention and Epidemiology, Oregon .Dept. Human Services, Annual Reports on Oregon's Death with Dignity Act.

[128] Or.Rev.Stat.127.815, sec.3.01. There is neither a requirement that the doctor know the patient well nor a requirement that the doctor hold a belief that the patient is in a situation of unbearable suffering. The average duration of doctor-patient relationship for physician-assisted suicide ranges from **10-18 weeks**. See Department of Human Resources, Oregon's *Death with Dignity Act, Annual Report, 2010.* The Oregon Health Division's summary report for 1998-2007, show that **3.4%** of Oregon doctors wrote all prescriptions for the **541** patients who availed of physician-assisted suicide in those years. The fact that the percentage of doctors prescribing medications that can end life is so low gives some credence to the claim that the right-to-die organisation, *Compassion and Choices*, provides assistance to patients in finding doctors who are prepared to write such prescriptions. For further discussion on this point see *Lewy, G, 'Assisted Death in Europe and America,* Oxford University Press, 2011, at 141 et seq.

[129] The doctor is not responsible for what happens after the prescription is written. However, he/she must counsel the patients about the importance of having another person present when the patient takes the medication. Or.Rev.Stat. 127,815, sec.3.01. See Office of Disease Prevention and Epidemiology, Oregon Dept. Human Services, Annual Reports on Oregon's Death with Dignity Act. The non-compulsory attendance of doctors when the patient is ingesting the prescribed medication has raised issues in respect of the responsibility for complications that may arise during ingestion. In its 2012 Annual Report the Oregon Public Health Division indicated that in 2012 there were no complications in **11** cases. However, there was a high number of **unknowns**. This may be the result of a change in the reporting questionnaire which occurred in mid-2011.The new procedure accepts information about time of death and circumstances surrounding death only when the physician or other health care provider is present at the time of death. Studies have indicated that a significant

of Health Services. Doctors are protected from criminal prosecution if they adhere to the requirements of the law. Recognising the moral issues raised by physician-assisted suicide the law places no legal obligations on doctors, pharmacists and healthcare systems to participate.[130] The law specifically states that it shall not be construed *"to authorise a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia.*[131]

The Oregon *Department of Human Services* is required to collect information regarding compliance with the Act and to make the information available annually.[132] The administrative rules provide that within seven days of writing a prescription the prescribing doctor must file a prescription report documenting compliance with the law.[133]In addition, within ten days of a patient's ingestion of the medication, the doctor must complete the prescribed *'Oregon Death with Dignity Act Attending Physician Interview'* form.[134]

Since the law was passed a total of **1,050** people have had Death with Dignity Act prescriptions written and **673** patients have died from ingesting medications prescribed under the Act.[135] Of the **77** deaths under the Act during 2012, most (**67.5%**) were aged **65** years or older; the median age was **69** years. As in previous years, most were white (**97.4%**), well-educated (**42.9%**) had at least a baccalaureate, and suffered with cancer (**75.3%**).[136]

Likewise, as in previous years, the three most frequently mentioned end-of-lifer concerns were: loss of autonomy (**93.5%**), decreasing ability to participate in activities that made life enjoyable (**92.2%**), and loss of dignity (**77.9%**).[137]

Two of the **77** patients who died during 2012 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for **7** patients (**9.1%**) during 2012 compared to **17.3%** in previous years.[138]

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number of Oregon doctors do not wish to attend when the patient takes the lethal medication. See *Lewy, G*, op.cit., fn.128 supra, at 131.

[130] Or.Rev.Stat. 127.885, sec.4.01 (4).

[131] Ibid, 127.880, sec.3.14.

[132] Ibid. 127.865, sec. 1(a).

[133] See Oregon Administrative Rule , 'Reporting Requirements of the Oregon Death with Dignity Act *<public.health.oregon.gov/ProviderPartnerResources/EvaluationReasearch/Death with/DignityAct/Pages/oars.aspx> accessed 17 December, 2012.*

[134] Oregon Department of Human Services Report, *'The Oregon Death with Dignity Act: A guidebook for Healthcare Professionals',* December, 2008, at para.14 *<www..ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignty-Act-Guidebook.pdf>*

[135] *http://public.health.oregon.gov/ProvideResearch/DeathwithDignityAct/Documents/year15.pdf 2012 Annual Report.*

[136] Ibid.

[137] Ibid.

Most (**97.4%**) died at home, and most (**97%**) were enrolled in hospice care either at the time the prescriptions was written or at the time of death. Excluding unknown cases, all had some form of health care insurance, although the number of patients who had private insurance (**51.4%**) was lower in 2012 than in previous years (**66.2%**), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (**48.6%**) compared to (**32.1%**).

As of 14th January, 2013, prescriptions for lethal medication were written for **115** people during 2012, compared to **114** during 2011. The **77** deaths under the provisions of the Act in 2012 represents **23.5** deaths per **10,000** total deaths.[139] The figures in the first report, in 1998, indicated that **24** prescriptions were written and **16** people died. There has been a steady increase in the numbers of prescriptions written and deaths under the Act.

The profile of patients who have died under the law has not changed appreciably in the fifteen years since the first report was published. The majority had a cancer diagnosis (**87%** in **1998; 75.3%** in **2012**); there is a slightly higher rate of men to women (**53% male** in **1998**, **50.6%** in **2012**); the median age was approx.**71** (**69** in **1998**, **69** in **2012**.)[140]

In 2012 ingestion status was unknown for **25** patients who were prescribed medication. **14** of these patients died, but follow-up questionnaires indication ingestion status had not been received at the time of writing.[141]

A bill, House Bill 2016,[142] seeking to impose mandatory counselling of all individual requesting a prescription for lethal medication to end their lives was placed before the Oregon State legislature in March, 2011. The bill died in committee. It was strongly opposed by supporters of physician-assisted suicide on the grounds that the bill, in their view, sought

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[138] Ibid.

[139] Rate per **10,000** deaths calculated using the total number of Oregon resident deaths in **2011** (**32,731**), the most recent year for which final death data is available.

[140] *2012 Annual Report. See fn.137 supra.*

[141] A procedure revision was made mid-year in 2010 to standardise reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for **11** of the **77** deaths during **2012**. Among those **11** patients, time from ingestion until death ranged from **10 minutes** to **3.5 hours**. *Ibid.*

[142] A Bill for an Act Relating to the Oregon Death with Dignity Act; amending ORS 127.800, 127.815, 127.825, 127.855, and 127.865.7*www.leg.state.or.us/11reg/measpdf/hb2000.dir/hb2016.intro.pdf*; House Bill 2016*http://www.compassionoforegon.org/2011/04/supporters-of-death-with-dignity-hail-failure-of-hb-2016/*.

"to create barriers to death with dignity", which were designed to burden patients with needless bureaucracy.[143]

(b) The Washington Experience:

As a result of the success of **Initiative 1000** (**I-1000**) in November, 2008, Washington State enacted its Death with Dignity Act, becoming only the second state in America to do so.[144] The Act came into force in July, 2009.

A similar initiative (**I-119**) was rejected in 1991 by a margin of **54%** to **46%. I-119**, however, would have allowed doctors to prescribe a lethal dosage of medication, and also to administer it if the terminally ill patient could not self-administer.[145] In short, **I-119** would have permitted both physician assisted suicide and euthanasia for competent adults with a terminal medical condition.[146] Initiative **I-1000** requires the patient to ingest the medication unaided.[147] Proposers of **I-119** invoked three principles, those of autonomy, the right to choose and quality of life.[148] Opponents stressed the primacy of the sanctity of life.[149]

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[143] Compassion & Choices Oregon, *'Supporters of death with dignity hail failure of House Bill 2016'* <*http://www.compassionoforegon.org/2011/04/supporters-of-death-with-dignity-hail-failure-of-hb-2016/*>

[144] *RCW70.245, "The Washington Death with Dignity Act"* <*wei.secstate.wa.gov/osos/en/Documnents/I1000-Text%20for%20web.pdf*> *accessed 12 January, 2013.* With some minor exceptions the Washington Act is a reprise of the Oregon statute. The measure was approved in the November 4, general election. **1,715,219** votes (**57.82%**) were cast in favour, **1,251,25**5 votes **(42.18%)** against. **30** of the State's **39** counties voted in favour of the initiative. *http://www.vote.wa.gov/elections/wei/Results.aspx?RaceTypeCode=M&JJurisdiction TypeID=-2&Election ID=26&ViewMode=Results; http://vote.wa.gov/Elections/WEI/ResultsByCounty.aspx?ElecyionID=26&RaceID=101369&CountyCOde=%20&JurisdictionTypeID=-2&RaceTypeCode=M&ViewMode=Results.*

[145] *http://wenatcheeworld.com/apps/pbcs.dll/article?AID=/20080714/NEWS03/971512377.*

[146] The terminal medical condition was defined as death anticipated within six months. Office of the Secretary of State, *'Complete Text of Initiative Measure 119' in Voters' Pamphlet:* State General Election (5 November 1991) (I-119).There were indications that notwithstanding the failure of **I-119** both physician-assisted suicide and euthanasia was practiced in Washington State. A 1996 survey of doctors indicated that some **12%** received one or more requests for physician-assisted suicide (**56 requests**) and **4%** received one or more requests for euthanasia (**58 requests**). The survey sample was of **1453** doctors (of whom **828** responded). See Carson & Crigger, *'Washington's 119'* (1992) 22 The Hastings Centre Report 7. **24%** of patients who requested physician-assisted suicide received prescriptions, twenty-one of whom died, and **24%** of patients who requested euthanasia received medication and died. See Back, et al, *'Physician-Assisted Suicide and Euthanasia in Washington State'* (1996) 275 (12) The Journal of the America Medical Association 919. The authors concluded that the most common patient concern at the time of the requests was non-physical. However, doctors were more inclined to grant the requests of patients who had physical symptoms.

[147] *See Ostrom, C, 'Initiative 1000 would let patients get help ending their lives'* http://seattletimes.nwsource.com/html/politics/2008193092_death21m.html.The Seattle Times, 21 September, 2008.

[148] See Jacobs, A.M., *'The Right to Die Movement in Washington: Rhetoric and the Creation of Rights'*, (1993) 36 Howard Law Journal 185. The campaign in support of **I-1000** was run by a coalition of various interests and was spearheaded by a former Washington Governor, Booth Gardner. The Chairperson of

The Washington Medical Association opposed the Initiative **I-1000** and continues to do so.[150] However, it has not made any attempt to have the Initiative repealed.

The provisions of the Death with Dignity Act are not dissimilar to those of the 1994 Oregon statute. They allow a competent adult,[151] who is resident in the state of Washington,[152] and has been determined by his or her attending doctor[153] and a consulting physician[154] to be suffering from a terminal disease,[155] having expressed a voluntary wish to die, to make a written request for medication that the qualified patient[156] must self-administer[157] to end life in a humane and dignified manner. A person does not qualify solely because of age or disability.

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the *Death with Dignity Disabilities Caucus*, Senator Darlene Fairley stated that *"as a matter of personal control and autonomy, it makes sense to let patients themselves decide what kind of medical care they want to receive and how long they want to suffer with a terminal illness."* Organisations that supported **I-1000** included aid-in-dying advocates from Oregon, the Death with Dignity National Centre, Compassion & Choices (national), Compassion & Choices of Washington, Compassion & Choices of Oregon, the American Medical Students Association, the American Medical Women's Association, The Lifelong AIDS Association, the ACLU, the National Women's Law Centre, the Washington Chapter of the National Association of Social Workers and the Washington State Public Health Association.

[149] Ibid. *The Coalition Against Assisted Suicide* opposed the measure. The *Coalition* included doctors and nurses, disability rights advocates and organisations, hospice workers, minorities, right-to-life organisations, Christian Churches and some politicians http://www.noassistsuicide.com/supporters.html.

[150] During the campaign to have **I-1000** passed the Medical Association urged voters to vote no. See *Jacobs, op.cit., fn 149 supra*. See also *Stern & DiFonzo, 'Terminal Ambiguity: Law, Ethics and Policy in the Assisted Suicide Debate'* (2007) 17 Boston University Public Interest Law Journal 99; *O'Reilly, K, '51 died under Washington's Assisted Suicide Law in 2010'*, American Medical News (28 March 2011) www.ama-assn.org/amednews/2011/03/28/prsb0328.htm.

[151] *'Adult'* means an individual who is 18 years of age or older. *Death with Dignity Act,* Sec.1: Definitions. *'Competent'* means that, *"in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communication if those persons are available."*

[152] Residency requirements include, but are not limited to: a Washington State driver's license, registration to vote in Washington State or evidence that the person owns or leases property in Washington State.

[153] *'Attending physician'* is defined as *"the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease."*

[154] *'Consulting physician'* means *"a physician who is qualified by speciality or experience to make a professional diagnosis and prognosis regarding the patient's disease."*

[155] *'Terminal disease'* is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

[156] The Act refers to the *"qualified patient"*, i.e. *"a competent, adult who is resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his/her life in a humane and dignified manner." Sec.1(11), Definitions.*

[157] *'Self-administer'* is defined as *"a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner."* It is to be noted that the Washington Act is more specific in this regard that its Oregonian counterpart. The definitions of *'qualified patient'* and *'self-administration'* enables doctors in Washington state to be clearer than their colleagues in Oregon as to which patients are qualified under the law together with a more distinct separation between the practice of physician-assisted suicide and euthanasia.

A valid request for medication must be signed and dated by the patient, and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, is acting voluntarily, and is not being coerced to sign the request.[158]

One of the witnesses must be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption; (b) a person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient; or (c) an owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

The patient's attending physician at the time the request is signed is not to be a witness.

If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses must be an individual designated by the facility and having the qualifications specified by the department of health rule.

The totality of the procedural safeguards are virtually identical to those in the Oregon Act: two oral requests, one witnessed written request, initial determination by prescribing physician of terminal illness, competency and voluntariness, confirmation by a consulting physician, possible counselling referral, waiting periods, the right to rescind and record keeping.[159]

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[158] Sec.3, Form of Written Request, *Death with Dignity Act, 2008.* To receive the requisite medication a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his/her attending physician at least **15 days** after making the initial oral request. At the time the qualified patient makes his/her second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request. A patient may rescind his/her request at any time and in any manner without regard to his or her mental state. At least **15 days** shall elapse between the patient's initial or request and the writing of the prescription. At least **48 hours** shall elapse between the date the patient signs the written request and the writing of the prescription.

[159] The attending physician makes the initial determination of whether a patient has a terminal disease, is competent, and has made the request for medication to enable him/her to die voluntarily, must request the patient demonstrate Washington state residency, and to ensure that the patient is making an informed decision, inform the patient of*: (i) his/her medical diagnosis; (ii) his/her prognosis; (iii) the potential risks associated with taking the medication to be prescribed; (iv) the probable result of taking the medication;(v)* the *feasible alternatives including, but not limited to, comfort care, and pain control; (vi) refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily; (vii) refer the patient for counselling if appropriate; (viii) recommend that the patient notify next of kin; (ix) counsel the patient about the importance of having another person present when the patient takes the medication prescribed and of not taking the medication in a public place; (x) inform the patient that he/she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the fifteen day waiting period; (xi) verify, immediately before writing the prescription that the patient is making an informed decision; (xii) fulfil the medical record documentation requirements; (xiii) ensure that all appropriate steps are carried out in accordance with the requirements of the Act*

The Department of Health is charged with the responsibility of requiring any health care provider who writes a prescription or dispenses medication under the Act to file a copy of the dispensing record and such other administratively required documentation[160] with the department no later than thirty calendar days after the writing of the prescription and dispensing the medication. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public. The Department, however, must issue an annual statistical report of the information collected.

Under *Section 19* of the Act a person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith in compliance with the statutory requirements. This includes being present when a qualified patient takes the prescribed medication. Only willing health care providers are required to participate in the provision of the medication to a patient. If a physician, or any other health care provider, is unable or unwilling to carry out a patient's request, and the patient transfers his or her care to a new provider, the first doctor or healthcare provider, must transfer, on request, a copy of the patient's relevant medical records to the new provider.

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before writing the prescription; (xiv) (a) dispense the medication directly, including ancillary medications intended to facilitate the desired effect to minimise the patient's discomfort, if the attending physician is authorised under statute and rule to dispense and has a current drug enforcement administration certificate; of (b) with the patient's consent, contact a pharmacist and inform him/her of the prescription; deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medication(s) directly either to the patient, the attending physician, or an expressly identified agent of the patient. The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death. *Sec 4: Attending Physician's Responsibilities.*

If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric pot psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counselling. Medication shall not be prescribed until the person performing the counselling determines that the patient is not suffering from any such disorder causing impaired judgment.

[160] Ibid. Sec.15, Reporting Requirements. The following forms must be filed: *(a) Written Request for Medication to End Life Form (completed by the patient); (b) Attending Physician Compliance Form (completed by the attending physician); and (c) Consulting Physician Compliance Form (completed by the consulting physician).* If a psychiatric or psychological evaluation has been conducted a *Psychiatric/Psychological Consultant Compliance Form* must be completed and be filed by the attending physician within **30** days of writing the prescription. Within **30** days of dispensing medication, the dispensing pharmacist must file a *Pharmacy Dispensing Record Form.* Likewise, within **30** days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the Act, or death from any cause, the attending physician must file an *Attending Physician After Death Reporting Form.* To receive the immunity protection provided by *RCW 70.245*, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner. Under Washington law a death certificate must be completed within **72** hours of death and filed with the local health agency where the death occurred. Local health official may hold death certificate for **30** to **60** days before filing them with the state Department of Health. As a result, the state health department may receive an *After Death Reporting Form* before the death certificate arrives.

The Washington Department of Health 2011 Death with Dignity Act Report[161] indicated that there were **103** patients to whom lethal medication was dispensed between 1st. January and 31st December, 2012 (compared to **87** patients in the comparable period in 2010). The 2011 Report also includes data received by the Department as of February 29th, 2012.[162]

Of the ***103***, **70** died after ingesting the prescribed medication, **19** died without having taken the medication, and no documentation was received in respect of the remaining **9.** It is possible that some, or all, of this latter figure are still alive, having chosen to wait to ingest the medication or not to use it. It is also possible that that some patients have taken the medication and died, but notification has not as yet been received by the Department of Health due to the fact that the After Death Reporting Form is required **30** days after death and the Death Certificate **60** days after death.

The characteristics of the **94** who died provide valuable indications of the age, sex, marital status, ethnicity, location, educational qualifications, illness, and end-of-life concerns:

- The age ranged between **41** and **101** years;
- **95%** lived in the Cascades;
- **94%** were white, Non-Hispanic;
- **46%** were married;
- **75%** had at least some college education;
- **78%** had cancer;
- **12%** had a neuro-degenerative disease, including ALS(Amyotrophic Lateral Sclerosis);
- **10%** had other illnesses, including heart and respiratory disease;
- **87%** had private, Medicare, Medicaid, or a combination of health insurance.

End-of-Life concerns included:

- Loss of autonomy, **87%**
- Loss of dignity, **79%**
- Loss of ability to participate in activities that make life enjoyable, **89%.**

Of the **70** patients who ingested the medication and dies:

- **93%** died at home;
- **83%** were enrolled in hospice care when the ingested the medication.

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[161] Washington State Department of Health, Washington State Death with Dignity Act (2011) 2 www.doh.wa.gov/dwds/forms/DWDA2011.pdf accessed 12 January, 2013.

[162] The prescriptions were written by **80** different doctors and the medication was dispensed by **46** different pharmacists.

Since the previous *Death with Dignity Report* was published, in March, 2011, the Department of Health received additional information on patients from prior years. As of February 29th 2012, **84** of the **87** patients in 2010, and **63** of the **65** patients in 2009, had died. The status of the **3** remaining 2010 and the **2** remaining in 2009 is still pending. If dead, the Department has not been so notified.

The three reports published to date by the Department of Health indicate that the matrix of end-of-life concerns has undergone some significant changes. For example, in the **2009** Report **36** patients (**82%**) listed loss of dignity as their primary concern. This increased to **43** patients (**64%**) in **2010** and by **2011** it had reached **72** (**79%**). By far the greater concern of patients appears to be inability to engage in activities which make life enjoyable. In **2009,** the relevant statistics were **40** (**91%**); **2010: 58** (**87%**) and **2011: 81** (**89%**). The figures for loss of autonomy were: **2009: 44**(**100%**); **2010: 60** (**90%**) and **2011: 79** (**87%**). The vast majority of patients list loss of autonomy, inability to engage in activities which make life enjoyable and loss of dignity as their main concerns. Concerns about inadequate pain control or the financial implications of treatment would appear to be of far less concern to patients wishing to die by lethal medication, **38%** and **4%** respectively in **2011.**

In **2011**, **5** patients were referred for psychiatric/psychological evaluation. This compares with **2** in **2010** and **3** in **2009.** The duration of the doctor/patient relationship ranged from **3 weeks** to **I year** or more. The duration between the first oral request and death ranged from **3 weeks** to **25 weeks** or more. The medications dispensed were Secobarbital: **66** (**70%**) and Pentobarbital: **28** (**30%**). There was only **one** instance where complications (regurgitation) arose. This compares to **none** in **2010** and **one** in **2009**. The time range (in minutes) between ingestion and unconsciousness was **1-120.** The time range between ingestion and death was **5 minutes** to **13 hours.**

(c) Montana

A constitutional challenge to the prohibition of Montana's physician-assisted suicide prohibition occurred in 2007.[163] Aiding or assisting suicide under the Montana Criminal Code is a criminal offence.[164] On conviction it is punishable by a maximum term of imprisonment not exceeding 10 years, a fine of $50,000, or both. If the conduct of the offender made him/her the agent of death, the offence will be criminal homicide, notwithstanding the

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[163] *Baxter v Montana No ADV-2007-787 Mon. 1st Dist. 5thDecember (2008) 1-2.*

[164] Section 45-5-105: *1.A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offence of aiding or soliciting suicide.*

consent or solicitations of the victim.[165] If death eventuates as a result of physician-assisted suicide the appropriate charge is one of homicide.[166] At Montana law, however, consent can be a defence to a criminal charge,[167] and the Supreme Court of Montana, in *Baxter v Montana*,[168] held that the consent of a terminally ill patient to physician-assisted suicide could be invoked as a defence to homicide by doctors, nurses and other health care personnel who, in fulfilment of the explicit wish of a patient to die, assist him/her with suicide.

In the District Court the plaintiffs in *Baxter* challenged the state's homicide laws in their application to physician-assisted suicide, on the grounds that provisions of the state's constitution – specifically those of equal protection, dignity and privacy – encompassed a right to assistance in dying for a competent terminally ill patient.[169] In the matter of equal protection the Court followed *Vacco v Quill*.[170] The refusal of life-sustaining treatment was dissimilar to physician assistance in hastening death by self-administering drugs.[171]

However, the Court held that *sections 10* (the right to privacy)[172] and *4* (the right to dignity)[173] of *Article II* of the Montana Constitution encompassed a *"right to die with dignity." "Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally ill patient to die with dignity."*[174]

On appeal the Montana Supreme Court upheld the decision of the District Court. However, it vacated the constitutional grounds for the finding and opted instead for a resolution within

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[165] See Montana Criminal Law Commission, Commission Comments, 2.45-5-2105.

[166] There are three categories of homicide under the *Montana Criminal Code*. Under *section 45-5-102*, a person commits the offence of deliberate homicide if the person purposely or knowingly causes the death of another person. Under *section 45-5-103*, a person commits the offence of mitigated deliberate homicide if the offender purposely or knowingly causes the death of another person but does so under the influence of extreme mental or emotional stress for which there is a reasonable explanation or excuse. Under *section 45-5-104,* a person commits the offence of negligent homicide if the person negligently causes the death of another person.

[167] Section 54-2-211(1).

[168] *2009 MT 449.*

[169] The lead plaintiff, Baxter, was terminally ill with lymphocytic leukaemia. His fellow plaintiffs were four doctors who treated terminally ill patients, and the not-for-profit *Compassion & Choices.*

[170] *Quill v Koppell, 870 F.Supp.78 (S.D.N.Y.1994), at first instance; rev'd sub nom .Quill v Vacco, 80 F.3d 716 (2d Cir.1996),in the 2nd.Circuit Ct. of Appeal; rev'd Quill v Vacco, 521 U.S.793 (1997), in the Supreme Court.*

[171] *Baxter Montana,* fn.165 supra, at 13.

[172] Sec.10: Right to Privacy – *The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.*

[173] Sec. 4: Individual dignity – *The dignity of the human being is inviolable. No person shall be denied the equal protection n of the laws. Neither the state, nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, colour, sex, culture, social origin or condition, or political or religious ideas.*

[174] *Baxter v Montana,* fn.163 supra, at 23.

statutory parameters. There was nothing in Montana Supreme Court precedent or in Montana statutes indicating that physician assistance with death was against public policy. While this appeared to fly in the face of the Montana Law Commission comment that a physician acting as the agency of death could not raise *"consent or even the solicitations of the victim as a defence to criminal culpability,"* the Supreme Court, however, found that a terminally ill patient's consent to physician assistance with death constitutes a *"statutory defence to the charge of homicide against the aiding physician when no other consent exceptions apply."*[175]

The majority opinion did not address whether consent can be a defence to a charge of homicide against a non-physician in the type of circumstances envisaged by the court. However, in a concurring opinion Justice Warner stated that the *"logic of the Court's opinion is not necessarily limited to physicians."*

Following this decision a draft bill, *LC1818*,[176] the *Montana Death with Dignity Act*, was proposed in the state legislature. The bill did not survive in committee and died in April, 2009. Had it been enacted it would have provided for physician-assisted suicide within parameters similar to those applicable in both Oregon and Washington.

In early 2011, two further bills were proposed in the Montana Senate: *SB167, Montana Death with Dignity Act* [177]– similar to *LC1818* – and *SB116, Prohibit physician-assisted suicide*,[178] whose objective was a complete ban on physician-assisted suicide. Neither proposal reached second reading stage. Both draft bills are deemed to be *"probably dead"*.[179]

(d) Vermont

In May, 2013, *Act No.39: An Act Relating to Patient Choice and Control at End of Life,* was signed into law in Vermont.

The relevant provisions are as follows:

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[175] *Baxter v Montana 2009 MT 449, at 50.*

[176] Bill LC1818*: A bill for an act entitled: "An act allowing a terminally ill patient to request medication to end the patient's life; establishing procedures; providing the right to rescind the request; providing definitions; providing immunity; and providing rulemaking authority."*

[177] Bill SB167,*"An Act allowing a terminally ill patient to request medication to end the patient's life; establishing procedures; providing the right to rescind the request; providing definitions; providing immunity for persons participating in good faith compliance with the procedures; providing rulemaking authority; and providing an immediate effective date."*

[178] Bill SB116, *"An Act prohibiting aid in dying; amending sections 45-2-211 and 50-9-205, MCA; and providing an immediate effective date."*

[179] *See Montana Legislature, 2011 Session: Detailed Bill Information (2011) http://leg.mt.gov/css/default.asp accessed 28th January, 2013.*

"A physician shall not be subject to any civil or criminal liability or professional disciplinary action if the physician prescribes to a patient with a terminal condition medication to be self-administered for the purpose of hastening the patient's death and the physician affirms by documenting in the patient's medical record [the required information]."

"A patient with a terminal condition who self-administers a lethal dose of medication shall not be considered to be a person exposed to grave physical harm...and no person shall be subject to civil or criminal liability solely for being present when a patient with a terminal condition self-administers a lethal dose of medication or for not acting to prevent the patient from self-administering a lethal dose of medication."

The eligibility requirements are that the patient be 18 years of age or older; be a resident of Vermont; be capable of making and communicating health care decisions for him/herself; have been diagnosed with a terminal illness that will lead to death within six months.

The relevant physician protocols include:

- The attending physician must be licensed in the same state as the patient;
- The physician's diagnosis must include a terminal illness, with six months or less to live;
- The diagnosis must be certified by a consulting physician, who must also certify that the patient is mentally competent to make and communicate health care decisions;
- If either physician determines that the patient's judgment is impaired, the patient must be referred for a psychological examination;
- The attending physician must inform the patient of alternatives, including palliative care, hospice and pain management options.

The first request must be made orally by the patient to his/her physician.

There is a 15 day waiting period.

The second request must be made orally to the patient's physician.

There is then a 48 hour waiting period before the prescribed medications are picked up by the patient.

The prescribed medication must be obtained from a pharmacy.

Usage of this law cannot affect the status of a patient's health or life insurance policies.

Neither physicians nor health care systems are obliged to participate.

(e) Georgia

In 2012, *Final Exit Network, Inc. v Georgia*[180] found that the state's statute which criminalises the activity of anyone who *"publicly advertises, offers or holds himself or herself out as offering that he or she will intentionally and actively another in the commission of suicide and commits any overt act to further that purpose"*, was a content-based restriction in speech that did not satisfy a strict level of constitutional scrutiny. The Georgia legislature immediately cured the constitutional defect by the insertion of a new provision in the *Official Code HB 1114 [16-5-5(b)]* which criminalises assistance with suicide. It removed the previous reference to the actor's speech. Under some circumstances, however, a person who is not a health care provider may be permitted to assist in a suicide, including apparently that of a person who is not terminally ill, irrespective of the person's motives.[181] There is a view that the Georgia legislature re-acted precipitately to the decision in *Final Exit Network, Inc. v Georgia*.[182]

(f) Massachusetts and other New England states

A proposal to legalised physician-assisted suicide in Massachusetts appeared on the ballot paper in that state in the general election of November 6th, 2012. The proposal was narrowly defeated. Proponents of the initiative – listed on the official ballot as *"Question 2"* and entitled *"An Act Relative to death with Dignity"* – pointed to the Oregon experience with legalised assisted suicide to support their claims that the Massachusetts initiative would be transparent, safe, and abuse free. Two national assisted suicide advocacy groups, Compassion & Choices (C&C) and the Death with Dignity Political Action Fund, both spin-offs of the former national Hemlock Society, were behind the measure. Their strategy, apparently, was to achieve success in Massachusetts and thereafter to concentrate on other New England states.[183] However, New England historically has been hostile territory for attempts to legalise prescribed suicide.[184] Legislatures in six New England states – Maine, New

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[180] *290 Ga.508 (2012).*

[181] See Georgia Code § 16-5-5(c).

[182] See Vollmar, V, 'Georgia's Assisted Suicide Ban Lacks Patient Safeguards', Jurist – Forum, 18 April, 2012 http://jurist.org/forum/2012/04/valerievollmar-assisted-suicide.php *accessed 28 January, 2012.*

[183] This had been the strategy adopted in the Pacific Northwest where assisted suicide is now legal in the states of *Oregon* and *Washington* and where a C&C instigated lawsuit, *Baxter v Montana*, resulted in the state Supreme Court ruling than no Montana statute or policy expressly makes doctor-assisted suicide illegal.

[184] But see Prokopetz & Lehmann, *'Redefining Physicians' Role in Assisted Dying'*, New England Journal of Medicine, July 12th, 2012, where the authors advocate that prescribed suicide should be made available to many more patients by eliminating the overriding objections physicians have to involvement in death-inducing practices. *"We propose a system that would remove the physician from*

Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut - have together rejected nearly 30 assisted-suicide bills since 1995. In 2000, a ballot initiative in Maine, similar to that which was on the ballot paper in Massachusetts in November, 2012, was defeated. Nonetheless, bills aimed at legalising assisted suicide are being considered currently in Connecticut, Vermont and New Jersey.

4. Judicial reasoning underpinning finding of unconstitutionality of prohibition of assisted suicide in states of Washington and New York

As mentioned earlier, the noted legal scholar and persistent and unapologetic opponent of the legalisation of euthanasia, Yale Kamisar, sounded a warning in 1995 that, because passive euthanasia had become a *fait accompli* physician-assisted suicide for the terminally ill, for those with an objective medical condition that significantly diminishes the quality of life, and for those whose wish to die is objectively reasonable. In such circumstances *"active voluntary euthanasia will become more thinkable, more tenable and more supportable."*[185] While he was not of the view that the U.S. Supreme Court would discover or recognise such a right he did state, rather ominously, that *"the possibility that it may can no longer be disregarded."* [186]

From the early 1990s onwards the constitutionality of state laws prohibiting assisted suicide had begun to be challenged - a fact of which Kamisar was not unaware. While the Supreme Court of Michigan ruled that the *due process* clause of the Fourteenth Amendment did not allow for a right to assisted suicide,[187] both the Supreme Court in Washington State and the Court of Appeals for the Second Circuit, which had jurisdiction over the states of New York, Connecticut and Vermont, found, in *Compassion in Dying v the State of Washington*[188] and in *Vacco v Quill,*[189]respectively, that a right to assisted suicide was immanent in the Fourteenth Amendment on the basis of Due Process and Equal Protection doctrines, respectively.

Within a relatively short time of Kamisar's expressing his stark, but nonetheless prescient views, the Chief Judge of the U.S. District Court in Seattle, Washington, Judge Rothstein, in

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direct involvement in the process...we believe that there is a compelling case for legalising assisted dying, but assisted dying need not be physician-assisted," Ibid, at 97, 99.

[185] Kamisar, Y, *'Physician-Assisted Suicide: The last Bridge to Active Voluntary Euthanasia', in Keown, J (ed), 'Euthanasia Examined: Ethical, Clinical and Legal Perspectives',* Cambridge University Press, 1995, at 244.

[186] Ibid.

[187] See fn.113 supra.

[188] *85 F.3d.1440 (9th.Cir.1996) (en banc).*

[189] *80 F.3d 716.* This case began in the United States District Court for the Southern District of New York as *Quill et al v Koppell 870 F Supp. 78 (1994).*

Compassion in Dying v Washington,[190] became the first federal judge to strike down a statute outlawing assisted suicide on Fourteenth Amendment Due Process grounds.

Virtually simultaneously, the Second Circuit Court of Appeals found, in *Quill v Vacco,*[191] that the state of New York had not fulfilled its constitutional obligation of treating alike all persons *"similarly circumstanced."* The state ban on assisted suicide was declared to be in violation of the *equal protection* doctrine. Terminally ill persons on life support systems *"are allowed to hasten their death by directing the removal of such systems,"*[192] but persons not on life support systems who are *"similarly situated...are not allowed to hasten death by self-administering prescribed drugs."*[193] The Court did add that *"a finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest."*[194] The majority concluded that to the extent that the statute prohibited a physician from assisting a mentally competent, terminally ill person to die by suicide, it was *"not rationally related to any legitimate state interest.*[195]

The decision in *Quill v Vacco,* in essence, meant that:

(a) mentally competent non-terminally ill people who were not attached to life-sustaining equipment had a right to determine the time and manner of their deaths because if they were on life *support* they would be able to do so by directing removal of such support, and

(b) mentally competent terminally ill people and *non*-terminally ill people, who were *unable* to perform the last, death-causing act themselves, and thus needed a physician to do it for them were entitled to physician-administered voluntary euthanasia because, except for the arbitrary fact that they lacked the capacity to perform the death-producing act themselves, they were *'similarly situated'* to other mentally competent person who wish to hasten their deaths and are able to perform the last act themselves.

The reasoning adopted and followed in both *Compassion in Dying v Washington* and *Quill v Vacco* is instructive and a brief review allows for the appropriate contextualisation of the

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[190] *79 F.3d 790: "[There is] 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 person to end his own life.....the state's interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention", at 816:*

[191] *80 F.3d 716.*

[192] Ibid, at 729.

[193] Ibid.

[194] Ibid.

[195] Ibid.

subsequent US Supreme Court decision in *Washington v Glucksberg*[196] which vacated both findings.

In *Compassion in Dying v Washington* Rothstein J invoked prior Supreme Court decisions to underpin a *"substantive"* component to the procedural language of the *Fourteenth Amendment.* Notwithstanding *"originalist"*[197] arguments this *"substantive"* component was held to impose a near absolute bar on certain government actions *"regardless of the fairness of the procedures used to implement them."*[198] The *"substantive"* rights adduced by the courts under the *Fourteenth Amendment,* as held in *Planned Parenthood of the State of Pennsylvania v Casey,*[199] pertained to intimate private matters such as *"marriage, procreation, contraception, family relationships, childrearing, and education."*[200]

Faced with a decision as to whether assisted suicide could be regarded as a new *"substantive"* right the judge found the reasoning in *Planned Parenthood v Casey,*[201] *"highly instructive."*[202] In that case – which re-affirmed the right to abortion found in *Roe v Wade* - the court had held that the most intimate and personal choices a person may make in a lifetime, *"choices central to personal dignity and autonomy,"*[203] were central to the liberty protected by the *Fourteenth Amendment*. *"At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."* [204]

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[196] 521 US 702 (1997).

[197] In particular, those of John Hart Ely and Robert Bork. See Ely, *'Democracy and Distrust 18', 1981*: *"[T]here is simply no avoiding the fact that the word that follows 'due' is 'process'...Familiarity breeds inattention, and we apparently need periodic reminding that 'substantive due process' is a contradiction in terms – sort of like 'green pastel redness.'"* Bork, R, *'The Tempting of America: The Political Seduction of the Law 238 (1998*): *"[Since the recognition of substantive due process] involved transforming the clause from one about due process to due substance, without any guide in constitutional text, history or structure as to what substance might be due, there was then no limitation on its meaning, natural or otherwise. The clause now 'means' anything that can attract five votes on the Court."*

[198] As held in *Daniels v Williams, 474 US 327 (1986).*

[199] *505 US 833 (1992), at 851.*

[200] *Compassion in Dying v Washington, 85 F.Supp, at 1459*

[201] *505 US 833 (1992), at 851.*

[202] Ibid.

[203] Ibid.

[204] Ibid. The passage from *Planned Parenthood v Casey*, in its entirety, reads: *"Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, childrearing and education....These matters, involving the mist intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the very heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State,"* at 851

Similarly, Judge Rothstein found the reasoning in *Cruzan v Director, Missouri Department of Health*[205] also of value in arriving at her determination. The right of a competent adult to refuse life-sustaining medical treatment raised the legitimate, and logical, question as to whether there was a difference - for purposes of finding a *Fourteenth Amendment* liberty interest - between refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final stages of life? Finding that there was no difference – on the grounds that both were *"deeply personal"* and *"at the heart of personal liberty"* - she held that the decision of a terminally ill person to end his or her life was one which was constitutionally protected.

This decision was reversed by a Ninth Circuit Court on the basis, inter alia, that any attempt to analogise seeking assisted suicide to the right to refuse medical treatment was groundless. The latter merely involved an omission or rejection of medical treatment while the former required an affirmative act to end life.[206] There was no basis in the history of American jurisprudence to justify the finding of a constitutional right to assistance with death.

However, the Ninth Circuit Appeals Court[207] re-instated the trial court decision. It held that the judge in the lower court had been correct in her analysis of autonomy based on *both Planned Parenthood v Casey* and *Cruzan v Director, Missouri, Department of Health*. Basic life decisions are constitutionally protected, and *"[l]ike the decision whether or not to have an abortion, the decision how and when to die is one of them."*[208] There was no difference *"for the purposes of finding a Fourteenth Amendment liberty interest between the refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final stages of life."* Both were at *"the heart of personal liberty."* Consequently, the Due Process Clause of the Fourteenth Amendment applied. The court did not find it necessary to address the question Equal Protection.

The court disavowed the notion that history and tradition were the sole criteria in substantive due process inquiries. If that were the case it would not have been possible for the Supreme Court in *Loving v Virginia,*[209] for example, to have declared an anti-miscegenation law unlawful given that such laws were not uncommon when the *Fourteenth*

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[205] *429 US 261 (1990).*

[206] *"When you start to assert a claim that another...should help you bring about your death, you ask for more than being left alone...You seek the right to have a second person collaborate in your death," Compassion in Dying, 49 F.3d, at 594.*, per Noonan J. While of no relevance to the substance of the decision it is interesting to note that Noonan J, as a committed Catholic, was a known opponent of pro-choice.

[207] *Quill v Vacco, 80 F.3rd 716.*

[208] Per Reinhardt J, at 813.

[209] *388 U.S. 1, 1967.*

Amendment to the Constitution was passed after the Civil War in 1868. Likewise, the court in *Lawrence v Texas*[210] had overturned a Texas law which proscribed homosexual sodomy notwithstanding the fact that it also pre-dated the enactment of the Fourteenth Amendment.[211] A similar situation pertained to the recognition of a right to abortion in *Roe v Wade*.[212] In *Eisenstadt v Baird* [213]it had been found that the laws prohibiting the sale of contraceptives to unmarried persons violated the Due Process Clause of the Fourteenth Amendment on the basis that prior cases – albeit ones which had dealt with married couples – engendered a general right to *"reproductive privacy."* While this latter finding can be been defended robustly as an *equal protection* decision, nonetheless it is of relevance to note that at the time the decision was made the sale of contraceptives to unmarried persons was illegal in many states of the Union.

In *Quill v Vacco*,[214] at first instance, the plaintiffs, led by Dr Timothy Quill,[215] challenged New York's law prohibiting intentional assistance with suicide or the promotion of suicide on the grounds that it violated the *"substantive"* component of the Fourteenth Amendment's Due Process clause. If it was found that no due process right to assisted suicide existed, the plaintiffs argued in the alternative that the equal protection clause of the Amendment rendered the prohibition unlawful.

Their claims were rejected. Reliance on the reasoning adopted and followed in *Casey* was inapt. The Supreme Court had not intended decisions in respect of procreation and abortion to *"lead automatically to the recognition of fundamental rights on different subjects."*[216] The plaintiffs had failed to demonstrate that assistance with suicide has *"any historic recognition as a legal right."*[217] In the matter of *equal protection* it was held that the distinction at New York law between a statutory right to refuse medical treatment and assistance with death

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[210] *539 US 558*

[211] The Court referred at some length to legal developments in European jurisdictions and, in arriving at its determination, did not confine itself to consideration if indigenous history only. While the majority decision did jurisprudential developments elsewhere the dissenting opinion was strongly of the view that the only relevant history was American history. See *Lawrence v Texas, 539 U.S. 558, at 598.*

[212] *410 US 113(1973).* As a matter of historical record abortion was not legal in the majority of states in 1986 but the court, notwithstanding the ready availability of contrary historical evidence of ancient, common law and contemporary legal provisions against abortion, endorsed this new right.

[213] *405 US 438 (1972).*

[214] *870 F.Supp.78 (S.D.N.Y. 1994)*

[215] Quill had written an article in the New England Journal of Medicine discussing and defending his decision to prescribe barbiturates to a cancer patient, even though she admitted she might use them at some date in the future to kill herself. See *'Death with Dignity',* 324 New Eng.J.Med.691 (1991). See also his *'The Ambiguity of Clinical Intentions',* 329 New Eng. J. Med. 1039 (1993).

[216] *870 F.Supp.78 (S.D.N.Y. 1994), at 83.*

[217] Ibid.

was based on the former *"merely allowing nature to take its course"* while the latter invoked *"intentionally using an artificial death-producing device."* [218]

Notwithstanding the contention by the state that the distinction between refusing treatment and assisting suicide was based on the fact that one was an omission and the other an affirmative act the Second Circuit court reversed the trial court's finding. The *act/omission* distinction was *"irrelevant"* because *"the cause of death in both cases is the suicide's conscious decision to put an end to this own existence."*[219]

The Court held that there was *"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 person to end his life."*[220] In consequence, physicians who were willing to do so, could prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness. The equal protection clause of the *Fourteenth Amendment,* which provides that all persons in similar circumstances are to be treated alike, applied.[221]

The judgement drew attention to the various standards of scrutiny employed by the courts to determine the constitutionality of legislation. It held that the statutes under challenge fell within the category of social welfare legislation and, therefore, were subject to *"rational basis scrutiny."*

The court analysed both case law and legislative developments in respect of the refusal of treatment. The majority observed that those who were in the final stages of terminal illness who are on life support systems were allowed to hasten their deaths by directing the removal of those systems, while those who were *"similarly situated"*, apart that is, from not being attached to life-support systems, were not allowed to hasten death by self-administering prescribed medication.

The unequal treatment which had been found did not serve any legitimate state purpose. To the extent that the challenged statutes prohibited persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed

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[218] Ibid, at 84.

[219] *Quill v Vacco, 80 F.3d 716, at 729.* In so finding, the court relied on Scalia J's concurrence in *Cruzan, 429 US 261 (1990), at 296.*

[220] Ibid, at 816

[221] In is of interest to note that the Supreme Court of Michigan, in *People v Kervorkian, Hobbins v Attorney General, 210 Mich. App. 601,534 NW 2d 172(1995)* held that because of the absence of criminal penalties for an act of suicide and the existence of a pragmatic capacity to commit suicide it could not be concluded that there was a constitutional right to do so. *See fn.115 supra.*

drugs, they lacked a *"rational basis"* and were in violation of the *equal protection* clause of the *Fourteenth Amendment*.

As with the reasoning adopted and followed by the court in the Ninth Circuit court there is nothing to indicate that the majority in the Second Circuit was motivated by anything other than a logical and rational application of existing Supreme Court jurisprudence in the matter of the identification of personal rights.

5. Washington v Glucksberg - Disavowal by the US Supreme Court of a constitutional right to assisted suicide

The findings in *Compassion in Dying v Washington* and *Vacco v Quill* were consolidated and reviewed by the U.S. Supreme Court in *Washington v Glucksberg* in 1997. The Court held that assisted suicide was not a *facially*[222]guaranteed right under either *Due Process* or *Equal Protection*.

Chief Justice Rehnquist availed himself of the opportunity to reject the notion that the *due process* clause creates a constitutional guarantee of *"self-sovereignty"* which encompasses all *"basic and intimate exercises of personal autonomy."*[223] The reliance which the District Courts and the Courts of Appeals in both Washington and New York had placed on the *"mystery-of-life"* passage in *Planned Parenthood v Casey,*[224] was wrong.

He stated: *"That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate and personal decisions are so protected, and Casey did not suggest otherwise."*[225]

The Court reserved for a later case the question whether state laws banning assisted suicide are unconstitutional *as applied*[226] to terminally ill adults seeking death.

While Chief Justice Rehnquist dismissed the existence of a *facial* constitutional right to assisted suicide he encouraged a continuation of the earnest and profound debate *"about the*

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[222] That is, one that is unconstitutional in all possible applications A facial legislative challenge is one in which the challenger must establish that no set of circumstances exist under which the particular Act in question would be valid. See *United States v Salerno, 481 US 739 (1987), at 745.*

[223] *521 U.S.702 (1997), at 721.*

[224] *505 U.S. 833 (1992), at 851. See fn.206 supra.*

[225] *521 U.S.702 (1997), at 727-28.*

[226] This relates to a situation in which the narrower question – whether particular laws are unconstitutional when applied to specific individuals? – is in issue.

morality, legality, and practicality of physician-assisted suicide."[227] That he saw fit to include the *"legality"* of physician-assisted suicide as one of the legitimate elements of any such debate is, to say the least, somewhat surprising. It could not be thought unreasonable to contend that a finding by the Supreme Court of the United States was conclusive as to the legality or otherwise of the particular matter under consideration. This, after all, had been the case when the identification of the rights to education, child-rearing and abortion were definitively in issue before the Court.

It may well be that the Chief Justice was merely reaffirming the constitutional right of Americans to debate freely and openly any matter of either personal or societal concern without hindrance from the State. However, allied to the view expressed by Justice Sandra Day O'Connor in her separate opinion that the subject of assisted suicide should be returned for on-going consideration to the *"laboratory"* of the states, together with that of her colleague, Justice Souter,[228] who implied that the outcome of the reconsideration of laws prohibiting assisted suicide which had already begun in a number of states should result in the legalisation of such assistance, at least in some circumstances, it would not be illogical to infer a desire on the part of the Court, prior to its hearing - and deciding - any future case in respect of an *as applied* challenge, to be in possession of a more definitive jurisprudential and legislative consensus nationally as to the appropriate balance between personal autonomy and the duty of the state to preserve life, particularly in the matter of the timing and manner of death.

For his part, another member of the Court, Justice Stevens, did not appear in any way reluctant to hint as to how he would cast his vote in any *as applied* challenge brought by a competent, terminally ill patient. He averred that the *"liberty interest at stake in a case like this differs from, and is stronger than, ...the common law right to refuse medical treatment"* which underpinned the finding in *Cruzan v Director, Missouri Department of Health.*[229]

The majority view of the Ninth Circuit court that the sole basis for the recognition of a new right was the personal autonomy alluded to in both *Cruzan* and *Casey* was disavowed by the Supreme Court. To qualify as a new substantive right – in other words to fall within the fundamental liberty interest of the *Fourteenth Amendment* – a new right, according to the

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[227] *521U.S.702 (1997), at 735.* Rehnquist CJ averred that "*our holding permits this debate to continue, as it should n a democratic society*" – an implicit recognition that an *as applied* constitutional challenge might succeed in the future?

[228] Justice Souter cavilled at the potential for "*legislative foot-dragging*" in the matter and warned of the possibility of curial action "*regardless of the institutional preferability of the political branches as forums for addressing constitutional claims," at 788.*

[229] Ibid at 741.

Chief Justice, would have to fulfil two criteria: it must be "*implicit in the concept of ordered liberty*" such that "*neither liberty nor justice would exist if [it] was sacrificed*" and it would have to be "*deeply rooted in this Nation's history and tradition.*" [230]

A number of his Supreme Court colleagues disagreed with the Chief Justice's finding in this matter. Justice Souter, for example, was of the view that it is impossible to subject such analysis to "*any general formula*" other than that it should be "*like any other instance of judgment dependent on common-law method*" where the arguments employed are "*more or less persuasive according to the usual canons of critical discourse.*"[231]

While the finality attaching to the findings in *Washington v Glucksberg* in the matter of *a facial* right to assisted suicide might seduce the casual observer to conclude that the reasoning employed and followed by the supreme appellate court of the United States accorded fully with that employed in previous determinations in which constitutionally guaranteed personal rights had been identified it is apparent that the Supreme Court, in striving valiantly to adhere to the specificity of the matter under review – namely, whether the Washington and New York laws prohibiting assisted suicide were facially invalid in ***all*** possible applications - laid itself open to accusations of inconsistency particularly in respect of the nature and scope of the criteria to be invoked in the establishment of any new right.

In particular, the finding that there were no historical precedents for a recognition of a right to assisted suicide would appear, as was pointed out by Reinhardt J in the Ninth Circuit Court of Appeals, to be at variance with the application of the *'historical'* criterion in previous decisions, such as *Loving v Virginia,*[232] *Cruzan v Director, Missouri Department of Health*[233] and *Planned Parenthood v Casey,*[234] and in subsequent decisions, particularly that in *Lawrence v Texas.*[235]

In the matter of a distinction between a refusal of life-sustaining medical treatment – which the Second Circuit Court refused to acknowledge - that may result in death and assisted suicide, the Supreme Court stated that this distinction was based on the "*fundamental legal principles of causation.*" A patient who refuses medical treatment and dies as a result "*dies from an underlying fatal disease or pathology.*" If, on the other hand, "*a patient ingests lethal medication prescribed by a physician he is killed by that medication.*" The distinction survived

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[230] Ibid at 721.
[231] Ibid at 769.
[232] *388 U.S.1 (1967).*
[233] *497 U.S. 261 (1990).*
[234] *505 U.S. 833 (1992).*
[235] *539 U.S. 558 (2003).*

"rational basis review,"[236] because it *"comports with fundamental legal principles of causation."*[237]

Whether the Court, conscious as it undoubtedly must have been of the inevitability that subsequent forensic juristic analysis would uncover varying applications of the same test, proceeded as it did on the basis that the finding of a right to assisted suicide was either substantively unjustifiable or merely premature or both is a moot point. The fact, however, that the Court closely tracked, and dismissed, the interpretations which the Ninth and Second Circuit Courts of Appeals had devoted to its own previous findings in respect of autonomy and personal rights, particularly the interpretation which these Courts had accorded the *'mystery-of- life'* passage in *Planned Parenthood v Casey*, is indicative of a determination not alone to contextualise and restore what it believed to be the original meaning attached to such sentiments, but also to disabuse future curial attempts at extending them beyond what the court envisaged as their normal elasticity.[238]

However, in holding that the right to refuse life-sustaining medical treatment established in *Cruzan* and a right to assisted suicide were indistinguishable, it is extremely unlikely that the majority in the Ninth Circuit Court of Appeals would have done so had it any residual doubts as to the appropriateness of calling in aid previous Supreme Court determinations to inform and guide them in their reasoning. Given both the range and the provenance of life-style personal rights which had already identified and upheld, the justices of the Ninth Circuit might well have been convinced that the invocation of such iconic case law provided an unimpeachable basis for their conclusions. While they may have recognised a future Supreme Court review of their finding as inevitable – the controversial nature of the subject matter alone, irrespective of whatever conclusion the Court came to, would have dictated such a review - it would be less than generous not to acknowledge the jurisprudential logic underpinning the *en banc* Court's finding.

6. Conclusion

As is evident from the above presentation the jurisprudential terrain in the matter of assisted suicide in the United States is less than even and the likelihood of future *as applied* challenges to state statutes prohibiting such assistance cannot be discounted. That such a challenge has not emerged in the fifteen years since *Washington v Glucksberg* was decided is a matter of some surprise. Doubtless, when such a case, or cases, do eventuate, as they are

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[236] *521 U.S.(1997), at 801.*
[237] Ibid.
[238] On this see Gorsuch, *op.cit.* fn.4 supra, Chs.4,5,& 6.

almost inevitably bound to do, they will contribute further to an already colourful, albeit not always commendable, history of that jurisdiction's approach to third party assistance with death.

In truth, the current American disposition in the matters of euthanasia and assisted suicide is emblematic of the tensile strength which exists between a rights-based federal constitution and the independence with which individual states apply particular laws.

In addition, while much attention has been devoted to the advocacy of the putative constitutional right of an individual to decide the manner and timing of his or her death - and more particularly to the alleged right of an individual to receive assistance with suicide – far less attention has been paid to the ideological entanglement of end-of-life issues with the divisive cultural conflicts in America on the question of where the boundaries between personal autonomy and public authority, and between individual freedom and the notion of a common good, lie.[239]

What jurisprudential principles, therefore, are to be extracted from the reasoning adopted and followed in the Courts of Appeal in the Second and Ninth Districts, and from that applied by the Supreme Court in *Washington v Glucksberg*, in the matter of a putative right to assistance with death?

Is it possible, as Yale Kamisar feared that the Supreme Court, at some date in the future, will recognise as legitimate an *as applied* challenge to a state law prohibiting assisted suicide?

It is difficult not to agree with his reflections on these matters.[240]

First, notwithstanding their subsequent vacation by the Supreme Court the decisions in *Compassion in Dying* v *Washington* and *Quill v Vacco* are deeply evocative of the *rights-based* philosophical and jurisprudential approach which has characterised repeated attempts to change the law in respect of the availability of assistance with suicide from the 1960s onwards, and is likely to continue to inform future endeavours in that regard.

Second, notwithstanding its inherent contradictions, together with the patently disparate reasoning evident in the separate statements by a number of the justices who sat in *Washington v Glucksberg,* it is nonetheless a robust re-affirmation of the law in respect of the constitutionality of state statutes prohibiting assisted suicide.

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[239] See Nuland, SB, *'How We Die: Reflections on Life's Final Chapter'*, New York, Knopf, 1994.

[240] See Kamisar, *'Can Glucksberg survive Lawrence? Another Look at the End of Life and Personal Autonomy',* Mich. Law Review, vol.106, No.8, June 2008.

Third, *Washington v Glucksberg* provides the currently definitive touchstone for the evaluation by lower courts of any future applications for declaratory judgments of a putative constitutional right to assisted suicide.

Fourth, *Washington v Glucksberg* affords an invaluable insight into the not always consistent invocation and application by the Supreme Court of a spectrum of criteria when identifying the constitutional status of substantive new personal rights.

Fifth, *Compassion in Dying v Washington, Quill v Vacco* and *Washington v Glucksberg* graphically demonstrate the particular difficulties which United States courts, at all levels, are confronted by when striving to achieve an appropriate balance between the recognition of individual personal rights, such as autonomy and privacy, and the duty of the state to preserve life. While it is improbable that such a balance will be achieved any time soon, the possibility that the Supreme Court could, at some future date, recognise an *as applied* constitutional challenge to a state statute banning assisted suicide, is indicative of the underlying jurisprudential uncertainty attaching to the issue of the inviolability of life in that jurisdiction.

Sixth, whether the over-ruling of *Bowers v Hardwick* [241] in *Lawrence v Texas*[242] will eventuate in a re-consideration of *Washington v Glucksberg* in any subsequent determination by the Supreme Court in matters of individual personal rights is a moot issue. In *Lawrence v Texas* the Court held *that "the State cannot demean [the] existence [of homosexuals] or control their destiny by making their private sexual conduct a crime."*[243] While *Bowers* remained good law the likelihood of the establishment of a constitutional right to physician-assisted suicide was remote. In *Lawrence v Texas* the Court not only invoked the mystery-of-life passage in *Planned Parenthood v Casey* with approval but also stated that the sweeping language of the passage *"explain[s] the respect the Constitution demands for the autonomy of the person in making choices"* such as those personal decisions *"relating to marriage, procreation....family relationships and childrearing."*[244] This is in stark contrast to the stance adopted by the Supreme Court in *Washington v Glucksberg* in its dismissal of the interpretation accorded to the same mystery-of-life passage by both the court at first instance and the Ninth Circuit Court of Appeals when they both found its exposition of *"substantive"* due process inquiries *"highly instructive."* A reconciliation of the disparate interpretations by the Supreme Court of a single passage contained in one of its previous findings would appear impossible

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[241] *478 U.S. 186 (1986).* Bowers criminalised private homosexual conduct.
[242] *539 U.S. 558 (2003)*
[243] *Lawrence, 539 U.S. 558 (2003),* at 578.
[244] Ibid., at 574.

A view that any future attempt at expanding the un-enumerated substantive rights adduced by the courts to reside in the procedural language of the *Fourteenth Amendment* to include one which would allow for assistance with suicide, and thereby recognise an effective right on the part of an individual to decide the manner and timing of his/her death, had been neutralised by the decision in *Washington v Glucksberg,* would be an overly simplistic interpretation of the Supreme Court's finding. While the majority concurred that assisted suicide, historically, has never been condoned at American law – quite the contrary, in fact – nevertheless, a number of the judges who sat in the case, as has been demonstrated above, were less than definitive as to the permanent exclusion of any possibility of unconstitutional applications of such laws. The narrower question of an *as applied* right – that is one in which a law banning assisted suicide might be considered unconstitutional when applied to a specific individual – was not addressed by the Court.

That individual members of the then U.S. Supreme Court availed themselves of the opportunity presented by its review of the affirmative findings in respect of the unconstitutionality of laws prohibiting assisted suicide in the states of Washington[245] and New York[246]respectively, to leave open the possibility that consideration to a constitutional right to assisted suicide for competent, terminally ill persons in an appropriate future case might be met with something more than expressions of sympathy is emblematic of the unremitting discord which has characterised the subject of assisted death throughout the relatively short history of the United States.

In essence, much of this discord is attributable to those endeavours which are aimed at expanding the scope of the principle of personal autonomy. Notwithstanding trenchant disavowals by those who campaign for such an expansion of intentions other than allowing for the legal provision of assisted death for those who are terminally ill, adult, competent and who voluntarily express a clear wish to opt for death, the not completely unfounded suspicion persists that the emphasis on voluntariness is nothing more than a strategic step on the way to a more ambitious goal, namely the legalisation of active voluntary euthanasia.[247]

In their judgment in the *en banc* Ninth Circuit Court of Appeals – which upheld the earlier District Court finding that the Washington state law prohibiting assisted suicide placed an

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[245] *79 F.3d 790 (9th Cir. 1995).*

[246] *80 F.3d 716 (2d Cir. 1996)*

[247] A leading advocate of assisted suicide, Richard Epstein, unapologetically admits that the specific concentration on this category of assisted dying is part of a deliberate strategy aimed at achieving, ultimately, a public consensus in favour of the legalisation of euthanasia. He is scathing as to the *"lack of courage"* displayed by fellow advocates of assisted suicide who fail to openly endorse this objective. See his *'Moral Peril: Our Inalienable Right to Health Care?'* 1999, at 340.

undue burden on the exercise of a constitutionally protected liberty interest - the justices referred, albeit obliquely, to the impossibility, in circumstances where assisted suicide became a recognised right, for future litigants to draw a *"principled distinction"* between such an assisted suicide right and a putative right to euthanasia.[248]

Whether the Court, when confronted eventually by an *as applied* challenge,[249] will continue to prefer reasoning based on historical analysis - as it did in *Washington v Glucksberg* - to the exclusion of other considerations, such as those invoked in *Lawrence v Texas*, is the subject of futile speculation.

In the meantime, assisted suicide continues to be prohibited in all states other than Oregon, Washington, Montana and Vermont. However, it is possible that by the time the Supreme Court is faced with an *as applied* challenge more states, arising from repeated and determined legislative efforts, will have been added to this list.

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[248] *79 F.3d 790 (9th Cir.1995), at 831.*

[249] That is, one in which a law banning assisted suicide might be considered unconstitutional when applied to a specific individual.

Appendix A

38 states have laws which specifically prohibit assisted suicide. They are as follows:

Alaska: Alaska Stat. §11.41.120 (a)(2).

Arizona: Ariz. Rev. Stat. §13-1103 (A)(3).

Arkansas: Ark. ode §5-10-104 (a)(2) & s. 5-10-106.

California: Cal. Penal Code §401.

Colorado: Colo. Rev. Stat. §198-3-104 (1)(b).

Connecticut: Conn. Gen. Stat. § 53(a)-56(a).

Delaware: Del. Code. Title 11, §645.

Florida: Fla. Stat. §782.08.

Georgia: Ga. Code §16-5-5(b) & (c), as amended by House Bill 1114, 2012.

Hawaii: Haw. Rev. Stat. §707-702 (1)(b).

Idaho: Idaho Code §18-4017.

Illinois: §720 Code §35-42-1-2.5.

Indiana: Ind. Code §35-42-1-2.5.

Iowa: Iowa Code §707A.2.

Kansas: Kan. Stat. §21-3406.

Kentucky: Ky. Rev. Stat. §216-302.

Louisiana: La. Rev. tat. §14.32.12

(As of August, 2012, R.S.40:1299.55 & 1299.58.10(A) – in respect of consent to medical treatment, including life-sustaining procedures - were amended to state "*nothing in this Part shall be construed to condone, authorise, or approve assistance to suicide, mercy-killing, or euthanasia*").

Maine: Me. Rev. Stat. Title 17-A, §204.

Maryland: Md. Code §3-102.

Michigan: Mich. Comp. Laws §750.329a (1) & (3).

Minnesota: Minn. Stat. §609.215.

Mississippi: Miss. Code §97-3-49.

Missouri: Mo. Rev. Stat. §565.023.

Montana: (Montana's prohibition of assistance with suicide is governed by its general homicide laws. However, *Baxter v Montana, 2009 MT 449*, pursuant to *Mont.Code Ann. § 45-2-211(2),* held that there was a defence to homicide for a physician in the context of assisted suicide resulting from the consent of the patient).

Nebraska: Neb. Rev. Stat. §28-307.

New Hampshire: N. H. Rev. Stat. §630-4.

New Jersey: N.J. Stat. §2C:11-6.

New Mexico: N.M. Stat. § 30-2-4.

New York: N.Y. Penal Law. §120.30 & §125.15.

North Dakota: N.D. Cent. Code §12.1-16-04.

Oklahoma: Okla. Stat. Title 63, §§ 3141.1–3141.8.

Pennsylvania: 18 Pa. Cons. Stat. §2505.

Rhode Island: R.I. Gen. Laws § 11-60-4.

South Carolina: S.C. Code § 16-3-1090(B), (E), (F) & (G1).

South Dakota: S.D. Codified Laws §22-16-37.

Tennessee: Tenn. Code Ann. §39-13-216(a), (e), (f) & (g).

Texas: Tex. Penal Code §22.08.

Wisconsin: Wis. Stat. §940.12.

The penal codes of the following states specify that their medical directive statutes *"shall not be construed to condone assisted suicide"*:

Alabama

Massachusetts

Nevada

North Carolina

Ohio

Utah

West Virginia.

The Virginia Code [Va. Code Ann. §8.01-622.1 (Lexus 2000)], a civil statute, provides that a person may be enjoined from assisting suicide or may be liable for monetary damages by assisting or attempting to assist in a suicide.

At the time of writing legislation in respect of assisted suicide is pending in three states:

1. Connecticut: *Proposed Bill No.356, 2011: "An Act Concerning the Penalty for Assisted Suicide."* This bill provides for a mandatory minimum prison term of 2 years for the crime of assisted suicide.

2. Hawaii: SB 803, 2011: "*A Bill for an Act Relating to Death with Dignity*." This proposed bill is accompanied by *HB 1383: "A Bill for an Act Relating to Death with Dignity*, 2011, and *HB 1165: "A Bill for an Act Relating to Compassion in Passing, 2011."*

3. Pennsylvania: *Proposed Bill, SB 431, 2011: "An Act amending Title 20 (Decedents, Estates and Fiduciaries) of the Pennsylvania Consolidated Statutes, providing for procedures regarding the request and dispensation of lethal medication to patients seeking to die in a dignified and humane manner, for duties of attending physicians, for duties of consulting physicians, for insurance or annuity policies; imposing duties on the Department of Health; providing for immunities and for attorney fees; and imposing penalties."*

In the general election of November, 2012, the *Ballot Initiative (Petition Number 11-12) – Initiative on Physician-Assisted Suicide*, was defeated.

In the period 1990-2012 there were **91** failed proposals, including **4** Ballot Initiatives, in **25** states to legalise assisted suicide, the most being in the state of Hawaii (**12**). The Ballot Initiatives were in the states of California (*Proposition 161, 1992*: *"California Death with Dignity Act" [CA-DWDA],* defeated **54%** to **46%**), Maine (*Question 1, 2000, the "Maine Death with Dignity Act"*, defeated **51%** to **49%**), Michigan (*Measure B, 1998*, defeated **71%** to **29%**) and Washington (*Ballot Initiative 119, 1991*, defeated 54% to **46%**).

In **1994** the *Death with Dignity Act* was passed in **Oregon** following a Ballot Initiative, and in **Washington**, in **2008,** its *Death with Dignity Act* was enacted following a similar Initiative (**Initiative I-1000).**

The states in which attempts, including the number of such attempts, to have assisted suicide legalised were rejected are:

Alaska (1)

Arizona (7)

California (5)

Colorado (2)

Connecticut (4)

Hawaii (12)

Illinois (1)

Iowa (1)

Louisiana (1)

Maine (3)

Maryland (1)

Massachusetts (4)

Michigan (5)

Mississippi (1)

Montana (2)

Nebraska (3)

New Hampshire (5)

New Mexico (2)

New York (4)

Pennsylvania (2)

Rhode Island (5)

Vermont (9)

Washington (3)

Wisconsin (7)

Wyoming (1).

Chapter VIII - Canada

1. Introduction

While a jurisprudentially clinical appraisal of the formal law in Canada in the matters of euthanasia and assisted suicide is capable of summary conclusion - both are offences under the Criminal Code[1] – the debate as to the consistency of specific criminal law provisions, most especially section 241(b) which prohibits assistance with suicide, with the Canadian *Charter of Rights and Freedoms,* has been revivified by the recent finding in *Carter v Canada.*[2] Section 241(b) was struck down on the grounds that it infringed ss.7[3] and 15[4] of the Charter and as a consequence, was unconstitutional.

In summary, Smith J held that the impugned provisions unjustifiably infringed the plaintiffs' rights and freedoms. They were, therefore, of no force and effect, to the extent that they prevent physicians from providing assisted suicide, and voluntary euthanasia, to certain classes of patients. The ruling pertained specifically to cases of physician-assisted suicide or homicide.

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[1] Assisted suicide, voluntary, non-voluntary and involuntary euthanasia are criminal offences: *Criminal Code, ss. 241, 229. Section 229* provides that culpable homicide is murder (a) where the person who causes the death of a human being (i) means to cause his death, or (ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not: (b) where a person, meaning to cause death to a human being or meaning to case him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or (c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being. The defence of *'necessity'* is not available: *R v Latimer [2001] 1 S.C.R.3.* When Canada enacted its first comprehensive code in 1892 (*Criminal Code, S.C. 1892, c.29*), the offences of assisting suicide and attempting suicide were codified as *ss. 237 and 238.* These two provisions remained substantially the same, aside from renumbering, until 1954 when the Criminal Code underwent a general overhaul. At that time the maximum penalty for assisting suicide was reduced from life imprisonment to 14 years. Attempted suicide was converted to a summary conviction offence with a maximum penalty of six months imprisonment. The most significant change to the suicide provisions occurred in 1972 when Parliament passed *Bill C-2,* an omnibus criminal law amendment instrument. It abolished the offence of attempted suicide. The only other change of any substance saw *"counsels and procures"* in *s. 241(a)* amended to *"counsels"* in 1985. *Section 241* of the *Criminal Code* has remained unaltered since that time.

[2] *Carter v Canada (Attorney General), 2012 BCSC 886.*

[3] *Section 7* provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[4] *Section 15(1)* provides that every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

In effect, it was concluded that the law should allow physician-assisted suicide in cases involving patients who are diagnosed with a serious illness or disability and who are experiencing *"intolerable"* physical or psychological suffering with no chance of improvement.

Likewise, it was held that a remedy to protect the vulnerable from the loss of their *section 7* right to life, liberty and security of the person could be made available by way of the imposition of legal restrictions in a regime which permits of physician-assisted suicide.

The implementation of the Court's order was delayed for a year in order to allow Parliament sufficient time to amend the Criminal Code. Nonetheless, one of the plaintiffs, Gloria Taylor, who was suffering from amyotrophic lateral sclerosis (ALS of Lou Gehrig's disease), was granted a constitutional exception so that her wish to be assisted in death by a physician could be facilitated. However, Gloria Taylor died naturally in October, 2012.

The *Carter* decision was appealed by the federal government to the British Columbia Court of Appeal. A suspension of all aspects of the ruling, including the exemption granted to Taylor, was sought until the judgement was afforded a full hearing by the Court of Appeal. The appeal was grounded in the claim that *s. 241(b)* of the Criminal Code was constitutionally valid, and that the laws surrounding euthanasia and assisted suicide *"exist to protect all Canadians, including those who are most vulnerable, such as people who are sick or elderly or people with disabilities."*

While the substantive findings in *Carter* remain to be heard the Court of Appeal dismissed the government's request that Taylor's exemption be suspended pending a full hearing of the case. Justice Jo-Ann Prowse held that removing Taylor's exemption would cause her irreparable harm, something which would outweigh the interests of the federal government. She accepted that the exemption had important symbolic, and perhaps psychological, value which extended beyond Ms. Taylor to those who were similarly situated, whether or not they agreed with the decision under appeal. *"She may be a symbol, but she is also a person and I do not find that it is necessary for the individual to be sacrificed to a concept of the 'greater good', which may, or may not, be fully informed."*

In the event that the decision in *Carter* is upheld by the Court of Appeal the likelihood is that the matter will come before the Supreme Court of Canada for final determination. An affirmation of its findings in that forum would mean that both physician-assisted suicide and voluntary euthanasia were judicially-endorsed methods of third party assistance with death in that jurisdiction. In that event also, Parliament would be required to amend the current

law which has been unequivocally disposed otherwise since aiding suicide was enshrined as an offence in the first *Criminal Code*.[5]

Prior to the decision in *Carter v Canada* the *locus classicus* in the matter of the constitutionality of the proscription of physician-assisted suicide was *Rodriguez v British Columbia*[6] in which the Supreme Court of Canada had held that *s.241(b)* of the *Criminal Code* did not infringe the appellant's rights under ss. 7[7] or 12[8] of the Charter and, although her right to security of the person was engaged, any resulting deprivation was not contrary to the principles of fundamental justice. The Court concluded similarly with respect to any liberty interest which might have been involved.

In the interim between the decision in *Rodriguez* and that in *Carter* the Court of Appeal in Ontario, in *Wakeford v Canada*[9], declined to reconsider *Rodriguez*. The plaintiff in that case had sought a declaration that the assisted suicide prohibition in the Criminal Code unjustifiably discriminated against him contrary to *section 15*[10] of the Charter. The Ontario Court of Appeal endorsed the decision of the application judge, who had held that the claim failed to disclose a reasonable cause of action because the matter had been fully settled in *Rodriguez,* and there was no indication from the Supreme Court of Canada that the matter was open for reconsideration.[11]

The Supreme Court of Canada has referred to *Rodriguez* with approval, on a number of occasions, most notably in *Canada (Attorney General) v PHS Community Services Society,*[12] *A.C. v Manitoba (Director of Child and Family Services)*[13] *and R. v Caine.*[14]

It was not doubted in *Carter v Canada* that, pursuant to the long-established principles of *stare decisis,*[15] a decision of the Supreme Court of Canada was binding, as were decisions of

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[5] Criminal Code, S.C. 1892, c.29, s.237. Traditionally, the common law in Canada recognised that aiding suicide was criminal.

[6] *[1993] 3 SCR 519.*

[7] See fn.3 supra.

[8] Section 12 provides that everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

[9] *(2001) 81 C.R.R. (2d) 342 (Ont. Sup.Ct.), upheld (2002, 58 O.R. (3d) 65 (C.A.), leave to appeal to SCC refused, [2002] S.C.C.A. No. 72 [Wakeford].*

[10] *See fn.4 supra.*

[11] The application judge, Swinton J, stated: "*It is true that the Supreme Court of Canada has the power to overrule its past decisions. However, a lower court could not be quick to assume that it will do so, given the importance of the principle of stare decisis in our legal system. In my view, on a motion such as this, where there is a decision of the Supreme Court squarely on point, there must be some indication – either in the facts pleaded or in the decisions of the Supreme Court – that the prior decision may be open for reconsideration.*"

[12] *2011 SCC 44.*

[13] *2009 SCC 30*

[14] *2003 SCC 74.*

the Court of Appeal for British Columbia. Both of these courts had upheld the constitutionality of s. 241(b) of the Criminal Code in *Rodriguez.* The defendants in *Carter* - the state of Canada and the province of British Columbia – had submitted that *Rodriguez* was binding because the facts pertaining to one of the plaintiffs, Gloria Taylor, were virtually identical to those in *Rodriguez,* and the Charter provisions upon which the plaintiffs relied were the same as those raised in the earlier case. On these grounds alone it was submitted that it was not open to the Supreme Court of British Columbia to do anything other than dismiss the plaintiff's claim.[16]

While Smith J in *Carter* accepted that the rationales[17] for the doctrine were clear she nonetheless averred that respect for the law would diminish if it failed to adapt and change in response to changed circumstances and noted that the Supreme Court of Canada itself had overruled its own previous decisions on some occasions.

Despite an acknowledgment that the *"adjudicative facts"* with respect to one of the plaintiffs, Gloria Taylor, were very similar to those established with regard to the plaintiff in *Rodriguez* - both women, diagnosed with ALS, wished to end their own lives at the time of their choosing, with the assistance of a doctor – nonetheless it was found that the evidence as to what was referred to as *"the legislative and social facts"*[18] in *Carter* was different from that in *Rodriguez.*

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[15] The common law doctrine of *stare decisis* requires that cases involving materially the same facts and invoking the same legal principles be decided similarly. Granger J reviewed the doctrine in *Holmes v Jarrett (1993), 68 O.R. (3d) 667 (Ont. Ct. J. (Gen. Div.)), at 673* thus: *"The phrase stare decisis is an abbreviation of the Latin phrase stare decisis et non quieta movere [which] may be translated as 'to [stand] by decisions and not to disturb settled matters'. The 'rule' as it is often described, has been commonly understood in modern terms to mean that every court is bound to follow any case decided by a court above it in the hierarchy. However, as the entire phrase itself suggests, the doctrine of stare decisis also requires that cases be decided the same way when their material facts are the same."* See *Glanville Williams, 'Learning the Law', 9th ed., London: Stevens, 1973.*

[16] The defendants cited cases such as *R. v Arcand, 2010 ACA 363, at para. 184*; *R v Bernard, [1988] 2 S.C.R. 833, at para. 28* and *R v Chaulk, [1990] 3 S.C.R. 1303, at 1352-53,* in support of their proposition that a higher court's decision is binding, even if the lower court is of the view that the precedent is clearly wrong or based on some reasoning or precedent that has become questionable in the interim, and even if the lower court thinks that the general trend of a higher court's views is now to the contrary.

[17] The need for consistency, predictability and certainty in the law, and promoting respect for the law.

[18] *At para 942.* It was stated *at para 943* that a comparison between the legislative and social fact evidence in the case before her and that in *Rodriguez* was possible because the Attorney General for British Columbia had placed before the Court the entire record that had been before the Supreme Court of Canada in the prior case. This record included *"law review, medical journal and other articles and book chapters regarding the legal and ethical position with respect to assisted suicide; descriptions and evaluations of the experience in the Netherlands prior to legislation; statistical information regarding suicide in Canada; historical information bearing on the moral and legal prohibitions against suicide; information about palliative care, including specific palliative care options for patients with ALS; reports of the British Columbia Royal Commission on Health Care, the Law Reform Commission of*

On that, and other grounds, a constitutional exemption was granted to one of the plaintiffs, Gloria Taylor, in order to facilitate her choice of a physician-assisted death. This decision was upheld by the Appeal Court

To achieve some understanding of how, in the relatively short period of nineteen years, the issue of the constitutional compatibility of a particular provision of the Canadian Criminal Code with the rights and freedoms recognised by the *Charter* could result in such radically disparate findings it is necessary to subject the judicial reasoning adopted and followed in both *Rodriguez* and *Carter* to forensic dissection and examination.

Notwithstanding the majority decision in *Rodriguez* that *s.241(b)* did not deprive the appellant of her right to life, liberty and security of the person, or did not restrict her freedom of choice, or affect her ability to make fundamental decisions about her life, particular attention to the dissenting judgements in both the Appeal and the Supreme Courts of British Columbia in the case is required in order to establish whether, as distinct from it being portrayed as something of a sudden seismic jurisprudential shift, the decision to strike down *s.241(b)* in *Carter*, based on prior expressions of judicial disaffection with the application of legal prohibition of assisted suicide, may have been predictable.

The current Chief Justice of Canada, McLachlin CJ, was one of the members of the Supreme Court of Canada who, along with the then Chief Justice, Lamer CJ and two others, Cory and Hereux-Dube JJ, dissented from the majority opinion in *Rodriguez.* She is the only remaining member of the Court to have heard that case. Given that her term as Chief Justice does not end until 2017 the likelihood is that she will preside over any appeal for a review of the decision in *Carter v Canada* that comes before the Supreme Court. In that event it will be of interest to observe whether she concurs with the findings of Smith J in the Supreme Court *of British Columbia* that the evidence as to "*the legislative and social facts*" in *Carter* differed from that which was adduced in *Rodriguez.*

While not germane to an analysis of Canadian jurisprudence in the matter of euthanasia and assisted suicide, and of the judicial reasoning in both *Rodriguez* and *Carter*, it is of interest to note briefly that the history of third party assistance with death in that jurisdiction, although not exactly a mirror image of that of its proximate neighbour on the North American continent, does contain, from the late nineteenth century onwards, vestigial characteristics of a nation determined to ensure continued biological purity.

Canada and the British Medical Association on Euthanasia; an expert report from a medical ethicist; Gallup Survey evidence regarding Canadian public opinion with respect to euthanasia; surveys of laws in other jurisdictions; and information about the positions taken by medical associations."

While not appearing to have been affected to the same extent by either social Darwinism or the eugenic tenets of Francis Galton in its approach to assisted dying nonetheless a number of Canadian provinces, most notably Alberta and British Columbia, did embrace compulsory sterilisation for mentally impaired persons.

The social philosophy which advocated the improvement of human hereditary traits through various forms of state intervention was not as universally embraced as it had been in the Unites States of America in the period from 1859, when Darwin's *Origin of Species* was first published, until 1942, when reports of the atrocities committed against institutionalised mentally ill patients by the Nazi regime in Germany resulted in a perceptible attitudinal realignment from biological criteria to a rights-based orientation on the part of both policy formulators and those who argued for the legalisation of assistance with death.

However, it is indisputable that in the latter years of the nineteenth century and the first half of the twentieth a sizeable portion of Canadian society desired its own *"master race".*[19] This was exemplified in the harsh rhetoric of those who publicly advocated eugenic policies as a means of averting the danger of *"national degeneration."*[20]

In 1929 the province of Alberta enacted the *Sexual Sterilisation Act* which, according to McWhirter, was reminiscent of the sterilisation laws of National Socialist Germany, in that it reflected *"legalised biases towards certain medical syndromes which ...seem to qualify for sexual sterilisation."*[21] British Columbia enacted a similar sexual sterilisation law in 1933 and in McLaren's view the sterilisation debate in British Columbia *"reveals that in fact eugenically based racial concerns were all-pervasive in inter-war Canadian society and the most extreme policies tended to be advanced, not by conservatives, but by progressives and medical scientists."*[22]

As late as 1937 the Eugenics Society of Canada, citing *"developments in Nazi Germany as worthy of emulation,"* lobbied the Ontario government to introduce amending medical legislation which would allow for particular procedures to ensure the *"purification"* of Canada.

Such views were not new. In 1908 the *League for the Care and Protection of Feeble-Minded Persons* was established in the province of Nova Scotia and those who espoused eugenics,

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[19] See Dr.Alexander Peter Reid, quoted in McLaren, A, *'Our Own Master race: Eugenics in Canada, 1885-1945',* Don Mills, Ontario, Oxford University Press, 1990.
[20] *Ibid.*
[21] McWhirter, K.G , *'The Alberta Sterilisation Act: A Genetic Critique',* The University of Toronto Law Journal, 19.3 (1969), 424-431.
[22] McLaren, *op.cit., fn.19 supra.*

including leading academics, such as E.W.McBribe, a professor at McGill University, were unapologetic in their contention that what were referred to as "*mental defectives*" were a "*mutation created in the slums*", who, in an earlier age, "*would have perished.*" "*But nowadays, with the growth of ....unthinking sentimentality, strenuous efforts are being made not only to keep their offspring alive but to allow them to breed at the expense of the more competent members of the community.*"[23]

2. The Law in Canada in respect of *Euthanasia and Assisted Suicide*

Section 14 *of the Canadian Criminal Code* provides that no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.[24]

The 1995 Report of the Special Committee of the Senate of Canada, entitled *Of Life and Death*[25], defined euthanasia as:

"*the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering where that act is the cause of death.*"

Section 241 states that everyone who

> *(a) counsels*[26] *a person to commit suicide, or*

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[23] Ibid. The eugenicist Francis Galton had reasoned that in protecting the weak and the underprivileged society was at odds with the '*natural selection*' responsible for their extinction. Only by changing such social policies, he argued, could society as a whole be rescued from a "*reversion towards mediocrity*" or the "*regression towards the mean*". In his *Hereditary Genius*, published in 1869, he concluded that since artificial selection could be used to exaggerate traits in other animals similar results could be achieved when this process was applied to humans.

[24] *Section 222* of the *Code* defines homicide, and states that *(1) a person commits homicide when, directly, or indirectly, by any means, he causes the death of a human being; (2) homicide is culpable or not culpable; (3) homicide that is not is not an offence; (4) culpable homicide is murder of manslaughter or infanticide; (5) a person commits culpable homicide when he causes the death of a human being; (a) by means of an unlawful act; (b) by criminal negligence; (c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death; or (d) by wilfully frightening that human being, in the case of a child or sick person. (6) Notwithstanding anything in this section, a person does not commit homicide within the meaning of this Act by reason only that he causes death of a human being by procuring, by false evidence, the conviction and death of that human being by sentence of the law.*

[25] Available at <*http://www.parl.gsa.ca/content/SEN/Committee/351/euth/rep/led-tc-e.htm*>

[26] Section 22(3) defines "*counsel*" to include "*procure*".
Other relevant sections of the *Code* include:
S.21(1)(b) renders a person who does or omits to do anything for purposes of aiding any person to commit an offence, a party to the offence.
S.21(2) *renders persons acting with a common intention to carry out an unlawful purpose and to assist each other in carrying out that purpose, parties to any offence is they knew or ought to have known that the commission of the offence would be probable consequence of carrying out the common purpose.*

(b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

3. The Doctrine of Informed Consent in Canadian Law

Canadian jurisprudence accords primacy to the doctrine of informed consent within the totality of its approach to medical care. No medical procedure may be undertaken without a patient's consent. Information sufficient to enable the patient to evaluate the risks and benefits of a proposed treatment, and other available options, must be provided.

Writing for the Court in *Malette v Shulman*[27] Justice Robins explained that the right of self-determination which underlies the doctrine of informed consent *"also obviously encompasses the right to refuse medical treatment."*[28]

In *Fleming v Reid*[29] the Public Trustee, on behalf of two mentally incompetent patients who were involuntarily detained in a psychiatric facility, sued to enforce their right to refuse the administration of certain neuroleptic drugs their treating psychiatrist considered beneficial to their mental conditions. When they were competent, the patients had expressed their wish

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S.22(1) *provides that where a person counsels another person to be a party to an offence and that other person is otherwise a party to that offence, the person who counselled is also a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.*

[27] *(1990) 72 O.R. (2d) 417, 67 DLR (eth) 321 (Ont.CC) 61, 62,65.*

[28] *Ibid at 328. "A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even of the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment." Malette* arose when a physician, aware that his severely injured and unconscious patient was carrying a card identifying herself as a Jehovah's Witness and requesting that she not be given a blood transfusion under any circumstances, nevertheless administered a blood transfusion to save her life. The Court concluded that the effect of the plaintiff's card was to restrict the treatment which could be provided to her, and that the physician's administration of the transfusion therefore constituted a battery. The Court stated: *"At issue is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults...are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based", at 336.* Likewise, *"the patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to reserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others", Ibid.*

[29] *(1991) 4 O.R. (3d) 74 (Ont.C.A.) [Fleming].*

not to receive those drugs which could have significant and unpredictable side effects. *Malette was followed*[30].

The provisions of the Ontario Mental Health Act, R.S.O. 1980, c.262, granting a physician the authority to override the competent wishes of a patient (when it was deemed in the patient's "*best interests*" to do so) were found to be an unjustifiable infringement of the security of the person guaranteed in section 7 of the Charter of Rights and Freedoms.

The principle of patient autonomy was brought into sharp focus in *Nancy B. v Hotel Dieu de Quebec,*[31] where the request was for a previously-initiated treatment to be withdrawn.[32]

The Court held that *"[t]he logical corollary of [the] doctrine of informed consent is that the patient generally has the right not to consent, that is the right to refuse treatment and to ask that it cease where it has already been begun"*[33] When the question as to whether this right was limited by the criminal law arose it was concluded that the Criminal Code, specifically, ss.45, 216, 217 *and* 219, did not impede the withdrawal of the treatment keeping the plaintiff alive. An individual who terminated *Nancy B's* respiratory support was *"letting nature take its course",* and was not in any way offending the criminal law. Consequently, an order permitting the plaintiff's physician to terminate respiratory support upon her request was granted

In *Rodriguez v British Columbia (Attorney General)*[34] the Supreme Court of Canada confirmed that patients have the right to refuse or discontinue treatment and cited both the *Malette v Shulman* and *Nancy B* decisions.[35]

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[30] *"The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment,"* per Robins J.A., at 85-86.

[31] *(1992) 86 D.L.R. (4th) 385 (Que.S.C.) [Nancy B].*

[32] The 25-year old plaintiff was afflicted with *Guillain Barre Syndrome*, an irreversible neurological disorder which in her case had led to total and permanent paralysis, and to complete dependence on mechanical respiration. She sought an injunction requiring the hospital to withdraw the respiratory support upon her request. The plaintiff was pronounced mentally competent by the hospital's psychiatrist and it was accepted that her request was freely given and informed. The core issue confronting the court was summarised by the presiding judge, Dufour J: *"What Nancy B is seeking, relying on the principle of personal autonomy and her right of self-determination, is that the respiratory support treatment being given her cease so that nature may take its course; that she be freed from slavery to a machine as her life depends upon it. In order to do this, as she is unable to do it herself, she needs the help of a third person. Then, it is the disease which will take its natural course",* at 392.

[33] Ibid at 390.

[34] *[1993] 3 SCR 519.*

[35] *"Canadian courts have recognised a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued. This right*

In *A.C. v Manitoba (Director of Child and Family Services),*[36] the Court re-affirmed these common law principles regarding informed consent,[37] and in *Ciarlariello v Schacter*[38] the foundational importance of individual autonomy and self-determination in common law principles was upheld.[39]

However, notwithstanding repeated judicial affirmations of these common law principles the fact remains that many patients are not competent to make medical decisions in their own regard. In order to provide for such situations most Canadian provinces and territories have enacted legislation in respect of advance directives.[40] Where there is no such legislation the common law continues to govern.[41] An individual's known preferences regarding future treatment will prevail in the event that he or she later becomes incompetent.[42]

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has been specifically recognised to exist even if the withdrawal from or refusal of treatment may result in death," Ibid, at 598.

[36] *2009 SCC 30 [A.C.].*

[37] Arbella J, for the majority, stated: *"The legal environment for adults making medical treatment decisions is important because it demonstrates the tenacious relevance in our legal system of the principle that competent adults are, -and should be – free to make decisions about their bodily integrity. At common law, adults are presumptively entitled to direct the course of their own medical treatment and generally must give their 'informed consent' before treatment occurs, although this presumption of capacity can be rebutted by evidence to the contrary. (See Lucinda Ferguson, 'The End of and Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions', paper prepared for the Law Commission of Canada, October 29, 2004, at 5). When competency is not in question, this right "to decide one's own fate" - Re T (adult:refusal of medical treatment) [1992] 4 All ER 649 (CA), at 661 – includes the unqualified right to refuse life-saving medical treatment,"* Ibid, at paras 39-40.

[38] *[1993] 2 S.C.R. 119.*

[39] *"It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient",* Ibid. at 135.

[40] In British Columbia, the province in which the decisions in both *Rodriguez* and *Carter* were made, the appropriate legislative instrument is the *Representative Agreement Act, R.S.B.C. 1996, c.405, ss.2&7.* Where an individual does not have a representation agreement, the *Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c.181, s.11* allows a health care provider to administer treatment with the consent of a personal guardian or representative. *Section 16 (1)* prescribes a list of third parties from whom a health care provider may obtain *"substitute"* consent.

[41] *Carter v Canada [2012] BCSC 886, at para. 222.*

[42] See *Malette (1990) 72 O.R. (2d) 417; Fleming (1991) 4 O.R. (3d) 74 (Ont. CA).* In circumstances where a patient is incompetent and his or her treatment preferences are unknown, both at common law and under applicable statutory regimes, medical decisions will be made in the patients *"best interests"*. See *Conway v Jacques (2002) 214 DLR (4th) 67 (Ont.CA).* In some instances this may allow the withdrawal of life-sustaining treatment from an incompetent patient. In *Rodriguez, at 598-99,* the majority referred with seeming approval to the decision by the House of Lords in *Airedale NHS Trust v Bland [1993] AC 789, 2 ELR 316,*where such a procedure was approved.

4. Relevant Case Law in respect of euthanasia

There have been prosecutions in Canada for acts of euthanasia, the most controversial of which occurred when Robert Latimer was charged with the first-degree murder of his 12 year-old daughter who suffered from a severe form of cerebral palsy.[43] Latimer had placed his daughter in the family utility vehicle and piped exhaust fumes into the sealed passenger compartment. On arrest he informed the police that his priority was to put his daughter out of her pain.

After a trial by jury Latimer was convicted of second-degree murder and sentenced to life imprisonment with no possibility of parole for ten years. His appeal to the Saskatchewan Court of Appeal was dismissed. In early 1996, however, the Supreme Court of Canada agreed to hear a further appeal and in February, 1997, a new trial was ordered arising from allegations of jury tampering. Latimer was again found guilty of second-degree murder. At the sentencing hearing his lawyer submitted that he should be grated a *"constitutional exemption"*, or, in the alternative, the judge should find the mandatory minimum sentence of ten years to be *"cruel and unusual punishment"* due to the circumstances of the case. The mandatory sentence, it was argued, would be a violation of the defendant's rights under the *Charter of Rights and Freedoms*. The sentencing judge found that a ten year sentence would be *"grossly disproportionate"* to the offence and sentenced Mr Latimer instead to two years less a day, half of which was to be served in a provincial jail and half on his farm.[44]

Latimer was released on day parole in March, 2008 and was granted full parole in December, 2010.

In 1997, in Halifax, Dr Nancy Morrison was charged with the first-degree murder of a terminally-ill cancer patient. The patient had cancer of the oesophagus. When all treatment methods proved to be unsuccessful it was agreement was reached between the patient's family and Dr Morrison that active life support would be disconnected. When ventilation

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[43] She could not walk, talk or feed herself. Evidence was adduced that she suffered considerable pain as a result of her condition.

[44] In 2001, the Supreme Court ruled that Latimer's crime could not be justified through the defence of *'necessity'* and found that, despite the special circumstances of the case, the lengthy prison sentence imposed was not cruel and unusual, and therefore did not breach *s.12* of the *Charter.* The Court also ruled that Latimer was not denied rights to jury nullification, as no such rights exist. His sentence was upheld. The Court did note that *s.749* of the *Criminal Code* provides for the royal prerogative of mercy. However, this was a matter for the executive, not the courts, to consider. A 1999 opinion poll had found that 75% of Canadians believed that Latimer acted out of compassion and should receive a more lenient sentence. The same poll found that 41% believed that *'mercy killing'* should be legal. See *'Three quarters (73%) of Canadians believe Robert Latimer ended his daughter's life out of compassion',* IPSOS News Centre, 10 January, 1999.

ceased the patient continued to suffer significant pain and distress, notwithstanding increased doses of analgesic drugs. Dr Morrison unilaterally decided to administer nitro-glycerine and potassium chloride, neither of which have any therapeutic value. The patient died instantly. However, Dr Morrison was not sent for trial.[45]

Prosecutions for the offence of assisting a suicide were taken in both British Columbia and Quebec in 2004. A British Columbia court acquitted a 73-year old woman of aiding and abetting in the suicide of two others in 2002. The defendant, and active member of the *Right to Die Society of Canada* had sent literature outlining various methods of suicide to the two women and had admitted that she had been with them when they died.

In Quebec Marielle Houle was charged with aiding and abetting the suicide of her son, aged thirty-six. She pleaded guilty to the offence and was sentenced to three years' probation with conditions. Her lawyer had submitted that a one year conditional sentence would be appropriate. The Superior Court judge stated that the sentence imposed took into account the particular circumstances involved and was not to be seen as a precedent for other cases.[46]

In 2005, Andre Bergeron was charged with the attempted murder of his wife. She had been diagnosed with *Friedreich's ataxia* (a progressive neurological disorder) in 1980. Bergeron attempted to asphyxiate her with a plastic bag. She died three days later. In 2006, it was announced that the charge against Bergeron had been changed from one of attempted murder to one of assisted suicide. He was sentenced to three years' probation for aggravated assault.

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[45] At a Preliminary Inquiry it was noted that the patient had been given abnormal amounts of morphine and other painkillers prior to Morrison's involvement. Hughes Russell J held that the patient could have died ether from the disproportionate amounts of painkillers administered before the doctor was professionally engaged, or as a result of the intravenous line delivering the various drugs not working, from natural causes. Consequently, *"a jury instructed could not convict the accused of the offence charged, any included offence or any other offence and therefore she is hereby discharged."* An appeal of this decision was dismissed by the Nova Scotia Supreme Court in 1998. While the presiding judge, Hamilton J, disagreed with the preliminary decision, and was of the view that there was some evidence before the Preliminary Inquiry judge on which a reasonable jury could return a verdict guilty by manslaughter, he nonetheless found that this was not sufficient to quash the decision – the judge at first instance had acted within his jurisdiction. Shortly thereafter the Public Prosecutor announced that there would not be an appeal.

[46] Her stressed that it was not the court's role either to legislate in the matter of assisted suicide or to articulate an opinion on the law; rather it was the responsibility of legislators to determine the law and the duty of citizens to elect their legislators. He averred that the risks of recidivism on the part of the defendant were non-existent and that since she was not a threat to society there was no reason to incarcerate her.

In September, 2006 a 62-year-old man pleaded guilty to aiding the suicide of his wife who had been experiencing intolerable back pain which various specialists were unable to cure or alleviate. An Ontario Court imposed a sentence of three years' probation.

In June, 2007, a British Columbia court sentenced a general practitioner, Ramesh Kumar Sharma, to two years less a day to be served in the community. He had been found guilty of aiding in the suicide of a 93 year-old woman suffering from heart problems by prescribing a lethal dose of drugs. His license to practice medicine was revoked by the British Columbia College of Physicians.

Also in June, 2007, the Royal Canadian Mounted Police decided not to bring a charge of aiding and abetting in the suicide of another against a man who had accompanied his wife to the *Dignitas* clinic in Switzerland. The police stated that no breech of the Criminal Code had occurred in Canada.

5. Commissions and Committees

(a) Law Reform Commission

In its 1983 Report the *Law Reform Commission of Canada*, in its *Report on Euthanasia, Aiding Suicide and Cessation of Treatment,* recommended against the legalisation of decriminalisation of voluntary active euthanasia. It also recommended that aiding suicide should not be decriminalised where assistance has been rendered to a terminally bill person.[47]

In 1987, the Commission published proposals to amend the Criminal Code.[48] Mercy killing should be treated as second-degree murder – what it described as "*ordinary murder*" – rather than as first-degree murder, or "*pre-meditated murder*". Second-degree murder would carry no fixed or minimum jail term.

(b) Special Senate Committee

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[47] The Commission had originally recommended that the consent of the Attorney General should be required before prosecutions could be brought under *s.241(b).* After a negative public response it retracted this recommendation.

[48] Specifically, so that "*the homicide provisions not be interpreted as requiring a physician to undertake medical treatment against the wishes of a patient, or to continue medical treatment when such treatment has become therapeutically useless, or from requiring a physician to cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person.*" See *Report 20, 'Euthanasia, Aiding Suicide and Cessation of Treatment', 1983, at 34-35.*

In the wake of the decision in *Rodriguez*[49] a Special Senate Committee was appointed in 1994 to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The Committee issued its final Report, entitled *Of Life and Death*[50], in June 1995. This was the last comprehensive review of the question of assisted suicide by a Canadian public body until 2012 when the Quebec Select Committee, mandated by that province's legislature to consult the public on the topic of dying with dignity, made its report. The Special Senate Committee was unable to achieve unanimity on either issue. The entire Committee recommended that the offence of counselling suicide under *s.241(a)* remain intact. While a majority of the members recommended no amendments to *s.241(b)* of the Criminal Code, namely that prohibiting aiding and abetting suicide, a minority recommended that an exemption be added to permit persons to assist in a suicide under clearly defined safeguards and conditions.[51]

In addition, regulations would be required to deal with monitoring and enforcement of these safeguards.[52]

Those Committee members who were opposed to changing the existing legislation with respect to assisted suicide were primarily concerned with maintaining the fundamental social value of respect for life.[53]

The entire Committee recommended that both involuntary and non-voluntary euthanasia remain a criminal offence. However, it also recommended amendments to the Criminal Code to allow for less severe penalties in cases of non-voluntary euthanasia where the essential elements of *"compassion"* or *"mercy"* were present. To that end it suggested either the creation of a third category of murder that would not carry a mandatory life sentence, or the

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[49] *[1993] 3 SCR 519.*

[50] See fn. 25 supra.

[51] At minimum such conditions would include the following elements:
(i) the individual must be competent and must be suffering from an irreversible illness that has reached an intolerable stage, as certified by a medical practitioner;
(ii)the individual must make a free and informed request for assistance, without coercive pressure;
(iii) the individual must have been informed of and fully understood his/her condition, prognosis and alternative comfort care arrangements, such as palliative care, which are available;
(iv) the individual must have been informed of and must fully understand that he/she has a continuing right to change his/her mind about committing assisted suicide;
(v) a health care professional must assess and certify that all of the foregoing conditions have been met.

[52] Records of all applications for and instances of assisted suicide would have to be maintained. To avoid abuse, procedural safeguards would require review both prior to and after the act of assisted suicide. Further, no person should be obliged to provide assistance in suicide.

[53] They were also concerned about the risks associated with changes to the law. In their view, legalisation could result in abuses, especially with respect to the most vulnerable members of society. Similarly, there was concern over the issue of the *"slippery slope"*. Changes in the law with respect to competent persons could lead the way to possible changes in the law for incompetent persons.

creation of a separate offence of compassionate homicide. In either case the Committee advised that the essential elements of *"compassion"* and *"mercy"* be clearly and narrowly defined in legislation.[54]

(c) Medical Profession

The medical profession in Canada is opposed to the legalisation of either voluntary euthanasia or assisted suicide. In its policy document, *Euthanasia and Assisted Suicide,* revised in 2007,[55] the Canadian Medical Association (CMA), which represents the majority of Canadian doctors, states that euthanasia *"must be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life. The Association does not support euthanasia or assisted suicide."*

Before any change in the legal status of euthanasia or assisted suicide could be envisaged the CMA urged consideration of specific concerns.[56]

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[54] A minority if the Committee recommended amendments to the Criminal Code to permit voluntary euthanasia for competent individuals who are physically in capable of committing suicide, subject to the same or similar safeguards recommended for assisted suicide. In the alternative, the minority recommended amendments to create a less severe penalty for this offence.

[55] The Canadian Medical Association, Ottawa, 2007. The 2007 revision replaced two previous policy documents by the Association: *Physician-Assisted Death 1995* and *Euthanasia and Assisted Suicide 1998.*

[56] *(i) adequate palliative care services should be made available to all Canadians;*
(ii) suicide-prevention programmes should be maintained and strengthened where necessary. In any debate about providing assistance in suicide to relieve the suffering of persons with incurable diseases, the interests of those at risk of attempting suicide for other reasons must be safeguarded;
(iii) a Canadian study of medical decision making during dying should be undertaken in order to evaluate the current state of Canadian practice. If physicians participating in such a study were offered immunity from prosecution based on information collected, as was done during the Remmelink Commission in the Netherlands, the study could substantiate or refute the reported allegations that euthanasia and assisted suicide take place;
(iv) the public should be given adequate opportunity to comment on any proposed change in legislation. The law should be determined by the wishes of society, as expressed through Parliament, rather than by court decision;
(v) consideration should be given to whether any proposed legislation [e.g. Oregon Revised Statutes. The Oregon Death with Dignity Act, ss.127.800 – 127.995] can restrict euthanasia and assisted suicide to the indications intended. Research from the Netherlands and Oregon demonstrate that a large percentage of patients who request aid in dying do so in order to maintain their dignity and autonomy. If euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges, based on the Canadian Charter of Rights and Freedoms, to extend these practices to other who are not competent, suffering of terminally ill. Such extension is the "slippery slope" that many fear. Courts may be asked to hear cases involving euthanasia for incompetent patients on the basis of advance directives or requests from proxy decision makers. Such cases could involve neurologically impaired patients or new-borns with severe congenital abnormalities. The "Groningen Protocol", which sets out five criteria for the provision of euthanasia to incurably ill babies, was adopted in Holland. Psychiatrists recognise the possibility that a rational, otherwise well person may request suicide. Such a person could petition the courts for physician-assisted suicide.

(d) Royal Society of Canada

In November, 2011, a six-member *Expert Panel of the Royal Society of Canada* published its Report, entitled *End-of-Life Decision Making*, in response to national and international changes to the landscape of end-of-life care. Noting the recommendations of the 1995 *Special Senate Committee Report*, the *Panel* asked whether a careful reconsideration of the same issues would result in the same conclusions in the present day.

It unanimously recommended that the prohibitions on assisted suicide and voluntary euthanasia in the *Criminal Code* be modified to allow both practices in carefully circumscribed and monitored circumstances. As lesser options for reform, the *Panel* recommended prosecutorial guidelines that would be explicit as to the circumstances in which a prosecution for assisted suicide or voluntary euthanasia would not be in order, and the implementation of diversion programmes and restorative justice processes for cases of this nature. It identified a number of core elements of a permissive regime.[57]

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[57] These included:
(i) **Features of the person**: The person making the request must be competent or, while competent, must have expressed a wish for voluntary euthanasia through a valid advance directive. If a physician is uncertain about the competence of the person making the request, he/she must take all the necessary steps to resolve the uncertainty, for example, by consulting with a colleague with greater experience or expertise. Any age restrictions for access should flow from the mature minor law in the particular jurisdiction;
(ii) **Features of the decision**: The decision must be voluntary and informed.
(iii) **Features of the person's condition:** "Terminal illness" should not be a prerequisite for requesting assistance because it is too vague, under-inclusive, and there is no precise science to providing a prognosis of terminal illness in terms of a specific length of time;
(iv) **Features of the request for assistance:** Written or otherwise recorded requests are preferable but a verbal request is sufficient if properly documented. The time required to elapse between the initial request and the granting of assistance will depend on the time required to ensure that the person's request is voluntary and informed, and that the individual is competent. Once all of the other conditions have been met, there must be a short (for example, 24-hour) pause before the assistance is provided to allow confidence that all of the conditions and procedural requirements have been satisfied. Beyond that the Panel did not recommend any delay requirements.
(v) **Features of the provider:** Health care professionals should be permitted to provide assistance with suicide or voluntary euthanasia. They must not be obligated to provide such assistance but, if unwilling, should refer the individual making the request to another professional who is willing to consider it. It is an open question whether only health care professionals should be permitted to provide assistance. The Panel recommended that permission to provide assistance be granted only to those who have the knowledge and skills necessary to ensure that the conditions for access (namely, competence, voluntariness, and conveyance of information) have been met, and with whom the oversight system can meaningfully function. Furthermore, the more restrictive the list of those permitted to provide assistance, the less that group should be permitted to refuse to provide assistance.
(vi) **Oversight & control:** A national oversight commission should be established to monitor and report annually and publicly on assisted suicide and voluntary euthanasia in Canada. To maintain public trust in the system, the commission would collect data and report such data in aggregated form. To prevent mistaken or intentional violations of the new law, the commission would also expertly assess specific

(e) Quebec National Assembly's Select Committee

In March, 2012, the Quebec National Assembly's *Select Committee on Dying with Dignity* issued its Report which included a number of recommendations concerning palliative care, palliative sedation and advanced medical directives, as well as assisted death. In the matter of assisted death the Committee recommended amendments to relevant legislation to recognise medical aid in dying as appropriate end-of-life care when a physician assesses the person making the request as meeting certain eligibility requirements.[58]

The Committee also recommended guidelines,[59] together with a body responsible for verifying whether acts of medical aid in dying were carried out according to the legal conditions, publishing an annual report that includes statistics on medical aid in dying, and publishing a report on the implementation of medical aid in dying provisions every five years. The Committee further recommended that the appropriate committee of the National Assembly examine the oversight body's five-year report.

(f) Legislative Endeavours

Since 1991, nine private member's bills have been introduced in the Canadian House of Commons to amend the Criminal Code in a way that would decriminalise assisted suicide or

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cases with appropriate follow-up, which could consist of engagement with specific individual providers or more general educational programmes.

[58] These included:

(a) The person is a Quebec resident according to the Health Insurance Act; (b) the person is an adult capable of consenting to treatment under the law; (c) the person hi/self or herself requests medical aid in dying after making a free and informed decision; (d) the person is suffering from a serious, incurable disease; (e) the person is in an advanced state of weakening capacities, with no chance of improvement; (f) the person has constant and unbearable physical and psychological suffering that cannot be eased under conditions he or she deems tolerable.

[59] Including that all requests for medical aid in dying must be made in writing by way of a signed form and the request must be repeated within a reasonable period of time, depending on the type of disease. The attending physician must consult with another physician on whether the request meets the eligibility criteria. That physician must be independent of the patient and the attending physician, and be competent with respect to the disease in question. Finally, the attending physician must complete a formal declaration of medical aid in dying.

An adult with the capacity to consent should be permitted to give an advance directive for medical aid in dying certain conditions.

The Committee also made a number of recommendations to protect physicians who may or may not choose to participate in the provision of assisted death. These included that : the Attorney General of Quebec to issue directives to the *Director of Criminal and Penal Prosecutions* to ensure that a physician who provides medical aid in dying in accordance with the legal criteria cannot be prosecuted; the *College des Medecins du Quebec* amend its *Code of Ethics* so that physicians may provide medical aid in dying in accordance with the criteria provided by law while confirming their right to conscientious objection and their obligation to refer their patient to another physician; and the *Ordre des Infirmieres et Infirmiers de Quebec* amend its *Code of Ethics* to allow members to help provide medical aid in dying is accordance with the criteria provided by law, while conforming their right to conscientious objection.

euthanasia. Three of these bills died with the prorogation of Parliament. The remaining six were debated in either the House itself or in committee.

The most recent was Bill C-384 entitled *An Act to Amend the Criminal Code* (*right to die with dignity*),[60] which was tabled in May, 2009. The bill proposed to amend *s.222* of the Criminal Code,[61] by adding a provision that a medical practitioner does not commit homicide if he aids a person who is at least eighteen, and who meets a number of other conditions, to die with dignity. It would also have amended *s.241 (b)* to permit a medical practitioner to assist in suicide under certain conditions. The bill was given a Second Reading[62] and its proposers referred, *inter alia,* to the profound and fundamental importance of dignity, the legalisation of the practice of physician-assisted death in other jurisdictions, and the limits of palliative care. Those opposing the bill expressed concerns about the inadequacy of safeguards and the inevitability of mistakes, the *"slippery slope"*, the potential for pressure on vulnerable people, and the devaluing of human life. In April, 2010, a motion to advance the bill to Committee Stage was defeated.[63]

(g) Public Opinion:

Results of a public opinion survey conducted in late 2010,[64] showed that when the question: *"Generally speaking, do you support or oppose legalising euthanasia in Canada?" was asked,* - but without a definition of *"euthanasia"* being provided - **63%** of the respondents said that they supported legalisation, **24%** opposed and **13%** were unsure. The representative sample was **1,005** adults and the results were statistically weighted according to the most current education, age, gender and region Census data to reflect the Canadian population as a whole. The margin of error was **+/- 3.1%, 19** times out of **20**. Results varied significantly among regions of the country, with respondents in Quebec showing the highest level of support **(78%)** and those in Alberta the lowest **(48%).**

When provided with some specific scenarios under which a patient might ask for a doctor's help in ending his or her life, the responses broke down as follows:

Euthanasia

Do you support or oppose allowing the doctor to end the patient's life under each one of these scenarios?

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[60] *2nd Sess., 49th Parl.*
[61] The homicide provision. See fn.24 supra.
[62] 2nd Sess., 40th Parl., 2ndOctober, 2009 at 5518.
[63] By a vote of 228 to 59.
[64] On 1st & 2nd December.

	Support	Oppose	Not Sure
A patient is in a coma with little or no hope of waking. The patient had previously specified they wished to have their life terminated if they were ever to find themselves in this condition:	**81%**	**13%**	**6%**
A patient is terminally ill and will die in less than six months. The patient is expected to suffer a great deal of physical and mental anguish during that time:	**78%**	**15%**	**7%**
A patient has a lifelong, but non-life threatening condition such as being quadriplegic and wishes to end his or her life:	**36%**	**55%**	**9%**
A patient wishes to die at the same time as their spouse or other loved one:	**13%**	**79%**	**8%**

These results were put into evidence by the plaintiffs in *Carter v Canada* albeit accompanied by an acknowledgement that opinion polls have limitations. Nonetheless it was argued that the results suggested that social consensus had shifted between 1993 and 2012 and that there was broad public support for assisted dying in Canada and in other Western democracies.[65]

Strong support for legalising voluntary euthanasia had been found in an earlier national survey, conducted in **2009.**[66] Of *1,006* Canadians surveyed nearly three-quarters **(71%)** Of

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[65] A similar survey had been conducted in Britain on 27th and 28th October, 2010. The representative sample was **2015** adults. The margin of error was **+/- 2.2%, 19** times out of **20**. The results were also statistically weighted. The results indicated that **67%** of the respondents supported legalising euthanasia, **19%** opposed and **14%** were unsure.

[66] By the Angus Reid organisation. Angus Reid Global Monitor: Montreal, Sept 2009. *http://www.angus-reid. com/*

respondents favoured such legalisation.[67] Similar results were obtained by a 2007 national survey by Ipsos Reid of **1,005** Canadians. This survey found that **76%** of respondents support the right to die for patients suffering from an incurable disease.[68] Respondents in Quebec showed the strongest support **(87%),** while those in Alberta showed the least support **(66%).**

The high level of public support for legalising voluntary euthanasia and assisted suicide under specific circumstances has scarcely changed over the past ten to fifteen years.[69]

The Royal Society of Canada Expert Panel's Report *'End of Life Decision Making',*[70] published shortly before the decision in *Carter v Canada*[71] was handed down, stated that *"it can be inferred"*, based on the results of the various surveys that have been held from the mid-1990s onwards, *"that the majority of the Canadian public would support legislation permitting voluntary euthanasia and assisted suicide for people suffering from incurable physical illness."*[72]

A poll conducted in 2009 among **2,025** medical specialists in Quebec found that **75%** were ***"certainly"*** or ***"probably"*** in favour of legalising euthanasia, as long as the practice was regulated.[73] In October, 2009, the College of Physicians in Quebec released a report entitled

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[67] Ibid.

[68] See Dougherty K, *'Legalised euthanasia has potential for "ethical slips" Couillard warns; most Quebecers advocate assisted suicide',* The Gazette, Montreal, 11 June, 2007, at A9.

[69] In a 1995 cross-sectional survey of ***2,019*** Canadians, Singer and colleagues found that a majority of respondents support legalising voluntary euthanasia **(66%)** and assisted suicide **(58%)** if the person is competent and unlikely to recover from his/her illness. *See Dougherty, K, 'Legalised euthanasia has potential for "ethical slips" Couillard warns; most Quebecers advocate assisted suicide',* The Gazette, Montreal, 11 June, 2007, at 11. Support was only slightly less **(58%)** for legalising voluntary euthanasia if the family of an incompetent person who is unlikely to recover (but whose wishes about end of life are unknown) request euthanasia for that person. By contrast, most respondent disapproved of a law allowing voluntary euthanasia **(78%)** or assisted suicide **(79%)** if the person is incompetent but likely to recover. See *Singer, PA, Choudray, S, Armstrong, J, Meslin, LM, & Lowry, FH: 'Public opinion regarding end-of-life decisions – influence of prognosis, practice and process',* Social Science and Medicine , 1995, December, 41(11): 1517-21. These results can be compared to those of a 1994 survey of **356** people in Edmonton, which revealed a high degree of public support **(65%)** for voluntary euthanasia for elderly, terminally ill people in severe pain, but significant opposition to this practice for people in other circumstances. **65%** opposed voluntary euthanasia for elderly disabled people who say they feel a burden on their family, **83%** opposed voluntary euthanasia for elderly disabled people who say they feel lonely and have only minor physical ailments, and **75%** opposed voluntary euthanasia for people with chronic depression which is resistant to treatment. In this survey, although the public was generally supportive of voluntary euthanasia for terminally ill patients, a roughly equal number of respondents **(63%)** said they believe that legalising this practice for such patients would lead to euthanasia for several other unsupported reasons. See *Genius, SJ, Genius, SK, Chang, WC, 'Public attitudes toward the right to die',* Canadian Medical Association Journal, 1994, March 1, 150 (5), 701-8.

[70] *RSC, November, 2011,170 Waller Street, Ottawa, ON K1N 0b9, www.rsc-src.ca*

[71] *[2012] BCSC 886.*

[72] *Op.cit., fn.70 supra, at 24.*

[73] *'Quebec Specialists support legalising euthanasia': http://www.cbc.ca/news/canada/montreal/story/2009/10/13quebec-md-spec-euthanasia.html accessed 24 January, 2013.*

'Physicians, Appropriate Care and the Debate on Euthanasia', calling for an open discussion on the question of euthanasia in the context of end-of-lifer care. The report stated that if euthanasia were to be permitted it should be conducted in the context of care and considered a medical act.[74]

In Canada, the level of public support for legalising voluntary euthanasia and assisted suicide is comparable to that in the UK, but markedly higher than that in the Unites States of America, according to a 2009 survey of national samples.[75] Canadians demonstrated slightly less support **(71%)** than that of Britons **(77%)** and nearly twice that of Americans **(45%).** By a measure of public support, Canada appears to be roughly equal to the Netherlands,[76] where both voluntary euthanasia and physician-assisted suicide are carried out legally.[77]

When compared with the general public, physicians in Canada, as in other jurisdictions,[78] are significantly less supportive of legalising voluntary euthanasia or assisted suicide, and many are vehemently opposed. Although the reasons for such opposition have not been sufficiently explored among Canadian physicians, studies of American and British doctors suggest a strong association between opposition to legalising physician-assisted suicide and voluntary euthanasia and religious belief.[79]

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[74] *College des Medicines du Quebec, 2009, Physicians, Appropriate Care and the Debate on Euthanasia: A Reflection, http://www.cmq.org/en/Medias/Profil/Commun/Nouvelles/2009/~/media/208E2B537FB144FAAE33DEB458D3AA90.ashx?91027 accessed 24 January, 2013.*

[75] *Britons, Canadians on the same page on legalising euthanasia. Angus Reid Global Monitor: San Francisco, September, 2009. http://www.angus-reid.com/.*

[76] Rietjens, JA, Heide van der A, Onwuteaka-Philipsen, BD, Mass van der PJ, Wal van der G, *'A Comparison of attitudes towards end-of-life decisions: survey among the Dutch general public and physicians',* Social Sciences and Medicine, 2005, October,61(8): 1723-32.

[77] In 2006 a clear link between the Dutch public's support for voluntary euthanasia and a number of features it considers important for a "*good death*" was established. These include an influence on the dying process through personal decisions about treatment and the time of death, avoiding being a burden on relatives, and preventing sever suffering and loss of dignity.. See Rietjens, JA, Heide van der A, Onwuteaka-Philipsen, BD, Maas van der PJ, Wal van der G, *'Preferences of the Dutch general public for a good death and associations with attitudes towards end-of-life decision-making',* Palliative Medicine, 2006, October, 20(7): 685-92.

[78] Such as the United States of America: See Whitney, SN, Brown, BW Jr, Brody, H, Alcser, KH, Bachman, JG, Greely, HT, *'Views of United States Physicians and members of the American Medical Association House of Delegates on physician-assisted suicide',* Journal of General Internal Medicine, 2001, May, 16(5), 290-6 and the UK: See Lee, W, Price, A, Rayner, L, Hotopf, M, *'Survey of doctors' opinions of the legalisation of physician-assisted suicide',* BMC Medical Ethics, 2009, March 5, 10:2; Seale, C, *'Legalisation or euthanasia or physician-assisted suicide; Survey of doctors' attitudes',* Palliative Medicine, 2009, April, 23 (3), 205-12.

[79] Further, in surveys of doctors in the UK, opponents were also more likely to be palliative care specialists (see *Seale, op.cit., fn.78 supra*) or those caring for the dying (see *Lee et al, op.cit., fn 78 supra*). The view of physicians in the Netherlands contrast with those of physicians in Canada, the United States and the UK, in that a large majority **84%** - of Dutch physicians support assisted suicide and/or voluntary euthanasia (see *Rietjens et al, op.cit., fn.76 supra*).

The attitudes of patients in Canada towards voluntary euthanasia and assisted suicide would appear to be not dissimilar to those in the Unites States, the UK and the Netherlands. Studies suggest that patients generally, including Canadian patients, are interested in or request euthanasia or assisted suicide not because of any singular reason; instead, their motivation arises from a complex combination of physical, psychosocial, and existential suffering – importantly, a type of suffering that has objective as well as subjective elements.[80]

In *Carter v Canada*[81] the respondent - the State - submitted that notwithstanding the findings of any opinion poll or survey, whether in favour or not of an amelioration of the law proscribing euthanasia and assisted suicide, methods of estimating public opinion were unreliable and were of no assistance to the Court. Similarly, lawyers for British Columbia argued that public opinion polls were not relevant to the determination of societal consensus and cited *Suresh v Canada (Minister of Citizenship and Immigration)*[82] in support.[83]In short,

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In its *'End of Life Decision Making' Report (RSC, November, 20111, 170 Waller Street, Ottawa, ON K1N Ob9, www.rsc-src.ca), The Expert Panel of the Royal Society* identified key features in the matter of Canadian practices and attitudes, including that (i) the vast majority of Canadians die in institutions in their old age; (ii) the Canadian population had undergone and was undergoing rapid change – becoming increasingly aged and more diverse; (iii) legal and medical academic literature suggested that the attitudes and perspectives of the very old toward assisted suicide and euthanasia had not been ascertained, nor was the literature well-attuned to First Nations and the ethnically and culturally diverse populations found in that jurisdiction. Hearing from these voices was integral to an informed debate on end-of-life care; (iv) advance-care planning remained a topic not sufficiently discussed. The absence of explicit dialogue between patients and health care providers was a matter of concern; (v) the use of sedation as a modality of care at the end of life appeared to be increasing without concurrent increasing clarity on the appropriateness of various kinds of sedation in various circumstances. There was a pressing need for national consensus guidelines; (vi) a significant majority of the Canadian population appeared to support a more permissive legislative framework for voluntary euthanasia and assisted suicide.

[80] It is notable that patients in these jurisdictions cite similar reasons for considering or asking for physician-assisted suicide and voluntary euthanasia. In 2009, Ganzani and colleagues studied *56* patients from the state of Oregon (where eligible patients receive help legally from physicians to commit suicide), who had requested physician-assisted suicide or had contacted a physician-assisted suicide advocacy organisation. The authors found that the main reason for such requests were the patients' desire to influence the circumstances of their death, loss of independence, worries about future pain, poor quality of life, and inability to care for themselves. See Ganzani, L, Goy, ER, Dobscha, SK, *'Oregonians' reasons for requesting physician aid in dying'*, Archives of Internal Medicine, 2009, March, 9, 169(5), 489-92. Similarly, in 2006, Chapple et al interviewed *18* terminally ill patients in the UK, and found that those who support legalising voluntary euthanasia or assisted suicide emphasised concerns about future pain, fear of indignity, loss of control, and cognitive impairment. See Chapple, A, Ziebland, S, McPherson, A, Herxheimer, A, *'What people close to death say about euthanasia and assisted suicide: a quantitative study'*, Journal of Medical Ethics, 2006, December, 32(12), 706-10. In a 2009 study, by Pasman and colleagues, Dutch patients who had formally requested aid in dying said that their "*unbearable suffering*" (which is one of several conditions for receiving euthanasia in the Netherlands) consisted of physical elements, including pain, but, more often, non-physical elements, including dependence, an inability to lead a normal daily life, and mental suffering over steady deterioration. See Pasmann, HR, Ruriup, ML, Willems, DL, Onwuteaka-Philipsen, BD, *'Concept of unbearable suffering in context of un-granted requests for euthanasia: qualitative interviews with patients and physicians'*, Boston Medical Journal, 2009, November, 16(339), b4362.

[81] *2012 BCSC 886.*

[82] *2002 SCC 1.*

Canadian consensus was to be found in the refusal of successive governments and Parliaments to legalise assisted dying, in the Special Senate Committee Report, and in the position of the Canadian Medical Association, statutory and judicial pronouncements, and the views of individual palliative care physicians. International consensus was to be found in the overwhelming majority of Western democracies that prohibit the practices.

6. The *Rodriguez* case

On appeal from the British Columbia Court of Appeal the Supreme Court of Canada, in *Rodriguez v British Columbia (Attorney General)*[84], by a 5-4 majority, held that s. 241(b) of the Criminal Code did not infringe either s.7 or s.12 of the Charter of Rights and Freedoms.[85]

In order to discern whether there had been any prior judicial indications that a finding such as that in *Carter v Canada,*[86] where s.241(b) was struck down as unconstitutional, might eventuate it is valuable, having reviewed the reasoning of the majority[87] in the Court of Appeal, to devote particular attention to the dissenting judgement of McEachern CJBC[88] in that court, and to those of Lamer CJ and McLachlin J in the Canadian Supreme Court.

In the Court of Appeal Sopinka J delivered the verdict on behalf of the majority. Having declared himself impressed with the caveat of Professor Lawrence Tribe in his text *American Constitutional Law* [89] he dealt with the alleged infringements seriatim, beginning with liberty

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[83] At para 50: "*In Burns, at para 76, the then Minister for Justice, in his decision on the order to extradite the respondents Burns and Rafay, emphasised that 'in Canada, Parliament has decided that capital punishment is not an appropriate penalty for crimes committed here, and I am firmly committed to that position'. While we would hesitate to draw a direct equation between government policy or public opinion at any particular moment and the principles of fundamental justice, the fact that successive governments and Parliaments have refused to inflict torture and the death penalty surely reflects a fundamental Canadian belief about the appropriate limits of a criminal justice system.*"

[84] *[1993] 3 S.C.R.519.* Ms. Rodriguez sought a declaration that s.241(b) of the Criminal Code was invalid on the basis of alleged infringement of her rights under ss.7, 12 and 15(1) of the Charter. She was unsuccessful in the Supreme Court of British Columbia before Melvin J *([1992] BCJ No.2738 [Rodriguez BCSC]).* The British Columbia Court of Appeal dismissed her appeal (*McEachern CJBC dissenting*), and the Supreme Court of Canada dismissed her appeal from that decision.

[85] The minority dissenting judgments of the Chief Justice of Canada, Lamer CJ, of McLachlin J, as she then was, and of both Cory J and L'Heureux-Dube J, were based on alternative evaluations of the impact of s.241(b)of the Criminal Code on the rights and freedoms provided for in ss.7 and 15(1) respectively of the *Charter* and are of particular relevance to the subsequent finding by Smith J in *Carter v Canada [2012] BCSC 886* that the section was unconstitutional.

[86] *[2012] BCSC 886.*

[87] La Forest J, Sopinka J (who delivered the judgment on behalf of the Court), Gonthier J, Iacobucci J and Major J.

[88] McEachern CJBC held that the criminal prohibition against assisted suicide violated the appellant's constitutional "*right to life, liberty and the security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*"

[89] *2nd ed., 1988, at 1370-71* (Professor Tribe of Harvard University was a contributor to the famous *amicus curiae* brief, known as the *Philosophers' Brief,* in *Washington v Glucksberg 521 US 207 (1997)):*

and security of the person interests, which, he averred, could not be divorced from the sanctity of life – the third value protected by s.7 of the Charter. While *s.241(b)* deprived the appellant of *"autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of the person,"* any resulting deprivation was *"not contrary to the principles of fundamental justice."* The same conclusion was applicable in respect of any liberty interest *"which may be involved."*

The requisite balance between the state and the individual in arriving at the *'principles of fundamental justice'* had been identified in *Thompson Newspapers Ltd v Canada (Director of Investigation and Research, Restrictive Trade Practices Commission*[90] and confirmed in *Cunningham v Canada.*[91]

In the instant case the issue before the court was whether the blanket prohibition on assisted suicide was arbitrary or unfair in that it was unrelated to the state's interest in protecting the

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"The right of a patient to accelerate death as such – rather than merely to have medical procedures held in abeyance so that disease processes can work their natural course – depends on a broader conception of individual rights than any contained in common law principles. A right to determine when and how to die would have to rest on constitutional principles of privacy and personhood or on broad, perhaps paradoxical, conceptions of self-determination.
Although these notions have not taken hold in the courts, the judiciary's silence regarding such constitutional principles probably reflects a concern that, once recognised, rights to die might be uncontainable and might prove susceptible to grave abuse, more than it suggests that courts cannot be persuaded that self-determination and personhood may include a right to dictate the circumstances under which life is to be ended. In any event, whatever the reason for the absence in the courts of expansive notions about self-determination, the resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalising euthanasia, rather than respecting people, may endanger personhood."

[90] *[1990] 1 SCR 425.* At 539 a Forest J, referring to his own reasons in *R v Lyons [1987] 2 SCR 309, at 327,* and *R v Beare [1988] 2 SCR, at 402/3,* stated that one must *"consider (the impugned measure) against the applicable principles and policies that have animated legislative and judicial practice in the field."* He concluded that *"what these practices sought to achieve was a just accommodation between the interests of the individual and those of the state, both of which factors play a part in assessing whether a particular law violates the principles of fundamental justice....The interest in the area with which we care here concerned involve particularly delicate balancing....and as the various common law countries have approached it in rather different ways. I do not wish to undertake the invidious task of examining which is the better way....what is important is that the Charter provisions seem to me to be deeply anchored in previous Canadian experience. By this I do not mean we must remain prisoners of our past. I do mean, however, that in continuing to grope for the best balance in specific contexts, we must begin with our own experience..."*

[91] *[1993] 2 SCR 143.* McLachlin J, as she then was, concluded that the appellant had been deprived of a liberty interest protected by *s.7* of the *Charter.* In deciding whether the deprivation was in accordance with the principles of fundamental justice she stated, *at 151/2, "The principles of fundamental justice are concerned nit only with the interest of the person who claims his liberty has been limited, but with the protection of society."* A fair balance, substantively and procedurally, needed to be struck between these interests. See *Re BC Motor Vehicle Act [1985] 2 SCR, per Lamer J, at 502; Singh v Minister of Employment and Immigration [1985] 1 SCR 177, per Wilson J, at 212; Pearlman v Manitoba Law Society Judicial Committee [1991] 2 SCR, per Iacobucci J, at 882. "In my view the balance struck in this case conforms to this requirement.*

vulnerable, and whether it lacked a foundation in the legal tradition and societal beliefs which were said to be represented by the prohibition.

However, *s.241(b)* of the Criminal Code was *"grounded in the state interest in protecting life"* and reflected the policy of the state that *"human life should not be depreciated by allowing life to be taken."*[92] Consequently, it did not infringe s.7 of the Charter.

The majority also held that *s.241(b)* did not infringe s.12 of the Charter, which provides that everyone has the right not to be subjected to any cruel and unusual treatment or punishment.[93]

Rather than deciding on *"the difficult and important issues"* raised by the application of s.15 of the *Charter* it was preferable, in the view of the majority, *"to assume that the prohibition on assisted suicide in the Criminal Code infringes s.15, since any infringement of s.15 by s. 241(b) is clearly justified under section 1 of the Charter."*[94]

In consequence, the Appeal Court held that *s.241(b)* had *"a pressing and substantial legislative objective and meets the proportionality test. A prohibition on giving assistance to commit suicide is rationally connected to the purpose of s. 241(b), which is to protect and maintain respect for life."*[95]

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[92] *"This state policy is part of our fundamental conception of the sanctity of life"* and *"no consensus can be found in favour of the decriminalisation if assisted suicide,"* To the extent that there was a consensus *"it is that human life must be respected."* Parliament's repeal of the offence of attempted suicide from the Criminal Code was not a recognition that suicide was to be accepted by Canadian society. *"Rather, this action merely reflected the recognition that the criminal law was an ineffectual and inappropriate tool for dealing with suicide attempts"* and *"given the concerns about abuse and the great difficulty in creating appropriate safeguards, the blanket prohibition on assisted suicide is not arbitrary or unfair. The prohibition relates to the state's interest in protecting the vulnerable and is reflective of fundamental values at play in our society."*

[93] *"Even assuming that 'treatment' within the meaning of s.12 may include that imposed by the state in contexts other than penal or quasi-penal, a mere prohibition by the state on certain action cannot constitute 'treatment' under s.12."*
The appellant was not subjected by the state to any form of cruel and unusual treatment of punishment. *"There must be some more active state process in operation, involving an exercise of state control over the individual, whether it be positive action, inaction or prohibition. To hold that the criminal prohibition in s.241(b) without the appellant being in any way subject to the state administrative or justice system, falls within the bounds of s.12 would stretch the ordinary meaning of being 'subjected to...treatment' by the state."*

[94] *Section 15* of the Charter provides that every individual is equal before the law and has the right to the equal protection of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
Section 1 of the Charter guarantees the rights and freedoms set out in the Charter subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[95] The Court also held that the protection and respect for life was *"grounded on a substantial consensus among western countries, medical organisations and our own Law Reform Commission that in order to protect life and those who are vulnerable in society effectively, a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to modify this*

Sopinka J's judicial colleagues, Lamer CJ and McLachlin J, had held that, pursuant to *s.52 (1)* of the Constitution Act, 1982, *s.241(b)* be declared without force or effect, on condition that such a declaration be suspended for one year from the date of the judgement in order to give Parliament adequate time to decide what, if any, legislation should replace *s.241 (b)*. It would be appropriate also to grant the appellant, subject to compliance with certain conditions, a constitutional exemption from the operation of *s. 241(b)* during the period of suspension. A stipulation requiring a court order to permit the assistance of suicide in a particular case , and only when a judge is satisfied that the consent is freely given, would ensure that only those who truly desire to bring their lives to an end could obtain assistance.

However, Sopinka J found these sentiments unpersuasive on the grounds that nothing in the *Charter* mandated the granting of such an exemption. The safeguards recommended for the regulation of assisted suicide as envisaged by Lamer CJ and McLachlin J would serve merely as guidelines, and *"were vague, unenforceable and would add to legal uncertainty."*[96]

For completion, and prior to an analysis of the rationale for the findings of Lamer CJ and McLachlin J in the Supreme Court of Canada, it is appropriate to review the dissent of McEachern CJ in the British Columbia Court of Appeal.

7. The McEachern CJ dissent in the British Columbia Court of Appeal

McEachern CJ characterised the evolution of the assisted suicide provision at common law and in statute as the culmination of *"a fairly recent, enlightened medical-jurisprudential trend*

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approach by creating exceptions or formulating safeguards to prevent excesses have been unsatisfactory. Section 241(b) is thus not overbroad since there is no halfway measure that could be relied upon to achieve the legislation's purpose fully. In dealing with this contentious, complex and morally laden issue, Parliament must be accorded some flexibility. In light of the significant support for s.241(b) or for this type of legislation, the government had a reasonable basis for concluding that it had complied with the requirement of minimum impairment. Finally, the balance between the restriction and the government objective is also met."

[96] *"To add to the uncertainty of the conditions, they are to serve merely as guidelines, leaving it to individual judges to decide upon application whether to grant or either the right to commit suicide. In the case if the appellant, the remedy proposed by the Chief Justice, concurred in by McLachlin J, would not require such an application. She alone is to decide that the conditions or guidelines are complied with. Any judicial review of this decision would only occur if she were to commit suicide sand a charge were laid against the person who assisted her. The reasons of McLachlin J remove any requirement to monitor the choice made by the applicant to commit suicide so that the act might occur after the last expression of the desire to commit suicide is stale-dated."*
Sopinka J was also concerned as to the possibility of abuse: *"Since much of the medical profession is opposed to being involved in assisting suicide because it is antithetical to their role as healers of the sick, many doctors will refuse to assist, leaving open the potential for the growth of a macabre speciality in this area reminiscent of Dr Kervorkian and his suicide machine."*

towards greater humanity and sensitivity towards the awful problems of terminally ill citizens."[97]

He canvassed the various options open to the terminally ill which are lawful in Canada, including the right to refuse medical treatment and the right to terminate life-supporting devices. He emphasised, however, that should a terminally ill patient opt for physician-assisted suicide, this would not only be unlawful for the doctor, but also could subject the patient to charges of conspiracy and, until his or her death, to the charge of being a party to commit the offence by those assisting him or her.

He rejected the appellant's contention that the reasonable management of terminal illness does not engage the common law, stating that physician-assisted suicide could not be considered palliative care. In his view, the only route open to Ms Rodriguez was under the Charter. After reviewing the nature of the purposive inquiry into Charter rights and its relation to questions of human dignity, McEachern CJ held that:

"considering the nature of the rights protected by the Charter in other cases, I have no doubt that a terminally ill person facing what the appellant faces qualifies under the value system upon which the Charter is based to protection under the rubric of either liberty or security of the person. This would include at least the lawful right of a terminally ill person to terminate her own life, and, in my view, to assistance under proper circumstances."[98]

He supported this finding principally through reliance on the decision in *Morgentaler,*[99] and specifically those passages which highlighted the flexibility of the protection afforded by the liberty and security of the person components of s.7. A *prima facie* violation of both components of s.7 arises when the state imposes prohibitions that have the effect of prolonging the physical and psychological suffering of the person.[100]

The appellant, therefore, was entitled to rely on both the liberty and security of the person elements of section 7.[101]

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[97] *Rodriguez v Attorney General of British Columbia, Attorney General of Canada (1993) 76 C.C.L.R. (2d) 145,* at 163.

[98] At 158. He continued: *"it would be wrong, in my view, to judge this case as a contest between life and death. The Charter is not concerned only with the fact of life, but also with the quality and dignity of life. In my view, death and the way we die is a part of life itself."* Ibid.

[99] *R v Morgentaler [1988] 1 SCR 30.*

[100] *"...a person suffering a terminal illness wishing to end her life when death is near...would be prima facie entitled to protection against state-imposed prohibitions which have the effect of imposing continued physical and psychological suffering upon her,"* at 26.

[101] *Ibid.*

Could this deprivation of a terminally ill person's rights under s.7 have been carried out, however, in accordance with the principles of fundamental justice?

Once again support was gleaned from *Morgentaler* for the view that a provision which operates unequally or causes manifest unfairness would not conform to the substantive element of the principles of fundamental justice. Likewise, *Re B.C. Motor Vehicle Act*[102] had established that the substantive element of fundamental justice was not confined to matters described in ss. 8 to 14 of the Charter. The dicta of Lamer J in that case, to the effect that fundamental justice includes whatever might reasonably be expected in and from a society and a system of justice which is *"founded upon the belief in the dignity and worth of the human person and the rule of law"*[103] was invoked.[104]

The notion that the courts should abnegate responsibility for interpreting the law and await further direction from Parliament was rejected. The provisions of s.7 were patently clear.[105]

Having found a violation of s.7 McEachern CJ declined to address the other possible infringements under ss. 12 and 15(1).[106] He held s.241 to be unconstitutional, but only in so far as the operation of the section affected the applicant in her unique circumstances. While acknowledging the distinction which had been drawn by Lamer J in *Schachter v Canada*[107] between remedies under s.24 (1) of the Charter and s. 52 (1) of the Constitution Act, 1982, he preferred to fashion a remedy under s.24(1), directly tailored to the appellant, but structured so as to offer a guideline to future claimants in analogous circumstances. The section was inoperative to the extent that it affected the appellant and any physician assisting her. She could proceed to arrange for physician-assisted suicide, contingent on her, and her physician's, compliance with certain conditions which would prevent criminal liability.[108] The substantive criteria were those of terminal illness, a competent, voluntary and enduring request, and *"unbearable physical pain or severe psychological distress."* [109]

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[102] *[1985] 2 SCR 486.*
[103] *Ibid at 512.*
[104] *At 161.*
[105] They were *"enacted for the purpose of ensuring human dignity and individual control, so long as it harms no one else. When one considers the nobility of such purpose, it must follow as a matter of logic as much as of law, that any provision which imposes an indeterminate period of senseless physical and psychological suffering upon someone who is shortly to die anyway cannot conform with any principle of fundamental justice. Such a provision, by any measure, must clearly be characterised as the opposite of fundamental justice",* at 164.
[106] *See fn.4 supra.*
[107] *[1992] 2 SCR 679.*
[108] At 168-69.
[109] At p.169 the judge stated: *"These conditions have been prepared in some haste because of the urgency of the appellant's circumstances, and I would not wish judges in subsequent applications to*

8. The dissenting judgements of Lamer CJ and McLachlin J in the Supreme Court of Canada

(a) Lamer CJ

Having traversed the reasoning adopted and followed by McEachern CJ in the British Columbia Appeal Court, the dissenting judgments of Lamer CJ and McLachlin J, as she then was, can be contextualised within a minority, but nonetheless significant, jurisprudential

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regard them other than as guidelines." Notwithstanding this caution, however, it is of value to reprise them in full:

*"**First**, the appellant must be mentally competent to make a decision to end her own life, such competence to be certified in writing by a treating physician and by an independent psychiatrist who has examined her not more than 24 hours before arrangements are put in place which will permit the appellant to actually terminate her life and such arrangements must only be operative while one of such physicians is actually present with the appellant.*

Such certificate must include the professional opinion of the physicians not just that she is competent, but also that, in the opinion of such physicians, she truly desires to end her life and that, in her opinion, she has reached such decision of her own free will without pressure or influence from any source other than her circumstances.

The fact that the appellant has made her intentions known by bringing these proceedings, and in many other ways, may be taken into consideration by the physicians in reaching their opinions, but they will of course be careful to ensure that the appellant has not changed her mind since making her earlier declarations.

***Second,** in addition to being mentally competent, the physicians must certify that, in their opinion (i) the appellant is terminally ill and near death, and that there is no hope of her recovering; (ii) that she is, or but for medication would be, suffering unbearable physical pain or severe psychological distress; (iii) that they have informed her, and that she understands, that she has a continuing right to change her mind about terminating her life; and, (iv) when, in their opinion, the appellant would likely die, (a) palliative care should be administered to her, and (b) if palliative care should not be administered.*

***Third,** not les s that there clear days before any psychiatrist examines the appellant fir the purposes of preparing a certificate for the purposes aforesaid, notice must be given to the Regional Coroner for the area of district where the appellant is to be examined, and the Regional Coroner or his nominee, who must be a physician, may be present at the examination of the appellant by a psychiatrist in order to be satisfied that the appellant does indeed have mental competence to decide, and does in fact decide, to terminate her life.*

***Fourth,** one of the physicians giving any certificate as aforesaid must re-examine the appellant each day after the above-,mentioned arrangements are put in place to ensure she does not evidence any change in her intention to end her life. If she commits suicide, such physician must furnish a further certificate to the Coroner confirming that, in his or her opinion, the appellant did not change her mind.*

***Fifth,** no one may assist the appellant to attempt to commit suicide or to commit suicide after the expiration of thirty-one days from the date of the first mentioned certificate, and, upon the expiration of that period, any arrangements made to assist the appellant to end her life must immediately be made inoperative and discontinued. I include this condition to ensure, to the extent it can be ensured, that the appellant has not changed her mind since the time she was examined by a psychiatrist."*

McEachern J said this limitation troubled him greatly *"as I would prefer that the appellant be permitted free choice about the time when she wishes to end her life. I am, however, unwilling to leave it open for a longer period because of the concern I have that the appellant might change her mind. She is able to proceed at her preferred pace by delaying the time for her psychiatric examination until the time she thinks she is close to the time when she wishes to end her ordeal. If she delays causing her death for more than thirty-one days after such examination then there is a risk either that she had not finally made up her mind, or that, as is everyone's right, she has changed it, or possibly that she is no longer competent to make such a decision.*

***Sixth,** the act actually causing the death of the appellant must be the unassisted act of the appellant herself, and not of anyone else",* at 169-70.

approach to the compatibility between *s.241(b)* of the Criminal Code and certain rights and freedoms contained in the Charter.

Unlike the finding of a legislative violation of s.7 by McEachern CJ, Chief Justice Lamer in the Supreme Court of Canada held that *s.241(b)* infringed s.15[110] of the Charter. Persons with disabilities who are or would become unable to end their lives without assistance were discriminated against by that provision because, unlike persons capable of causing their own deaths, they were deprived of the option of choosing suicide. In addition he held that s.1 of the Charter did not save s. *241 (b).*[111]

Having found an infringement under s.15(1) it was not deemed necessary to address the constitutionality of *s.241(b)* under ss.7 or 12.

Lamer CJ's analytical approach merits examination.

At the outset he invoked *Andrews v Law Society of British Columbia*[112] as confirmation of the way in which the right to equality contained in s.15(1) of the *Charter* should be considered. He reiterated the view he himself had expressed in *R v Swain*[113] in summarising the method of analysis to be used in considering a complaint under s.15(1).[114]

Applying these criteria Lamer CJ held that *s.241(b)* created an inequality which was imposed on persons unable to end their lives unassisted solely because of physical disability, a personal characteristic which is among the grounds of discrimination listed in s.15(1). For these people, the principle of self-determination had been limited.[115]

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[110] See fn.4 supra.

[111] *"The means chosen to carry out the legislative purpose of preventing possible abuses do not in my opinion impair as little as reasonably possible the right to equality enshrined in s. 15(1) of the Charter."*

[112] *[1989] 1 SCR 143.* McIntyre J had defined discrimination as *"a distinction, whether intentional or not but based on ground relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society"*, at 174.

[113] *[1991] 1 SCR 933.*

[114] *"The court must first determine whether the claimant has shown that one of the four basis equality rights has been denied....this inquiry will focus largely on whether the law has drawn a distinction (intentionally or otherwise) between the claimant and others, based on personal characteristics. Next the court must determine whether the denial can be said to result in 'discrimination'.....In determining whether the claimant's s.15(1) rights have been infringed, the court must consider whether the personal characteristic in question falls within the ground enumerated in the section or within an analogous ground, so as to ensure that the claim fits within the overall purpose of s.15 – namely, to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society"*, at 192.

[115] While *"at first sight persons who cannot commit suicide and those who could are given identical treatment under s.241(b) of the Criminal Code, they are nevertheless treated unequally since by the* ***effect*** *of that provision persons unable to commit suicide without assistance are deprived of any ability*

Could the infringement which he had found be justified, however, under s.1[116]of the Charter?

The standard that the state must satisfy under *s.1* was established in *R v Oakes.*[117] There are two elements, the first of which considers the validity of the legislative objective while the second considers the validity of the means chosen to achieve that objective. In the Chief Justice's view the context in which *s.241(b)* operated was altered when, in 1972, Parliament removed the offence of attempted suicide from the Criminal Code.[118]

Self-determination became the paramount factor in the state regulation of suicide. If no external interference or intervention could be demonstrated, the act of attempting suicide could no longer give rise to criminal liability. Where state interference was present, and therefore the evidence of self-determination less reliable, the offence of assisted suicide could then be triggered.

However, while remaining facially neutral in its application, *s.241(b)* gave rise to a deleterious effect on the options open to persons with physical disabilities, whose very ability to exercise self-determination was premised on the assistance of others.[119]

The objective of *s.241(b)* had to be considered also in the larger context of the legal framework which regulates the control individuals may exercise over the timing and circumstance of their death.

It had been established, in *Malette v Shulman*[120] that patients could compel their physicians not to provide them with life- sustaining treatment, and in *Nancy B. v Hotel-Dieu de Quebec*[121] that patients undergoing life-support treatment could compel their physicians to discontinue such treatment, even where such decisions might lead directly to death. The rationale underlying these decisions was the promotion of individual autonomy. An

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to commit suicide in a way which is not unlawful, whereas s. 241(b) does not have that effect on those able to end their lives without assistance," Ibid.

[116] *Section 1 of the Charter guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.*

[117] *[1986] 1 SCR 103.*

[118] *"The evidence suggests that the offence of attempted suicide was repealed in order to reflect the prevailing societal view that suicide was an issue related more to health and social policy than to the ambit of the criminal justice system. Parliament by so doing was acknowledging that the threat of jail offered minimal deterrence to a person intent on terminating his or her life."*

[119] *"In other words, can it be said that the intent of Parliament in retaining s.241(b) after repealing the offence of attempted suicide was to acknowledge the primacy of self-determination for physically able people alone? Are the physically incapacitated, whether by reason of illness, age or disability, by definition more likely to be vulnerable than the physically able? These are the vexing questions posed by the continued existence of the offence of assisted suicide in the wake if the repeal of the attempted suicide provision."*

[120] *(1990) 72)R (2d) 417 (CA).*

[121] *(1992) 86 DLR (4th) 385 (Que.SC).*

individual's right to control his or her own body did not cease to obtain merely because the individual had become dependent on others for physical maintenance of the body; in such circumstances, this type of autonomy was often most critical to an individual's feeling of self-worth and dignity.[122]

While the Chief Justice found that *s.241(b)* satisfied the first criterion of the *Oakes* test he did aver, nonetheless, that the repeal of the offence of attempted suicide demonstrated that Parliament *"will no longer preserve human life at the cost of depriving physically able individuals of the right to self-determination."*

However, given the importance of the legislative objective, was Parliament justified in depriving persons with disabilities of their right to an equal measure of self-determination?

This element of his inquiry comprised three separate components: (a) that the means chosen to achieve the legislative objective were rational, fair and not arbitrary; (b) that the means chosen impair as minimally as is reasonably possible the right in question and (c) that the assessment of whether the infringement on the right was sufficiently proportional to the importance of the objective that is sought to be achieved. Only if the legislation survived each of these components could the limitation of the Charter right or freedom be found justifiable under s.1.

In the event, he found that the prohibition of assisted suicide to be rationally connected to the objective of protecting vulnerable persons who may be contemplating terminating their own life.

In the matter of minimal impairment, however, the judge was unable to see how preventing against abuse in one context must result in denying self-determination in another. He was un-persuaded by the government's apparent contention that it would not be possible to design legislation that was somewhere in between complete decriminalisation and absolute prohibition. He found that an absolute prohibition that was indifferent to the individual or the circumstances in question could not satisfy the constitutional duty on the government to impair the rights of persons with physical disabilities as little as reasonably possible.[123]

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[122] In support of this point Lamer CJ quoted from Ronald Dworkin's *'Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom',* Vintage, New York, 1993, at 217: *"Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."*

[123] *"Section 241(b) cannot survive the minimal impairment component of the proportionality test, and therefore I need not proceed to the third component of the proportionality test. As a result I find the infringement of s.15 by this provision cannot be saved by s.1."*

Having stated that the most common remedial order where a statutory provision is found to violate the *Charter* was a declaration that the provision be henceforth of no effect, he recognised that an immediate declaration of invalidity was not always advisable, especially where, as was the case in *Rodriguez,* the provision pursues an important objective but was not over-inclusive.[124]

Consequently, he held that the declaration that *s.241(b)* was of no force or effect should be suspended *"for a period long enough to allow Parliament to address this most difficult issue."*

"In my view, one year from the date of this judgement would give Parliament adequate time to decide what, if any, legislation should replace s. 241(b)."

This suspension of the declaration of invalidity, however, while it would afford relief to those affected by the legislation once the suspension period expired, did not provide an immediate remedy to the appellant in the instant case.

The Chief Justice reprised his own dicta in *Nelles v Ontario*[125] where, in the context of discussing the meaning of *'court of competent jurisdiction'* in *s.24(1)* he had averred that *"to create a right without a remedy is antithetical to one of the purposes of the Charter which surely is to allow courts to fashion remedies when constitutional infringements occur."*[126] He did admit, however, that because the Supreme Court had never before been faced by a litigant denied a personal remedy because the legislation was challenged under *s.52* of the *Constitution Act, 1982* rather than *s.24 (1)* of the Charter, prior cases were unclear on the precise status and rights of persons subject to the law during a period of suspended validity. The case before the Court raised, for the first time, the necessity of granting a personal remedy in conjunction with a suspended declaration of invalidity.

Therefore, notwithstanding the fact that the possibility of an exception where otherwise, or temporarily, valid legislation is declared unconstitutional in its application to a particular group had only been recognised previously in *obiter* statements of the Supreme Court, nonetheless he was of the view that an appropriate personal remedy for Ms Rodriguez during the period of suspension was justified. He did accept that an over-broad blanket prohibition should not be tempered by allowing judicially granted exemptions to nullify it and that the criteria on which such an exemption would be granted must be external to the Charter.

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[124] *"Were the Court to strike down the provision effective immediately, those whom the government could protect constitutionally with a more tailored provision, and who indeed should be protected, would be left unprotected. This would pose a 'potential danger to the public' as understood in Schachter"*, the case which he had invoked earlier.

[125] *[1989] 2 SCR 170.*

[126] At p.196.

The remedy requested by the appellant, and that fashioned by McEachern CJ in the Appeal Court of British Columbia, could best be understood as *'constitutional exemptions'*. While McEachern CJ did not use this term the Chief Justice opined that it was clear that this was the remedy he had in mind. However, the exemption was to be available only on the authority of a superior court, and granted on terms outlined by McEachern CJ in his judgement.[127] The criteria suggested there provided - apart from one exception[128] - adequate safeguards that the concerns necessitating the suspension of invalidity were not present in any case which might come before the courts.

While Chief Justice Lamer was concerned that the decriminalisation of assisted suicide might increase the risk to those vulnerable to manipulation by others, he contended that speculation to this effect and the fear of a "*slippery slope*" could not justify including within the purview of the provision those who are not vulnerable and who would freely consent to suicide.

A complete prohibition on assisted suicide was too severe an impediment of the right of the physically disabled and could not be saved under *s.1* of the *Charter.*

In summary, therefore, the Chief Justice of Canada, in 1993, held that a *'constitutional exemption'* be made available to the appellant.[129]

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[127] See fn.96 supra.

[128] *"I have held that s.241 (b) violates the equality rights of* ***all*** *persons who desire to commit suicide but are or will become physically unable to do so unassisted. Restricting the remedy to those who are terminally ill, and suffering from incurable diseases or conditions, as McEachern BCCJ would have, does not follow from the principles underlying may holding, and might well itself give rise to a violation of the equality rights of those who do not fit that description but wish to commit suicide and need assistance. Therefore, I would eliminate that part of McEachern BCCJ's conditions for a court order granting the constitutional exemption," at 234.* Consequently, the "*unbearable physical pain or sever psychological distress*" which were among the substantive criteria outlined by McEachern BCCJ in the British Columbia Court of Appeals, and the criterion of "*terminal illness*" were not relevant in view of the fact that a violation of the right to equality of all those incapable of committing suicide unaided had already been found. To restrict the exemption to the terminally ill might violate the rights of those who are unable to commit suicide unaided but are not terminally ill. McEachern BCCJ would have restricted the remedy to individuals suffering from terminal illness.
Another aspect of McEachern BCCJ's order cause Lamer CJ some concern:
"One of McEachern CJ's conditions is that the act of terminating the appellant's life be hers and not anyone else's. While I believe this to be appropriate in her current circumstances as a mechanism can be put in place allowing her to cause her own death with her limited physical capabilities, why should she be prevented the option of choosing suicide should the physical condition degenerate to the point where she is no longer even physically able to press a button or blow into a tube? Surely, it is in such circumstances that assistance is required most. Given that Ms Rodriguez had not requested such an order, however, I need not decide the issue at this time. Therefore, I prefer to leave it to be resolved at a later date." Ibid.

[129] The conditions attaching to the order were:
(i) the exemption may only be sought by way of application to a superior court; (ii) the applicant must be certified by a treating physician and independent psychiatrist, in the manner and at the time

Therefore, the constitutional questions:

(a) Does s.241 (b) of the Criminal Code of Canada infringe or deny, in whole or in part, the rights and Freedoms guaranteed by ss.7, 12 and 15(1) of the Canadian Charter of Rights and Freedoms?

and

(b) If so, is it justified by s.1 of the Canadian Charter of Rights and Freedoms and therefore not inconsistent with the Constitution Act, 1982?

were answered '*yes*' and '*no*' respectively.

(b) McLachlin J:

In *Rodriguez* McLachlin J, as she then was, held that *s.241 (b)* violated the right to security of the person included in s.7 of the Charter and that this violation was not saved by section 1.[130] This right had an element of personal autonomy which protects the dignity and privacy of individuals with respect to decisions concerning their own body.

A legislative scheme which limits the right of a person to deal with her body as she chooses may violate the principles of fundamental justice under s.7 if the limit is arbitrary.

A particular limit will be arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation.

When considering whether a law breaches the principles of fundamental justice under s.7 by reason of arbitrariness, the focus must be on whether a legislative scheme infringes a particular person's protected interests in a way that cannot be justified having regard to the objective of this scheme.

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suggested by McEachern BCCJ, to be competent to make the decision to end her own life, and the physicians must certify that the applicant's decision has been made freely and voluntarily, and at least one of the physicians must be present with the applicant at the time the applicant commits assisted suicide; (iii) the physicians must also certify: (a) that the applicant is or will become physically incapable of committing suicide unassisted, and (b) that they have informed him or her, and that he or she understands, that he/she has a continuing right to change his/her mind about terminating his or her life; (iv) notice and access must be given the Regional Coroner at the time and in the manner described by McEachern BCCJ; (v) the applicant must be examined daily by one of the certifying physicians at the time and in the manner outlined by McEachern BCCJ; (vi) the constitutional exemption will expire according to the limits set by McEachern BCCJ; and, (vii) the act causing the death of the applicant must be that of the applicant him/herself, and not of anyone else.

[130] *Section 1 of the Charter guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.*

The principles of fundamental justice require that each person, considered individually, be treated fairly by the law. The fear that abuse may arise if an individual is permitted that which she is wrongly denied plays no part at the s.7 stage. Any balancing of societal interests of the individual should take place within the confines of s.1 of the Charter. Parliament had put into force a legislative scheme which makes suicide lawful but assisted suicide unlawful. The effect of this distinction was to deny to some people the choice of ending their lives solely because they are physically unable to do so, preventing them from exercising the autonomy over their bodies available to other people. The denial of the ability to end their life was arbitrary and amounted to a limit on the right to security of the person which did not comport with the principles of fundamental justice.

Persuasive as she found the reasons given by Lamer CJ, McLachlin J did not view the case as one falling within the ambit of s.15 of the Charter. She believed that to treat it as such might deflect the equality jurisprudence from the true focus of *s.15* – i.e., *"to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society."*[131]

Rather, she was of the view that *s.241(b)* infringed s.7.[132]

She held that the reasoning of the majority in *R v Morgentaler*[133] was dispositive of the issues in the appeal. In that case it was established that s.7 of the Charter protects the right of each person to make decisions concerning his or her body - flowing from the fact that decisions about one's body involve *"security of the person"* which s.7 safeguards against state interference which is not in accordance with the principles of fundamental justice.[134]

The matter for resolution before the Court was whether it was proper that the claimant be asked to serve as a scapegoat.[135]

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[131] Per Lamer CJ in *R v Swain [1991] 1 SCR 933, at 992.*

[132] *"In my view the denial to Sue Rodriguez of a choice available to others cannot be justified. The potential for abuse is amply guarded against by existing provisions in the Criminal Code, as supplemented by the condition of judicial authorisation, and ultimately, it is hoped, revised legislation,. I cannot agree that the failure of Parliament to address the problem of the terminally ill is determinative of this appeal. Nor do I agree that the fact that medically assisted suicide has not been widely accepted elsewhere bars Sue Rodriguez's claim. Since the advent of the Charter, this Court has been called upon to decide many issues which formerly lay fallow. If a law offends the Charter, thus Court has no choice but to so declare."*

[133] *[1988] 1 SCR 30*

[134] *"Security of the person has an element of personal autonomy protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she has the autonomy to declare what is best for his or her body."*

[135] *"There may be no reason on the facts of Sue Rodriguez's case for denying her the choice to end her life, a choice that those physically able have available to therm. Nevertheless, she must be denied that*

The principles of fundamental justice, however, require that each person, considered individually, be treated fairly by the law. The fear that because unlawful acts might arise if an individual is permitted that which she is wrongly denied *"plays no part at this initial stage."*[136]

The distinction drawn between suicide and assisted suicide was arbitrary.[137] *"The effect of the distinction is to prevent people like the appellant from exercising the autonomy over their bodies available to other people."* Consequently, *"the s.241(b) prohibition violates the fundamental principles of justice"* and *"s.7 is breached."*

The important state interest in ensuring that people do not take the lives of others is not absolute. The state does not criminalise all acts that result in the death of another. Where there is a valid justification for death – as in self-defence – criminal liability is not engaged. The argument that the prohibition of assisted suicide was justified because the state has an interest in criminalising wilful acts that contribute to another person's death was rejected.[138]

In summary, *s.241(b)* could not be saved under s.1 of the Charter. The objective of the provision was to combat the possibility that legalising assisted suicide might lead to abuses resulting in the death of individuals who had not genuinely and voluntarily consented to death. While such a possibility was a matter of legitimate concern McLachlin J was of the view, however, that it was not sufficient to outweigh the appellant's right to end her life when she wished to do so. Concerns about abuse, she suggested, could be dealt with under existing provisions of the Criminal Code and by requiring court orders to permit assisted suicide in individual cases.

In conclusion, the respective roles of Parliament and the Courts, was addressed. The task of the court was not to *"second guess Parliament's objective in criminalising the assistance of suicide."* It was much more modest endeavour – *"to determine whether, given the legislative scheme regulating suicide which Parliament had put in place, the denial to Sue Rodriguez of*

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choice because if the danger that other people may wrongfully abuse the power they have over the weak and ill, and may end the lives of these persons against their consent. This, Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat."

[136] *"In short, it does not accord with the principles of fundamental justice that Sue Rodriguez be disallowed what is available to others merely because it is possible that other people, at some other time, may suffer, not what she seeks, but an act of killing without true consent."*

[137] *"To borrow the language of the Law Reform Commission of Canada '[it] is difficult to justify on grounds of logic alone'."* See *'Working Paper 28: Euthanasia, Aiding Suicide and Cessation of Treatment', (1982),* at 53. *"In short, it is arbitrary. The objective that motivates the legislative scheme that Parliament has enacted to treat suicide is nor reflected in its treatment of assisted suicide."*

[138] Also rejected was the distinction between passive and active intervention to end life: *"If the justification for helping someone to end life is established, I cannot accept that it matters whether the act is 'passive' – as in the withdrawal of support necessary to sustain life – of 'active' – as in the provision of a means to permit a person of sound mind to choose to end his or her life with dignity."*

the ability to end her life is arbitrary and hence amounts to a limit on her security of the person which does not comport with the principles of fundamental justice. The focus is not on why Parliament has acted, but on the way in which it has acted."

While she concurred generally in the remedy proposed by Lamer CJ – namely, the granting of a *'constitutional exemption'* – she was not convinced that some of the conditions laid down by his guidelines were essential.

"In the case at bar, where the plaintiff's own act will trigger death, it may not be necessary to ascertain the consent on a daily basis, nor to place a limit of 31 days on the certificate."

The requirements in each case would vary; but the essential in all cases was that the judge be satisfied that if and when the assisted suicide takes place, it would be with the full and free consent of the applicant.[139]

9. The Finding in *Carter v Canada* in the Supreme Court of British Columbia

Having contextualised the jurisprudential landscape in the matter of third party assistance with death in Canada post-*Rodriguez*, and having taken account of the opinions expressed by a number of public bodies, including special committees of both provincial national assemblies and the Canadian House of Commons, and having reviewed the judicial reasoning underpinning the dissenting judgements of the Chief Justice of British Columbia, and those of the Chief Justice of Canada and McLachlin J, as she then was, it is now possible to approach the reasoning adopted and followed in *Carter v Canada*[140] with a greater degree of dispassion than might have been possible in the absence of the prior jurisprudential and curial history to which it is indebted.

Of particular interest will be whether there is an identifiable line of authority in the conditions outlined by McEachern CJ for permissible acts of physician-assisted suicide, and the granting of constitutional exemptions, in his dissent in the Court of Appeal in British Columbia, and likewise in the dissents of Lamer CJ[141] and McLachlin J in the Supreme Court of Canada.

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[139] *"I would leave the final order to be made by the chambers judge, having regard to the guidelines suggested by McEachern CJ below and the exigencies of the particular case."*
Cory J concurred with the views of Lamer CJ and McLachlin J. In his view the right to die with dignity should be afforded protection under *s.7* of the *Charter*.

[140] *[2012] BCSC 886.*

[141] In the Canadian Supreme Court Lamer CJ had had indicated his willingness to order a physician to assist Sue *Rodriguez* in suicide but refrained from doing so on the ground that the appellant had not sought such an order. At the time he heard the case a lawyer, Jocelyn Downie, served as a clerk in his

The plaintiffs in *Carter*[142] challenged several provisions of the *Criminal Code* relating to assisted suicide, most particularly *s.241(b).* They claimed that the law violates the equality guarantee in *s.15*[143] of the *Charter* on the grounds that able-bodied persons can commit suicide without assistance, but disabled persons may not be able to do so, and are thus *"deprived of the ability to choose and carry out their death in a lawful way."*

They also argued that the law against assisted suicide violates the *Charter* guarantees of *"life, liberty and the security of the person"* contained in *s.7* with respect to the *"grievously and irremediably ill,"* who seek physician-assisted suicide and persons wishing to assist them to obtain that service, including physicians.

The third legal argument advanced by the plaintiffs was that *"treatment and management of the physical and emotional suffering of a grievously and irremediably ill patient"* were matters which fell within the *"exclusive jurisdiction"* of the provincial government, which was constitutionally mandated to manage health care. Since physician-assisted suicide and voluntary euthanasia were – according to the plaintiff Dr. Shoichet – *"important components of the provision of health care to grievously and irremediably ill patients,"* the lawsuit asked that sections of the *Criminal Code* – a federal statute – that prevent the provision of this *"health care"* should be struck down as an unconstitutional interference in provincial jurisdiction, *"to the extent that [they] prohibit physician-assisted dying."*

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office. Ms Downie is now a Professor in the Faculty of Law and Medicine at Dalhousie University in Halifax, Nova Scotia. She is a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences, and Canada Research Chair in Health Law and Policy. At a symposium in Ottawa in 2007, Professor Downie expressed the view that the Supreme Court of Canada might be willing to reverse its 1993 ruling in *Rodriguez.* She outlined the strategy for a legal challenge under Canada's *Charter of Rights* and Freedoms and said that she was looking for an ideal test case to use to strike down the legal prohibition of assisted suicide contained in the Criminal Code. Professor Downie provided assistance to the plaintiffs in *Carter* by instructing their expert witnesses. However, she herself was not a witness in the case.

[142] The plaintiffs were Lee Carter, Hollis Johnson, Dr William Shoichet, the British Columbia Civil Liberties Association (BCCLA), and Gloria Taylor. Lee Carter and Hollis Johnson had taken a family member to Switzerland to have death facilitated there. They were concerned that they might be prosecuted in Canada as a result. Dr Shoichet had expressed a willingness to perform physician-assisted death if it were no longer illegal. Gloria Taylor, aged 64, had amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), and was concerned that at some point in the progression of her illness she might be too disabled to commit suicide by her own hand. In her affidavit Ms Taylor had stated: *"My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that 'enough is enough' moment arrives....As Sue Rodriguez asked before me....whose life is it anyway?"* See *Carter v Canada [2012] BCSC 886, at paras 55 & 56.* Ms Taylor died naturally as a result of a severe infection in October, 2012. As its name suggest, the BCCLA is a civil rights advocacy group. Interventions in support of the plaintiffs were filed by the *Farewell Foundation for the Right to Die*, the *Canadian Unitarian Council* and the *Ad Hoc Coalition of People with Disabilities who are Supportive of Physician-Assisted Dying.* The *Christian Legal Fellowship (CLF)* and the *Euthanasia Prevention Coalition (EPC)* intervened in support of the absolute ban on assisted suicide.

[143] *See fn.4 supra.*

In summary, the plaintiffs sought court-ordered legalisation of third party assistance with death, and in particular of physician-assisted suicide.

Over the objections of the governments of Canada and British Columbia, a summary trial[144] rather than a conventional trial was held in the last two months of 2011.

The defendants in the case were the Attorneys General of British Columbia and Canada. A number of other parties had what is known in Canadian jurisprudence as intervener status.

The specific issues for the Court's consideration were:

1. Is the ban on assisted suicide in s. 241(b) of the Criminal Code contrary to s.15 of the Charter of Rights and Freedoms, which guarantees the right to equality? If so, is the infringement a reasonable limit that is demonstrably justified in a free and democratic society under s. 1 of the Charter?

2. Is the ban on assisted suicide contrary to s.7 of the Charter of Rights and Freedoms, which guarantees the right to life, liberty, and security of the person except in accordance with the principles of fundamental justice? If so, is the infringement a reasonable limit that is demonstrably justified in a free and democratic society under s. 1 of the Charter?

3. If there is an infringement of either s. 15 or s.7 of the Charter of Rights and Freedoms that cannot be justified, what is the appropriate remedy?

Smith J followed the analytical method established by precedent in adjudicating claims of violations of equality guarantees, and of violations of life, liberty and security of the person.[145]

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[144] A summary trial is a proceeding in which the evidence consists largely of affidavit evidence, legislative facts and expert opinion evidence. Because of Gloria Taylor's deteriorating condition and the inability of plaintiffs' counsel to represent them *pro bono* in a lengthy conventional trial, the judge agreed to a modified expedited summary trial.

[145] With regard to equality the requisite questions are:
(a) Is the law discriminatory? That is (i) does it create a distinction based on physical disability? And (ii) does the distinction create a disadvantage?
(b) If the law is discriminatory, can it, nonetheless, be demonstrably justified as a reasonable limit prescribed by law in a free and democratic society under s.1 of the Charter? That is: (i) is the purpose pressing and substantial?; (ii) are the means proportionate to the end? – specifically, is the limit rationally connected with the purpose, does the limit minimally impair the right and is the law proportionate in its effect?
The analysis of alleged violations of life, liberty and security of the person under s.7 is different, but some aspects of the analysis overlap with the s.15 analysis:
(a) does the law deprive the plaintiff of life, liberty or security of the person?
(b) is the deprivation in accordance with principles of fundamental justice?, specifically (i) is the deprivation arbitrary; (ii) is the law overbroad?; (iii) is the effect of the law grossly disproportionate to the problem it addresses?

With respect to equality claims under *s.15*, the burden of proof lies with the plaintiffs. They must show that the law is discriminatory. Under *s.7* they must prove that the law deprives them of life, liberty and security of the person and violates principles of fundamental justice. Justice Smith noted that, with respect to the latter, the plaintiffs had to show either that the law was not the least restrictive that could have been chosen to achieve it's purpose or was so extreme that it was "*disproportionate to any legitimate government interest*."

In the event that the plaintiffs proved that the law was discriminatory and/or that it improperly deprived them of life, liberty or security of the person, the burden of proof shifted to the government to justify the law under *s.1* of the *Charter*. The government would have to prove that the infringement of rights and freedoms was justified.

Notwithstanding the decision in *Rodriguez* that the *Criminal Code* prohibition of assisted suicide[146] was constitutional the Court in *Carter* decided to revisit the issue on the basis that it was appropriate for a number of reasons not least of which was that:

(i) there was significant evidence available from other jurisdictions where assisted suicide is permitted – including evidence of the effectiveness of safeguards to protect vulnerable individuals – that had not been available to the Supreme Court in 1993 when *Rodriguez* was decided;[147]

(ii) new legal principles had been developed in the interim dealing especially with the proper approach to interpreting s.7 and the right to life, liberty and security of the person.[148] Also, new principles had emerged regarding the proper approach to the interpretation of reasonable limits under *s.1* of the Charter,[149] and

(iii) a number of legal issues in *Carter* had not been conclusively decided in *Rodriguez*.

With regard to (1) above Smith J reviewed the specific evidence presented concerning the practice of assisted suicide and euthanasia, and the effectiveness of safeguards, in the American states of Oregon and Washington, in Belgium, the Netherlands, Luxembourg and Switzerland.

(c) if the law contravenes principles of fundamental justice, can it, nonetheless, be demonstrably justified under s.1 of the Charter of Rights and Freedoms?

[146] The Court defined '*assisted suicide*', or '*physician-assisted suicide*' as the "*act of intentionally killing oneself with the assistance of a medical practitioner who provides the knowledge, means, or both*", at para 38. It was "*closely related to voluntary euthanasia, which is the intentional termination of the life of a patient by a physician, at the patient's request, for compassionate reasons.*" Ibid. The term "*physician-assisted dying*" encompassed both physician-assisted suicide and voluntary euthanasia.

[147] At para 1001.

[148] At para 1002.

[149] At para 1003.

She found that in respect to compliance with safeguards the process in Oregon was *"working fairly well but could be improved,"* and compliance in the Netherlands was *"continually improving"* but was not ideal. Matters in Belgium were found to be less satisfactory. The judge acknowledged *"low rates of reporting...and high rates of LAWER (Life ending Acts Without Explicit Request)."*[150]

Nonetheless, there was no empirical evidence that legalising assisted suicide and euthanasia had imposed *"a particular risk to socially vulnerable populations"* in either the Netherlands or Oregon. The evidence *"does not support the conclusion that pressure or coercion is at all widespread or readily escapes detection"* in those jurisdictions.[151]

Having reviewed the evidence adduced in respect of the feasibility of safeguards,[152] and having traversed the issues of patient competence,[153] voluntariness,[154] informed consent,[155]patient ambivalence, [156] the elderly[157] and the disabled[158]Smith J averred:

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[150] She did not find, however, that there was evidence to suggest that the incidence of LAWER had declined since the legalisation of euthanasia in that jurisdiction.

[151] She summarised her views in these matters succinctly: *"Research findings show different levels of compliance with the safeguards and protocols in permissive jurisdictions, No evidence of inordinate impact on vulnerable populations appears in the research. Finally, the research does not clearly show either a negative or a positive impact in permissive jurisdictions on the availability of palliative care or on the physician-patient relationship."*

[152] At paras. 748-853.

[153] At paras. 762-769.While acknowledging the difficulties associated with ensuring that patients are competent to decide to seek assisted suicide or euthanasia, the judge held that *"it is feasible for properly-qualified and experienced physicians reliably to assist patient competence...so long as they apply the very high level of scrutiny appropriate to the decision and proceed with great care."*

[154] At paras. 799-815. Expert witness evidence concerning the subtlety of influences that can be brought to bear on patients was accepted. The evidence was provided by: Dr Gallagher, a Vancouver-based physician specialising in palliative care and chronic pain; Dr Harvey Chochinov, a Distinguished Professor of Psychiatry at the University of Manitoba and Director of the Manitoba Palliative Care Research Unit, Cancer-Care Manitoba; Professor Marnin Heisel, a clinical psychologist., research scientist and Associate Professor at the Schulich School of Medicine and Dentistry, University of Western Ontario. The judge also accepted the evidence of plaintiff witnesses *"that coercion and undue influence can be detected as part of a capacity assessment."* This evidence was provided by Dr Martha Donnelly, a geriatric psychiatrist and Associate Professor at the university of British Columbia in Vancouver; Dr Linda Ganzini, a geriatric psychiatrist and Professor of Psychiatry and Medicine and Director of the Division of Geriatric Psychiatry at the Oregon Health and Science University..

[155] At paras. 816-831. In Smith J's view the evidence adduced demonstrated that the issue of informed consent presented no more difficulty in the case of assisted suicide than in seeking or refusing medical treatment.

[156] At paras. 832-843.The judge concluded that *"it is feasible to screen out ....patients who are ambivalent, by assessing capacity and requiring some time to pass between the decision and its implementation."*

[157] At paras. 844-847.While it was recognised that the elderly are vulnerable to abuse and that the disabled *"face prejudice and stereotyping"* nonetheless it was found that there was *"no evidence that the elderly access physician-assisted dying in disproportionate numbers in permissive jurisdictions."*

[158] At paras. 844-847. Risks to the disabled can be avoided *"through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks."*

"My review of the evidence...leads me to conclude that the risks inherent in permitting physician-assisted death can be identified and very substantially minimised through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforce."

The plaintiffs, as has already been stated, argued that the law prohibiting assisted suicide infringed the right to equality because it placed an extra burden on individuals who are seriously physically disabled.[159] Committing suicide, or attempting to commit suicide, is not, in itself, a crime.[160] However, individuals who suffer from a serious physical disability are not capable of ending their lives and Ms. Taylor deposed that the *Criminal Code* prohibition on assisted suicide discriminated against her, and other individuals in a similar situation, on the basis of physical disability.[161]

The Government of Canada argued that because assisted suicide was prohibited for everyone – both able-bodied and physically disabled persons – there was no distinction or discrimination, and therefore no infringement of s.15.[162]

Similarly, it argued that there were end-of-life choices available to disabled persons that were legal, such as refusing or withdrawing treatment, or declining nutrition and hydration under palliative sedation.[163] Palliative sedation was a legal and accepted end-of-life practice. It involved doctor-imposed sedation in order to maintain an individual in a deep state of unconsciousness until the time of death, with or without the provision of nutrition and hydration.[164]

Ms Taylor argued that there was no ethical or logical reason to distinguish palliative sedation from assisted suicide, while the state of Canada argued that the key distinguishing factor was that with palliative sedation the doctor did not commit an action that was designed to end the patient's life.

Applying the two-step test, established by *Withler v Canada (Attorney General),*[165]as the criteria for determining whether an infringement of s.15 has occurred, the Court in *Carter* held that the prohibition of assisted suicide created a distinction in that it placed a burden on

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[159] *At para.1009.*
[160] *At para 1011.*
[161] Ibid.
[162] *At para 1075.*
[163] *At para 1065.*
[164] *At para 200.*
[165] *2011 SCC 12, [2011] 1 SCR 396*: 1. *Does the law create a distinction based on an enumerated or analogous ground? and, 2. Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?*

people with physical disabilities that was not placed on able-bodied individuals.[166] Physically disabled people may not be capable of taking their own lives and are faced with the dilemma of continuing to suffer or exposing another person to criminal charges for assisting them to commit suicide.[167]

The distinction was discriminatory because *"it perpetuates and worsens"* a disadvantage that is suffered by physically disabled persons.[168] The law does not respect the dignity and autonomy of physically disabled persons as they do not have the same ability to make the deeply personal choice of whether to end their own lives.

It was held accordingly that Ms.Taylor had proven an infringement of her right to equality under *s.15* of the Charter.[169]

Of necessity, the Court was obliged to adjudicate whether the infringement was demonstrably justified in a free and democratic society.

The so-called s.1 test[170]- in effect, a proportionality test - was invoked.

This test had been employed in *Rodriguez.* There, the Court had concluded that, assuming the law prohibiting assisted suicide was a violation of s.15 equality rights, it was justified.[171]

But, notwithstanding the normal invocation of the principle of *stare decisis* the Court in *Carter* decided to look afresh on the matter of s.1.[172]

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[166] *At para.1075.*

[167] *At para.1042.* The Court expressed concern that *"some resolve this dilemma by taking their lives before their illnesses progress to a point where they are no longer able to do so,"* Ibid. Although there were some methods of suicide available to physically disabled individuals, such as palliative sedation combined with the refusal of nutrition, the Court concluded that these means of suicide were far more onerous than those available to able-bodied individuals. See para 1076.

[168] *At para.1161.*

[169] *At para.1162.*

[170] The s.1 test encompasses a number of criteria:
1. Does the legislation have a pressing and substantial objective?
2. Are the means used to achieve the legislative objectives proportionate in that they do not breach Charter rights more than necessary? To answer the proportionality question courts ask:
(a) is there a rational connection between the legislation that is in violation of the Charter and the objectives of the legislation itself? In short, are the means rationally connected to the objectives?
(b) does the infringement minimally impair Charter rights?
(c) do the benefits of the legislation outweigh the harms associated with violating the Charter rights?

[171] *Rodriguez v British Columbia (Attorney General) [1993] 3 SCR 519 at 613-15,* cited in *Carter v Canada, 2012 BCSC 886 at para 1165.* The majority in *Rodriguez* did not conclusively decide whether the laws prohibiting assisted suicide infringed *s.15.* Instead, it found that even if they did infringe *s.15,* the infringement was justified under *s.1* of the *Charter.*

[172] The Court averred that it was doing this on the basis that:
(i) the Supreme Court in *Rodriguez* did not conclusively decide - which, of course, it did not – whether the laws prohibiting assisted suicide infringed s.15. The Supreme Court had stated that even if there

In *Rodriguez* it had been found that the objectives of the legislation were pressing and substantial. *Carter* came to the same conclusion.[173]

In *Rodriguez* the Supreme Court held that the law against assisted suicide was rationally connected to the purpose of *s.241(b)* of the Criminal Code.[174] The Court in *Carter* determined similarly.[175]

While the Supreme Court in *Rodriguez* held that the Criminal Code provisions were minimally impairing, because there was no other measures that could be relied upon to fully achieve the purpose of protecting vulnerable people from being coerced or forced into an assisted suicide, the Court in *Carter* concentrated its analysis on whether there were alternatives to the absolute prohibition which would achieve the objective of the legislation, without seriously infringing the rights under the Charter.

Smith J averred that one such alternative, albeit theoretical only, was one in which Parliament *"could prohibit assisted death but allow for exceptions. The exceptions could permit physician-assisted death under stringent conditions designed to ensure that it would only be available to grievously ill, competent, non-ambivalent, voluntary adults who were fully informed as to their diagnosis and prognosis and who were suffering symptoms that could not be treated through means reasonably acceptable to those persons."*[176]

While it was acknowledged that such exceptions, in practical application, might possibly place patients at risk because of the difficulty in designing and applying protocols which would obviate errors, a traversal of the evidence from other jurisdictions indicated that the risks of harm in those regimes that permit physician-assisted death can be greatly minimised.[177]

In the event it was held that since a less drastic means of preventing vulnerable persons from being induced to commit suicide was available to the government, the legislation was not

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was an infringement it was justified under s.1 of the Charter. The case had been decided on other grounds.
(ii) there was new evidence regarding the effectiveness of safeguards that was not available to the court in *Rodriguez.*
(iii)the law regarding the *s.1* test had evolved, and was no longer the same as it had been when *Rodriguez* was decided.

[173] *At para.1205.*
[174] *[1993] 3 SCR 519 at 613.*
[175] *At para.1209.*
[176] *At para.1233.*
[177] *At para.1240.*

minimally impairing. The defendants had failed to show that the legislation impaired Ms.Taylor's Charter rights as little as possible.[178]

Considerable attention was devoted to the final element of the proportionality test - whether the benefits of the legislation were proportionate to the harms that result from the violation of Charter rights?

In *Alberta v Hutterian Brethern of Wilson Colony*[179]it had been found that at the final step of the proportionality analysis the focus widens to include the seriousness of the infringement, and asks more broadly whether the *"benefits of the impugned law are worth the costs of the rights limitation."*[180] In that case McLachlin CJ had explained that only the final branch takes full[181]account of the severity of the deleterious effects of a measure on individuals or groups.

In the alternative, it was submitted by Canada that the Court must address whether the autonomy interests and suffering of some individual were outweighed by the public benefits of promoting the value of every life, preserving life, protecting the vulnerable, preventing abuses, maintaining the physician-patient relationship and promoting palliative care. Witness evidence in the 1995 *Special Senate Committee Report* was invoked in support.[182]

However, the plaintiffs argued that the deleterious effects of the law outweigh any salutary effects.

The prohibition of assisted death deprived a class of individuals of: *(i) the ability to end their lives at time and in the manner of their choosing, a matter of fundamental personal importance; (ii) the quality of their remaining life, if they decide that they must end their own suffering while they are still physically able to do so; and, (iii) the ability to put an end to physical pain and psychological stress.*

The stark choice[183] facing Ms Taylor was one of either disobeying the law or foregoing her constitutional rights.

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[178] *At para.1244.*

[179] *2009 SCC 37, [2009] 2 SCR 567.*

[180] Ibid. at para 77.

[181] Ibid. at para.76.

[182] The Report had acknowledged that palliative care can be ineffective for a small minority but *"that does not mean that the rare case should drive the social and moral fibre of this country in terms of its attitudes towards dying...We cannot say that we have to change the ethics of this country for the occasional dreadful, horrible case that cannot be accommodated by the system,"* cited at para 1250.

[183] The dicta of the majority in *Alberta v Hutterian Brethern of Wilson County 2009 ACC 37*, at 97 were called in aid: *"The incidental effects of a law passed for the general good on a particular religious practice may be so great that they effectively deprive the adherent of a meaningful choice. Or the government programme to which the limit is attached may be compulsory, with the result that the*

In response to Canada's assertion that the provisions sent a message that suicide was not an answer, the plaintiffs said that Canada mistakenly presumed that Canadians did not see a difference between assisted death in response to intolerable suffering at the end of life, and suicide arising out of mental illness or transitory sadness. They suggested that a regulated regime might be more effective at bringing suicidal people to the attention of the health care community.

Justice Smith averred that the law preventing physically disabled, grievously ill people who are suffering unbearably from receiving assistance in taking the steps to end their own lives imposed a disproportionate burden on such people in that it was not one that was imposed on able-bodied persons.[184]

Concluding her analysis Justice Smith averred that the legislation prohibiting assisted death had very severe and specific deleterious effects on persons in Gloria Taylor's situation. It categorically denied autonomy to persons who were suffering while the faced death in any event. It also had deleterious effects on some physician-patient relationships and on the kind of care that some patients received.[185]

It was held that the benefits of the impugned law were not worth the costs of the rights limitation they created.

In the matter of a possible infringement of the provisions of s.7[186]of the Charter by the absolute prohibition of assisted death, a determination was required as to whether there had been a deprivation of the right to life, liberty, or security of the person, and if so, whether the deprivation was in accordance with the principles of fundamental justice.

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adherent is left with a stark choice between violating his or her religious belief and disobeying the law: Multani v Commission scolaire Margerite-Bourgeoys, 2006 SCC 6, [2006] 1 SCR 256. The absence of a meaningful choice in such cases renders the impact of the limit very serious."

[184] *At para. 1264.*While accepting that the absolute prohibition might have some of the salutary effects alleged by the defendants, e.g., sending an anti-suicide message, and a message about the value of every life, including the lives of those who are elderly or disabled, nonetheless she noted that ""*by thwarting the wishes of persons who are physically disabled, grievously ill and suffering intractably, the law sends a negative message that their wishes, and their suffering, are not as important as are other considerations",* at 1267.

Consequently, "the law's positive general message about the value of human life must be weighed against its negative message specific to the people whom it moist directly affects", ibid.

[185] *"[Further] the evidence supports the conclusion that, from time to time, assisted death occurs in Canada, contrary to the law. The positive effect of bringing under regulation what has previously been unregulated must be taken into account",* at para 1282. Likewise, *"the salutary effects of the legislation are generalised and, in some instances, ambivalent. As well, for the reasons set out in my discussion of minimal impairment, I believe that the salutary effects of the legislation can be preserved by leaving an almost-absolute prohibition in effect, and permitting only stringently-limited exceptions."*

[186] See fn.3 supra.

The infringements claimed by the plaintiffs were arbitrariness, over-breadth and gross disproportionality.

The plaintiffs urged that Ms. Taylor's right to liberty was engaged by state interference with the right of grievously and irremediably ill individuals to a protected sphere of autonomy over decisions of fundamental personal importance.

The defendants, on the other hand, submitted that the jurisprudence on liberty interests did not go that far. In particular, Canada argued that the liberty interest did not protect an individual's choice of a particular medical treatment, though it might protect the right to refuse treatment, and did not protect a right to physician-assisted dying.

In *Rodriguez,* the Supreme Court held that Ms. Rodriguez's security of the person interest was affected by the assisted suicide prohibition because it denied her the ability to make a personal choice.[187] Sopinka J, for the majority, held that the criminal prohibition had the effect of depriving Ms.Rodriguez *"of the ability to end her life when she is no longer able to do so without assistance"* was *"a sufficient interaction with the justice system to engage the provisions of s.7 assuming a security interest is otherwise involved."* [188]

Following *Rodriguez,* Smith J found that *"Ms. Taylor's interest in security of the person and liberty, and the liberty interests of Mr. Johnson and Ms. Carter (through possible susceptibility to imprisonment) are engaged by the impugned legislation.*[189]

The engagement, or not, of the right to life by the legislation was addressed.

This matter had not been decided in *Rodriguez.* The appellant in that case had not claimed a deprivation of her right to life.

Rodriguez however did hold that the three rights provided for in s.7 – those of life, liberty and security of the person – influence the meaning of one another, and all should be taken into account in determining the content of the principles of fundamental justice.[190]

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[187] The Court had emphasised that the ability to make such a fundamental life choice was a component of security if the person: *"there is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these." Rodriguez v British Columbia (Attorney General)[1993] 2SCR 519 at 587-589, cited in Carter v Canada, 2012 BCSC 886,* at para 1293.

[188] Ibid at para. 585.

[189] However, she did not find it necessary to decide whether Dr Shoichet's interest was engaged.

[190] *Rodriguez v British Columbia (Attorney General) [1993] 3 SCR 519, at 585.*

Likewise, Charter rights as a whole should be read in the light of one another and with an understanding of the underlying values that they represent. One such value was the inherent value of human life. *"Canadian society is based upon the intrinsic value of human life and on the inherent dignity of every human being."*[191]

The plaintiffs referred to the dissenting judgments, in *Rodriguez,* of Chief Justice McEachern[192] in the British Columbia Court of Appeal and of Cory J[193] in the Supreme Court of Canada.

In the alternative, Canada argued that the s.7 right to life did not encompass quality of life issues, which it admitted might implicate security of the person, but not the right to life itself. The right to life did not include the right to choose death. It submitted that such an interpretation would directly contradict the plain and obvious meaning of a right to life and would mark a significant departure from existing Supreme Court of Canada jurisprudence.

This jurisprudence had consistently recognised that the right to life protected individuals from death or the risk of death, rather than conferring on them a right to die. It invoked the dicta of McLachlin CJ and Major J in *Chaoulli.*[194]

The defendants also referred to the majority decision in *Rodriguez.* Although the appellant did not assert that she was deprived of the right to life, they submitted that the reasoning of

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[191] Ibid.

[192] McEachern BCCJ had *"no doubt that a terminally ill person facing what the appellant faces qualifies under the value system which the Charter is based to protection under the rubric of either liberty or security of the person...to terminate her own life, and, in my view, to assistance under particular circumstances."* He went on to state that *"it would be wrong, in my view, to judge this case as a contest between life and death. The Charter is not concerned only with the fact of life, but also with the quality and dignity of life. In my view, death and the way we die is a part of life itself."* Ibid.

[193] In his dissent in *Rodriguez* in the Supreme Court of Canada – not alluded to in any detail earlier – Cory J, who in the main concurred with the findings of McLachlin J, found that the right to life was engaged by the impugned provisions: *"The life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s.7. It follows that the right to die with dignity should be well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity,"* at para 630.

[194] *Chaoulli v Quebec (Attorney General) 2005 SCC 35: "Not every difficulty rises to the level of adverse impact on security of the person under* s.7. *The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s.7 protection of the security of the person is engaged. Access to a waiting list is not access to health care....there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care.* ***Where lack of timely heath care can result in death, s.7 protection of life itself is engaged****. The evidence here demonstrates that the prohibition on health insurance results in physical and psychological suffering that meets this threshold requirement of seriousness,"* at para 123.

the majority in that case was inconsistent with the view that the right to life included a right to death.

They also referred to *Pretty v The United Kingdom*[195] where the European Court of Human Rights had declined to interpret the right to life as one which included the right to die, even to prevent suffering and indignity.

Justice Smith agreed with the defendant Canada that McLachlin CJ's comments in *Chaoulli* suggested that the right to life is engaged only when there was a threat of death, although security of the person could be engaged with respect to impingements on the quality of life.

"In my opinion, the security of the person and liberty interests engaged by the legislation encompass the essence of the plaintiffs' claim."[196]

The judge then addressed the issue as to whether a deemed deprivation of the right to life, liberty or security of the person was in accordance with the principles of fundamental justice.

At the time *Rodriguez* had been decided one principle of fundamental justice was found to be of relevance, namely that a law must not be arbitrary.[197] The majority concluded that *s.241 (b)* was not arbitrary. The law must not be based on a whim or fancy. The deprivation of *Ms Rodriguez's* security of the person was in accordance with the principles of fundamental justice. Consequently, there was no infringement of her s.7 rights.

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[195] *[2002] ECHR 427,* at paras. 37-40.

[196] *At para. 1321.* Smith J continued: *"Only one aspect of Ms Taylor's claim seems to implicate the right to lifer per se, in the sense of a right* ***not*** *to die. The plaintiffs urge that the legislation has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their own lives at an earlier date than would otherwise be necessary. That point is supported by evidence from Ms Taylor as well as other witnesses. In that respect, I agree with the plaintiffs that the right to life is engaged by the effect of the legislation in forcing an earlier decision and possibly an earlier death on persons in Ms Taylor's situation."*

[197] The majority had stated, at paras 594-595: *"Where the deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems to me that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose. This is, to my mind, essentially the type of analysis which E. Colvin advocates in his article 'Section Seven of the Canadian Charter of Rights and Freedoms' (1995), 68 Can Bar Rev. 560, and which was carried out in Morgentaler. That is, both Dickson CJ and Beetz J were of the view that at least some of the restrictions placed upon access to abortion had no relevance to the state objective of protecting the foetus while protecting the life and health of the mother. In that regard the restrictions were arbitrary and unfair. It follows that before one can determine that a statutory provision is contrary to fundamental justice, the relationship between the provision and the state interest must be considered, One cannot conclude that a particular limit is arbitrary because (in the words of my colleague, McLachlin J at pp.619-20) 'it bears no relation to, or is inconsistent with, the objective that lies behind the legislation' without considering the state interest and the societal concerns which it reflects.* ***The issue here, then, can be characterised as being whether the blanket prohibition on assisted suicide is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition."***

Since the matter had been determined by *Rodriguez,* and was binding, Smith J did not address the question of arbitrariness.

However, in the period since *Rodriguez* was decided the Supreme Court of Canada has identified additional principles of fundamental justice. The first, that of *"over-breadth"*, provides that restrictions on life, liberty and security of the person must not be more broadly framed than necessary to achieve the legislative purpose. The second is *"gross disproportionality"* – the idea that a legislative response to a problem is so extreme as to be disproportionate to the purpose of the legislation. While treated separately over-breadth and gross disproportionality are related and somewhat overlapping concepts.

However, in a number of Supreme Court cases it had been found preferable to treat them as distinct principles. Smith J, in some detail, traversed the judicial dicta in these cases in both matters which it is unnecessary to reprise here. It is sufficient to note that she held that the law which absolutely prohibits assisted suicide under any circumstances is too broad because the alternative, a prohibition with limited exceptions, would achieve the same legislative goal, namely, protecting vulnerable people from being induced to commit suicide at a time of weakness.[198]

The necessity of an absolute prohibition might be reinforced if physician-assisted death was clearly inconsistent with medical ethics, simply on the basis that in those circumstances any physicians providing assisted death would be those who were prepared to disregard ethical principles.

"However, as set out in my review of the evidence with respect to safeguards, in the opinion of a number of respected ethicists and practitioners, physician-assisted death in an individual case is not ethically distinguishable from currently legal and ethically accepted end-of-life practices."[199]

The judge, who also took into account the unknown extent to which physician-assisted death and assisted death by non-physicians already occurred in Canada,[200] concluded that the

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[198] *At paras. 1363-64.* Consequently, it was held that *".....the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable people from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death."*

[199] *At para. 1369.*

[200] *At para. 1370." I have found that the evidence support the conclusion that such deaths do occur, though likely in a very small number of instances. Moving a system to a system of physician-assisted death under strict regulation would probably greatly reduce or even eliminate such deaths and enhance the likelihood that only competent, full-informed, voluntary and non-ambivalent patients would receive such assistance."*

impugned legislative provisions were overbroad. The plaintiffs had established their claim under s.7 of the Charter.

While, strictly speaking, it was unnecessary to address the arguments regarding gross disproportionality the court did so anyway and concluded that its analysis of the *s.1* justification arguments was probative of the *"very severe and grossly disproportionate effect [the prohibition had] on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life."*[201]

"I have taken into account in that analysis not only the objective of the legislation found in Rodriguez, but also the other effects that the government say flow from it, with respect to enhancing respect for life, preventing 'wrongful deaths', protecting vulnerable people, supporting palliative care, and preserving the physician-patient relationship."[202]

Could this infringement, however, be demonstratively justified in a free and democratic society? In a prior ruling the Supreme Court of Canada had expressed doubt as to the likelihood of a breach of s.7 being justified under s.1 of the Charter.[203]

In the event, Smith concluded that the matter did not need to be addressed. For the reasons that *s.15* infringements were not justified, any infringement of s.7 was similarly not justified.

In consequence of her findings and the reasoning she adopted and followed Justice Smith declared that the impugned provisions unjustifiably infringed ss.7 and 15 of the Charter of Rights and Freedoms and were of no force an effect to the extent that they prevented physicians from providing assisted suicide and third party assisted death to a certain class of patients, a remedy was required.[204]

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[201] *At para. 1378.*

[202] *At para. 1377.*

[203] *In Re: BC Motor Vehicle Act [1985] 2 SCR 496*, at 85, in the context of a s.7 challenge to an absolute liability offence, Lamer CJ had stated: *"Administrative expediency, absolute liability's main supportive argument, will undoubtedly under s.1 be invoked and occasionally succeed. Indeed, administrative expediency certainly has its place in administrative law. But when administrative law chooses to call in aid imprisonment through penal law, indeed sometimes criminal law and the added stigma attached to a conviction, exceptional, in my view, will be the case where the liberty or even the security of the person guaranteed under s.7 should be sacrificed to administrative expediency. Section 1 may, for reasons of administrative expediency, successfully come to the rescue of an otherwise violation of s.7, but only in cases arising out of exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like."*

[204] Under *s.52(1) of the Constitution Act, 1982*, the Constitution of Canada is declared to be the *"supreme law of Canada"*, and *"any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."* A superior court has the power to strike down a law that is contrary to the provisions of the Charter.

Justice Smith said that it was the proper task of Parliament, not the courts, to determine how to rectify legislation that had been found to be unconstitutional.

"However, in a case such as this, where the unconstitutionality arises from the legislation's application in certain specific circumstances, it is incumbent on the Court to specify what those circumstances are."[205]

Prior to making the appropriate declarations[206] important modifications were made to the definitions of *'physician-assisted dying'*, *'grievously and irremediably ill persons'* and *'medical condition'* which the plaintiffs had submitted to the Court.

These modifications are of particular significance to the criticism of the *Carter* judgment to the effect that in striking down s.241(b) of the Criminal Code, and in creating conditions for exceptions, it also concluded that, in certain circumstances, what was described somewhat tautologically as *"consensual physician-assisted death by a medical practitioner,"*[207] - in other words voluntary euthanasia - would be legally permissible.

Smith J stated first, that her conclusion was that the unconstitutionality of the legislation under s.7 arose from its application to competent, fully-informed, non-ambivalent adult persons who personally (though not through a substitute decision-maker) request physician-assisted death, are free from coercion and undue influence and are not clinically depressed. With respect to s.15, the unconstitutionality of the legislation arose from its application to persons who fell under the description above and who, in addition, were materially physically disabled or were soon to become so.[208]

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[205] *At para.1386.* She made the following declaratory orders:
(a) a declaration that the impugned provisions unjustifiably infringe s/15 of the Charter, are of no force and effect to the extent that they prohibit physician-assisted suicide by a medical practitioner in the context of a physician-patient relationship, where the assistance ids provided to a fully-informed, non-ambivalent competent adult patient who: (i) is free from coercion and undue influence, is not clinically depressed band who personally (not through a substituted decision-maker) requests physician-assisted death; and (ii) is materially physically disabled or is soon to become so, has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.
(b) a declaration that the impugned provisions unjustifiably infringe s.7 of the Charter, and are of no force and effect to the extent that they prohibit physician-assisted suicide ***or consensual physician-assisted death*** *by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person ....(the remaining text being exactly the same as in (a) above).*
[206] *See fn.198 supra.*
[207] See *Declaratory Order B in respect of an infringement of s.7.*
[208] *At para.1388.*

Second, she did not accept that the term *'physician-assisted'* should include the provision of assistance by persons other than physicians.[209]

Third, she averred that she did not accept that the term *'grievously and irremediably ill persons'* "should incorporate reference to *'psychosocial suffering'*."[210]

Fourth, the reference to *'grievously and irremediably ill persons'* should be limited to those *"who were also in an advanced state of weakening capacities, with no chance of improvement."*[211]

Fifth, the legislative infringement of *s.15* stemmed from its prohibition of physician-assisted suicide, and *"the declaratory relief with respect to that infringement should be limited accordingly."*[212]

The plaintiffs had asked that the effect of the declarations of constitutional invalidity or inapplicability be suspended for a period of six months.

The defendant Canada argued that if there was to be a declaration of constitutional invalidity, its effect should be suspended for at least twelve months in order to allow Parliament sufficient time to draft and consider any legislation. It also stated that a further suspension could be necessary given the realities of the appeal process and the complexity of the issues Parliament would face.[213]

The plaintiffs characterised these argument as *in terrorem.* It would be remarkable, they contended, if the government was to elect not to enact any safeguards to protect individuals from the concerns they had voiced in the proceedings. They did accept however that no evidence had been adduced of catastrophic outcomes in those jurisdictions in which allegedly unregulated assisted dying regimes obtained.

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[209] *At para.1389.*
[210] *At para.1390.*
[211] *At para.1391.*
[212] *At para.1392.*
[213] The defendant British Columbia submitted that if the impugned laws were struck down there was no certainty that Parliament would enact legislation thereafter. It gave the example of Colombia, where no legislation had been passed after a decision of the Constitutional Court had legalised euthanasia in that jurisdiction, and pointed also to the absence of legal regulatory safeguards in Switzerland and Montana, where courts had similarly recognised assisted suicide. In addition, they argued that Parliament had not enacted any regulatory safeguards in the wake of the Supreme Court's 1988 decision in *Morgentaler* in respect of abortion. If physician-assisted death was proper medical treatment, as was suggested by the plaintiffs, there might be considerable debate as to whether Parliament even had the constitutional jurisdiction to enact safeguards, and called in aid *Reference re Assisted Human Reproduction Act [2010] SCC 61.*

Justice Smith was persuaded that a suspension of constitutional invalidity for six months would be insufficient and accordingly granted a suspension of one year.

However, this delay would be of no assistance to the plaintiff Ms. Taylor. The absolute prohibition under *s. 241(b)* of the *Criminal Code* would remain in effect for a full year during which time she would be denied the opportunity to seek assisted suicide if she was disposed to doing so.

In a jurisprudentially rare move, therefore, she acceded to the plaintiff's request for a constitutional exemption in the interim.[214]

The defendants contended that it would be inappropriate to grant a constitutional exemption in the instant case. It agreed that, as stated in *Corbiere v Canada (Minister of Indian and Northern Affairs),*[215] an exemption was available where the Court found that a law was invalid but suspended the declaration of invalidity. It referred to *Schachter v Canada*[216] for the proposition that a *'constitutional exemption'* was the exception and not the rule, a point which had been reinforced in *R v Ferguson.*[217]

In summary, it was Canada's position that, in creating a constitutional exemption with a set of safeguards, the Court would be usurping the function of Parliament and risking permitting physician-assisted death that would not fall under a scheme that Parliament might eventually

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[214] In making the request the plaintiff had relied on *Corbiere v Canada (Minister of Indian and Northern Affairs) [1999] 2 SCR 203* in which the Supreme Court had recognised that a constitutional exemption could be granted as an interim remedial measure accompanying a declaration of invalidity under *s.52(1)* of the Constitution Act, 1982. In *R v Ferguson [2008] 1 SCC 96* the claimant had applied for constitutional exemption from legislation creating a mandatory minimum sentence. Although the Supreme Court held that such an exemption is not an appropriate as a stand-alone remedy for a claimant who establishes that certain applications of a law are unconstitutional, it indicated that such exemptions may still be available in other cases, for example, when they accompany a suspended declaration of invalidity. The Court stated: *"The jurisprudence of this Court allows a s.24(1) remedy in connection with a s.52(1) declaration of invalidity in unusual cases where additional s.24(1) relief is necessary to provide the claimant with an effective remedy. However, the argument that s.24(1) can provide a stand-alone remedy for laws with unconstitutional effects depends on reading s.24(1) in isolation, rather than in conjunction with the scheme of the Charter as a whole, as required by principles of statutory and constitutional interpretation. When s.24(1) is read in context, it becomes apparent that the intent of the framers of the Constitution was that it functions primarily as a remedy for unconstitutional government acts,* at 63.

[215] *[1999] 2 SCR 203.*

[216] *[1992] 2 SCR*

[217] *[2008] 1 SCC 96.* Canada, citing *Osborne v Canada(Treasury Board) [1991] 2 SCR 69, at para 104,* submitted that, in fashioning *a Charter* remedy, a court must *"apply the measures that will best vindicate the values expressed in the Charter" and "refrain from intruding into the legislative sphere beyond what is necessary."* It also argued that the constitutional exemption sought raised serious concerns relative to the values underpinning the rule of law: *"certainty, accessibility, intelligibility, clarity and predictability."*

create. It would also be opening the door to applications for similar exemptions from other individuals.

The Court, however, was not persuaded by these arguments. Smith J pointed to the fact that *Corbiere,* had relied specifically on the facts of the *Rodriguez* case as exemplifying the circumstances in which a *'constitutional exemption'* would be justified. The conditions applicable to an exemption that McEachern CJ and Lamer CJ, in their dissenting judgments in the British Columbia Court of Appeal and the Supreme Court of Canada respectively, would have granted during the period of suspension of the declaration of invalidity, were also called in aid.

The plaintiff's request was granted.[218]

10. Conclusion:

While the judgment in *Carter* is both lengthy and comprehensive it is, nonetheless a decision of a trial court only, and one which is currently on appeal.

In order to determine that *s.241(b)* was unconstitutional it was necessary for the Court to distinguish the finding in *Rodriguez* that while s. 241(b) of the Criminal Code affected the appellant's right to liberty and security of the person this was a justifiable limitation given the inherent danger of the wrongful death of vulnerable and sick elderly people if the section were struck down. The majority in *Rodriguez* did not rule on the applicability of s.15 with

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[218] *At para.1413.* The following terms and conditions were appended:
***1. (a)** Ms Taylor must provide a written request for a physician-assisted death;*
***(b)** her attending physician must be attest that Ms Taylor has been:*
(i) informed of her medical diagnosis and prognosis;
(ii) informed of the feasible alternative treatments, including palliative care options;
(iii) informed of the risks associated with physician-assisted dying and the probable result of the medication proposed for use in her physician-assisted death;
(iv) referred to a physician with palliative care expert for a palliative care consultation.
***(c)** her attending physician and a consulting psychiatrist each attest that Ms Taylor is competent and that the request for physician-assisted death is voluntary; and*
***(d)** her attending physician attests to the kind and amount of medication proposed for use in any physician-assisted death that may occur.*
***2.**Ms Taylor mat then make an application to the British Columbia Supreme Court, without notice to any other party, and upon proof of the above to the Court's satisfaction, the Court shall order that:*
***(a)** a physician may legally provide Ms Taylor with a physician-assisted death at the time of her choosing provided that Ms Taylor is, at the material time:*
**suffering from enduring physical, psychological or psychosocial suffering that is intolerable to her and which cannot be alleviated by any medical treatment acceptable to her;*
** in the opinion of the assisting physician, or if necessary in the opinion of a consultant psychiatrist, competent, and voluntarily seeking a physician-assisted death;*
***(b)** notwithstanding any other provision of law, should Ms Taylor seek and obtain a physician-assisted death, that the assisting physician be authorised to complete her death certificate indicating death from her underlying illness as cause of death.*

reference to possible discrimination, but indicated if there was an issue it would also have been justified as a reasonable limit under s.1 of the Charter of Rights and Freedoms.

Reduced to its essential components the key, in summary, to understanding the decision in *Carter v Canada* revolves around two main considerations:

1. It did not distinguish between the ethics of current end-of-life practices, such as withholding life-sustaining treatment or providing pain management, and physician-assisted death.

The majority in *Rodriguez,* per Sopinka J, identified intention as being the critical differentiating factor.[219]

In *Carter* Smith J averred that *"Rodriguez addressed where to draw the line for legal purposes, rather than tackling the ethical question per se."*[220]

In the judge's view there appeared to be relatively strong societal consensus that:

"(i) Human life is of extremely high value, and society should never, or only in very exceptional circumstances, permit the intentional taking of human life;

(ii) Current end-of-life practices, including administering palliative sedation to relieve physical suffering and acting on patients' or substituted decision-makers' directions In the matter of physician-assisted death, however, she found - *"...weighing all the evidence"* – *"that there is a*

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[219] *"The fact that doctors may deliver palliative care to terminally ill patients without fear of sanction, it is argued, attenuates to an even greater degree any legitimate distinction which can be drawn between assisted suicide and what are currently acceptable forms of medical treatment. The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based on intention – in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death....The fact that in some cases, the third party will, under the guise of palliative care, commit euthanasia or assist in suicide and go unsanctioned due to the difficulty of proof cannot be said to render the existence of the prohibition fundamentally unjust"*, at para 607 (cited in Carter at para 324).

[220] *"The preponderant ethical opinion is that there is no bright-line ethical distinction, in an individual case, between physician-assisted dying and end-of-life practices such as withholding and withdrawing life-sustaining treatment or administering palliative sedation where the highly probable consequences is to hasten death*", at para 1336.

"The evidence shows that within the medical and bioethical community the question still remains open whether an ethical distinction is maintainable between withholding or withdrawing life-sustaining treatment and palliative sedation on the one hand, and physician-assisted death on the other. The preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death. I find the arguments put forward by those ethicists, such as Professor Battin, Dr. Angell and Professor Sumner, to be persuasive", at para 1335. Professor Battin is the author of numerous works on bioethics. See he *'The Least Worst Death: Essays in Bioethics on the end of Life', 1994, OUP.* Professor Sumner is a Canadian philosopher and retired Professor at the University of Toronto who specialised in ethical theory, applied ethics and bioethics.

clear societal consensus either way, in an individual case involving a competent, informed, voluntary adult patient who is grievously ill and suffering symptoms that cannot be alleviated. However, there is a strong consensus that if physician-assisted dying were to be ethical, it would only be with respect to those patients, where clearly consistent with the patient's wishes and best interests, and in order to relieve suffering."[221]

2. That vulnerable people can be protected from the loss of their s.7 right to life, liberty and security of the person, through legal restrictions, in a regime which permits of physician-assisted suicide. This conclusion was arrived at following a review of empirical, albeit selective, evidence available in respect of safeguards, from those jurisdictions, such as the Netherlands, Belgium and the state of Oregon in the United States, that have liberalised their law in end-of-life matters.[222]

The appeal of the decision by the British Columbia Supreme Court in *Carter* has yet to be heard. Meanwhile, however, the Irish High Court, in arriving at its determination in *Fleming v Ireland*[223] that the prohibition of assisted suicide contained in *Section 2 (2)* of that jurisdiction's Criminal Law (Suicide) Act, 1993, availed of the opportunity to analyse, albeit briefly, the reasoning employed by Lynn Smith J, particularly in the matter of "*new evidence*" regarding the safeguards which had been put in place in those jurisdictions where a more liberal legislative disposition towards assisted suicide had been adopted.

Unsurprisingly, the Irish court was unable to agree with Smith J's view that the accumulated evidence from more liberal jurisdictions in the matter of assisted dying "*shows that the risks inherent in legally permitted death have not, materialised in the manner that may have been predicted.*"

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[221] *At para.1358.* It should be noted that Smith J found the arguments of Professor Sumner with respect to the absence of an ethical distinction between suicide and assisted suicide, if suicide is ethical, to be persuasive: *"I agree that a distinction vanishes in the circumstances he specifies: the patient's decision for suicide is entirely rational and autonomous, it is in the patient's best interest, and the patient has made an informed request for assistance. The physician provides the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role."*

[222] *"The evidence shows that the effectiveness of safeguards depend upon, among other factors, the nature of the safeguards, the cultural context in which they are situated, the skills and commitments of the physicians who are responsible for working within them, and the extent to which compliance with the safeguards is monitored and enforced."* The evidence adduced as to the alleged success of the safeguards and the compliance rate was sufficient for Smith J to aver that *"[it] supports the conclusion that the risks of harm in a regime that permits physician-assisted death can be greatly minimised."* The evidence on which Smith J relied was reviewed, and discounted, in the recent Irish High Court case, *Fleming v Ireland [2013] IEHC 2.*

[223] *[2013] IEHC 2.*

While it would be foolhardy to attempt to predict the outcome of the appeal of the *Carter* finding it would be a matter of considerable surprise if it did not concur with the analysis conducted, and the conclusions reached by the Irish High Court. The reasoning adopted and followed by the Irish Court is examined in Chapter IX.

Chapter IX - Ireland

Whither merciful death after *Fleming v Ireland*?

"Each court seised of these issues has an awesome task to face. In doing so we have to rid ourselves of emotional overtones and emotive language which do not assist in elucidating the profound questions which require to be answered.

- *Butler-Sloss, LJ, Airedale NHS Trust v Bland [1993] AC 789, at 816.*

"The matter for resolution is of immense moral, legal, medical, ethical and philosophical importance."

- *O'Flaherty J, In re a Ward of Court (withholding medical treatment)(No.2),[1996] 2 IR 73 at 128.*

"Bland has indeed left the law in a 'morally and intellectually misshapen' state."

- *John Keown, 'Euthanasia, Ethics and Public Policy – An Argument against Legalisation' (paraphrasing Lord Mustill in Airedale NHS Trust v Bland [1993] AC 789 at 887), Cambridge University Press, 2002, p.236.*

1. Introduction

Until relatively recently the jurisprudential approach in Ireland to third party assistance with death was informed solely by the Supreme Court finding in *In re a Ward of Court*[1] that the withdrawal of artificial nutrition from an incompetent adult did not impermissibly or disproportionately impinge on the rights of the ward, particularly that of her right to life and, being in her *'best interests'*, was legal. The reasoning adopted and followed was a virtual mirror image of that employed in the earlier English case, *Airedale NHS Trust v Bland.*[2]

Prior to 2012, the Irish superior courts had not been asked to adjudicate on the legitimacy or otherwise of assistance which was intended to bring about an earlier than natural death in the case of a competent person who had expressed a voluntary wish to die by suicide but could only do so with the help of another. Neither had they been asked whether the statutory prohibition of such assistance was capable of amelioration in specifically defined circumstances. Likewise, the question whether the criminal proscription of assisted suicide

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[1] *In re a Ward of Court (withholding medical treatment)(No.2) [1996] 2 IR 79.*
[2] *[1993] AC 789.*

was constitutionally invalid or incompatible with the *European Convention on Human Rights* had never previously been in issue.

However, this relatively featureless legal landscape changed when proceedings in respect of a claim that section 2(2) of the Criminal Law (Suicide) Act, 1993, which criminalises assisted suicide, be declared invalid having regard to the provisions of the Constitution, and incompatible with the rights of the claimant pursuant to the European Convention on Human Rights and Fundamental Freedoms, came before the High Court in *Fleming v Ireland.*[3]

In the event that the Court found itself unable to grant the requested declarations that the ban on assisted suicide was either constitutionally invalid or ECHR incompatible, or both, the plaintiff, who was suffering from multiple sclerosis and wished to commit suicide at a time of her own choosing sought, in the alternative, an order directing the Director of Public Prosecutions to promulgate guidelines stating the factors that would be taken into account in deciding whether to prosecute, or to consent to the prosecution, of any particular person in circumstances such as those that would affect a person who assisted her – her partner - in ending her life.

In summary, the plaintiff, in her composite claim, sought a declaration by the Court that arising from her physical inability to commit suicide by her own hand the ban on assisted suicide disproportionately impaired her right to decide when and how she should die.

Unsurprisingly, the Court held that the claims of unconstitutionality and ECHR incompatibility were without substance. It re-affirmed the criminal proscription of third party assistance with death, irrespective of circumstances. This decision was appealed to the Supreme Court. In the event the Supreme Court upheld the lower court's finding.[4]

The High Court's somewhat gnomic observations in respect of the future role of the Director of Public Prosecutions, and whether it might be appropriate for her - in exercising her discretion to prosecute, or not - in a case of assisted suicide, to give *"full and careful consideration"*[5]to evidence of compliance with those prosecutorial policy factors invoked in other jurisdictions, particularly those of the English Crown Prosecution Service, caused no little jurisprudential surprise.[6]

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[3] *[2013] IEHC 2.*
[4] *[2013] IESC 19.*
[5] At para.175.

[6] Specifically, the Court averred (at para 171) that the *"very fact that UK guidelines on assisted suicide now exist must surely inform any exercise of discretion by the Director in this jurisdiction."* Other than

The implication of these observations is that while the DPP is statutorily prohibited from doing what is done elsewhere, nonetheless she is now expected, albeit in an *ex post facto* context, to deal with cases in a similar fashion, but based on the very guidelines she is not entitled to promulgate![7]

By any standards this would appear to be an unusual, if not unprecedented, jurisprudential departure on the part of three experienced members of the High Court and one which, on its face, has little to commend it.

Not alone does it smack of a nods and winks approach regarding prosecutorial policy in a matter as fundamental as the proscription of unlawful death, irrespective of circumstances, but it also creates a disturbing degree of public uncertainty as to the continued applicability of the legal proscription of assisted suicide. There is a grave danger that in the absence of judicial clarification the law may be brought into unnecessary disrepute.

It is intended to revisit the High Court's observations at a later juncture when the judicial reasoning adopted and followed in *Fleming* is analysed in greater detail. It is sufficient for now, however, to suggest – and, it is contended, not unreasonably - that if unchallenged, the views expressed by the High Court, may contribute further to the diminution at Irish law of the principle of the sanctity of life.

In recent decades the outer margins of this principle have been extended to a degree which, were one to indulge in dystopian prophesy, could result in third party assistance with death, in whatever form, ultimately prevailing as a policy option in respect of the care and treatment of the aged, the vulnerable and the terminally ill in Ireland.

2. The Law

As is the case in most other jurisdictions in which the Western jurisprudential tradition informs the legal approach to unnatural death the law in Ireland, currently, is unequivocal in the matters of euthanasia and assisted suicide. Both are criminal offences, the former being

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expressing confidence that the Director would exercise her discretion in *"a humane and sensitive fashion"* (at para 175) the Court failed to provide any indicia as to the existence of a credible legal basis for such assuredness.

[7] The Prosecution of Offences Act, 1974, which established the Office of the Director of Public Prosecutions, makes no provision of any kind for the Director to issue prosecutorial policy guidelines in respect of specific offences. Counsel for the DPP, at para 148, submitted that in the event that the Director did so she would be *"aiding a crime."* While the Director has published guidelines of a general nature in the past – the most recent being in 2010 – these are completely devoid of statutory force. Their stated intention is solely to give general guidelines to prosecutors so that a fair, reasoned and consistent policy underlies the prosecution process.

categorised at common law as either murder or involuntary manslaughter[8] and the latter, on foot of a specific statutory provision, attracting a maximum sentence of fourteen years imprisonment on conviction.[9] A prosecution for assistance with suicide may only be instigated, however, with the consent of the Director of Public Prosecutions. Suicide itself has been decriminalised since 1961.[10]

The definitions of voluntary euthanasia and assisted suicide employed in Ireland are no different to those applied in other jurisdictions. While the broad term euthanasia encompasses the concepts of non-voluntary and involuntary euthanasia the most commonly understood usage refers to what is known as voluntary active euthanasia.[11] This term is used to describe a situation in which one person kills another, at the other's request, in circumstances where the victim wishes, and intends, that his or her life be ended, and is mentally competent to make this decision.

However, the terms voluntary active euthanasia and assisted suicide are not synonymous. Each is a distinct offence and attracts different penalties under the criminal law.

In Ireland, therefore, it is murder for a doctor, or any person engaged in the care of an ill person, irrespective of prognosis, to administer treatment for the specific purpose of ending life. A voluntary request by a patient to be killed does not absolve the perpetrator of such an

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[8] In *re a Ward of Court (withholding medical treatment) (No.2) [1996] 2 IR at 121*, Hamilton CJ stated that *"even in the case if the most horrendous disability, any course of action or treatment aimed at terminating life or accelerating death is unlawful"* and *"it is important to emphasise that the Court can never sanction steps to terminate life."* See Hanafin, P, *'Last Rights: Death, Dying & the Law in Ireland'*, Cork University Press, 1997.

[9] Sec.2.2, Criminal Law (Suicide) Act, 1993. Similar measures exist in the **United Kingdom** - Suicide Act 1961, s 2(1); **Canada** – Criminal Code 1985, s 241; **Australia** – ACT Crimes (Amendment) Ordinance (No 2) 1990, s.17(1) and (2); NSW Crimes Act 1900, s.31 C (1) and (2); NT Criminal Code 1983, s.1868; Qld Criminal Code 1995, s.108; SA Criminal Law Consolidation Act 1935, s.13(a)(5); Tas Criminal Code 1924, s. 163; Vic Crimes Act 1958, s.6B(2); WA Criminal Code 1913.s.228.

[10] Suicide Act, 1961.

[11] There are three basic definitions of euthanasia: 1. *'Euthanasia'* as the active, intentional termination of life. On this definition, euthanasia is not simply a doctor doing something which he *foresees* will shorten life, but doing something *intending* to shorten life. 2. *'Euthanasia'* as the intentional termination of life by an act or by omission. Under this definition, euthanasia includes not only the intentional termination of the life of a patient by an act such as a lethal injection but also the intentional termination of life by an omission. Consequently, if a doctor who switches off a ventilator, or who withdraws a patient's tube-feeding, performs euthanasia if the doctor's intention is to kill the patient. Euthanasia by deliberate omission is often called passive euthanasia to distinguish it from active euthanasia. 3. *'Euthanasia'* as intentional or foreseen life-shortening. This definition encompasses not only the intentional termination of life by act or omission, but also acts and omissions which have the foreseen consequence of shortening life. At first sight it might well seem that there is very little difference between an intended and a merely foreseen result: *"If you **know** your conduct is going to have a particular result, isn't this the same as **intending** it? And the **result** is exactly the same, whether it is merely foreseen or intended. However, on closer examination, intention is significantly different from mere foresight."* See Keown, J, *'Euthanasia, Ethics and Public Policy: An Argument Against Legalisation'*, Cambridge University Press, 2002, at 10-16.

act of blame. It is not a defence that the patient asked, for whatever reason, for their life to be ended.[12] A doctor who actively assists a patient to commit suicide will incur criminal liability.

A request for death by a patient, terminally ill or not, is to be distinguished from the right of a competent patient to refuse medical treatment even if it leads to death.[13] This right, however, while rooted both in the common law and in the constitutional rights, judicially identified, to *'bodily integrity'*[14] and *'privacy'*,[15] is not an absolute one.[16] However, the right to refuse treatment did not sit easily with the ethos of the medical profession *"which was paternalistically based on the principle that the doctor knows best."*[17] Refusal of consent was viewed as *"not as an assertion of will, but rather as a symptom of unsoundness of mind."*[18]

A voluntary request on the part of the victim for help to kill him/herself does not ameliorate the criminal character of assistance with suicide. Assisted suicide is distinguishable from a refusal of life-sustaining treatment, provided either contemporaneously or in the form of an advance care directive, by a person while competent. The law in this matter was stated clearly by Lord Goff in *Airedale NHS Trust v Bland.*[19]

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[12] See Charleton, McDermott & Bolger, *"Criminal Law'*, LexisNexis, 1999, at 558.

[13] See *O'Flaherty J in Re a Ward of Court [1996] 2 IR 79 at 129.* In the same case, *at 156,* Denham J averred that *"medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.* It is interest to note that the following text in bold in the unreported approved judgment of Denham J, 27 July, 1994, at 24, does not appear in either *Re a Ward of Court (withholding medical treatment)(No.2) [1996] 1 IR 79 at 156* or in *Re a Ward of Court (withholding medical treatment)(No.2) 2 ILRM 401 at 454*: *"....medical treatment may be refused for other than medical reasons.* ***Such reasons may not be viewed a good medical reasons****, or reasons most citizens would regard as rational, but the person of full age and capacity may take the decision for their own reasons."*

[14] *Ryan v Attorney General [1965] IR 294.*

[15] *Kennedy v Ireland [1987] IR 587.*

[16] Costello J first suggested, extra-curially, that the claims of the common good might justify restrictions on the exercise of a constitutionally protected right to refuse medical treatment in the case of, for example, contagious disease. See Costello, *'The Terminally Ill - The Law's Concerns',* (1986) 21 Irish Jurist 35, at 42. In *Re a Ward of Court (withholding medical treatment) (No 2) [1996] 2 IR 79, at 156,* Denham J stated that the right was also not absolute in medical emergencies where patients are unable to communicate. This dictum was reprised by Hardiman J in *North Western Health Board v HW [2001] 3 IR 622, at 750-51.*

[17] See Madden, *'Medicine, Ethics and the Law',* Tottel Publishing, 2nd ed., 2002, para. 9.134.

[18] See Kennedy, *'Treat me Right: Essays in Medical Law and Ethics', 1991, at 337,* cited in Madden, op.cit., at para. 9.136

[19] *[1993] 1 All ER 82, at 866*: *".....in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with the patient's wishes."* This reasoning was followed in *Fleming v Ireland [2013] IEHC 2.*

Notwithstanding the ready availability of powerful pain-relieving drugs, including opiates, the fact remains that some patients, for a variety of reasons, including a low tolerance level or because they have become immune to their particular properties, face the prospect of a difficult and painful death.

3. Case Law

Irish case law regarding third party assistance with death, irrespective of type, is exceptionally, and perhaps surprisingly, jejune. There are no reported cases involving the prosecution of a member of the medical profession, of a family member or of an unrelated third party, for unlawful killing arising specifically from an act of euthanasia. Likewise, assisting a person wishing to commit suicide who is incapable of doing so unaided has not featured in case law.

Until *Fleming v Ireland* the one occasion where the seemingly intractable conjunction of moral, ethical, medical and legal considerations which assisted dying gives rise to, occurred in circumstances where the legality of the withdrawal of artificial nutrition and hydration was in issue, and then only in the context of an application by the committee of the ward for guidance as to her future care.[20]

Notwithstanding the absence of a consistent precedential line of case law, however, it had never been in doubt - based not only on the reasoning adopted and followed in In *Re a Ward of Court*,[21] but also on the findings in cases where the right to life was specifically addressed, namely *Attorney General v X*,[22] and *Roche v Roche*,[23] where the legal status of artificial embryos fell to be determined - that a clear jurisprudential template existed whereby interference with the imprescriptible criminal prohibition of unlawful killing would not be countenanced – in short, the continued maintenance of the sanctity of life principle – but which would allow, simultaneously, for the un-enumerated constitutional personal rights of *'self-determination'*, *'autonomy'*, *'bodily integrity'* and *'dignity'* to be respected and upheld.

While not specifically germane to case law, the recommendation by the Irish Council for Bioethics, in 2007, that competent adults, arising from their right to self-determination and their related rights to *'bodily integrity'*, *'privacy'* and *'dignity'*, should have the right to prepare an advance care directive,[24] and that of the *Law Reform Commission*, in 2008, that

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Even in such circumstances, however, the deliberate taking if a patient's life cannot be justified. The indisputable juristic and medical wisdom is that it is the doctor's duty to apply the requisite skills to relieve the suffering of the patient, but not to do so by killing him.

[20] *In Re a Ward if Court (withholding medical treatment) (No.2)[1996] 2 IR 79.*The circumstances in *Fleming v Ireland [2013] IEHC 2* did not relate to the withdrawal of artificial nutrition. The substantive issue related to the claim of disproportionate impingement on the right of an incapacitated individual not to avail of assistance with suicide, suicide itself not being a crime.

[21] *[1996] 2 IR 79.*

[22] *[1992] 1 IR 1.*

[23] *[2009] IESC 82.*

[24] *The Irish Council for Bioethics Opinion: Is it time for Advance Care Directives?, Dublin, 2007.*

these directives should be put on a statutory basis,[25]should nonetheless be noted.[26]The respective philosophies underpinning both these recommendation are indicative of the evolutionary trajectory of jurisprudential approaches to the question of continued life or death in Ireland currently.[27]

To date the legislative authorities have ignored the recommendations of both organisations and it is likely that they will continue to do so for the foreseeable future.[28]

However, if the benchmark of political, jurisprudential and societal upheaval which characterised the national debate – and continues to do so - in respect of whether abortion in specific circumstances should be legally available is anything to go by, it would not be unreasonable to suggest that a similar, if perhaps less emotively strident, moral and ethical contretemps could ensue were the recommendations of the Law Reform Commission be proposed for implementation.

Inevitably in the balance in any such engagement would be the question as to whether or not the currently perceived elasticity attaching to the constitutional principle of individual autonomy was capable of further expansion to encompass personal decisions as to the timing and manner of one's own demise.

While the courts in recent years have displayed less enthusiasm for the identification of new un-enumerated constitutional personal rights they have not been averse to applying those already found, particularly those of *'bodily integrity'*, *'privacy'* and *'dignity'*, to a degree that it could not be guaranteed that in the event that advance care directives were given a statutory basis the current balance between the rights of the individual and the duty of the state to protect life might not be appreciably disturbed.

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[25] *Law Reform Commission, Consultation Paper, Bioethics: Advance Care Directives, LRC CP 51-2008.*

[26] Both reports are examined in Section 8 below.

[27] The Bioethics Council was of the view that the *"weight of legal opinion in the Republic of Ireland recognises the right of competent adults to decide on the nature of their medical treatment. Refusal of treatment by a competent individual to facilitate a natural death is permitted, but this right does not extend to allow euthanasia of assisted suicide."* Op.cit., fn.24 supra, at 9. The Law Reform Commission disavowed any notion that its recommendations related to euthanasia. Any steps taken to hasten death in a manner that would, under current law, amount to murder or to assisting suicide, would *"not in any way be affected by the proposals being considered."* Op. cit. fn.25 supra, at 4.

[28] A Private Members' Bill recommending the statutory recognition of advance care directives has been submitted to the Dail by a Government back-bencher, Dr.Liam Twomey, TD. While the matter is being considered by the Minister for Health it is impossible to predict its fate. It is unlikely, however, that it will be accorded any degree of legislative urgency in a climate where the political environment continues to be convulsed by matters relating to the beginning of life.

4. Airedale NHS Trust v Bland

The reasoning employed in *Re a Ward of Court* to a large degree reflected that employed in *Airedale NHS Trust v Bland*.[29] This reasoning has been described as a subversion of the common law in end-of-life matters.[30]

The facts in *Bland*, as outlined in the court of first instance, were as follows: The patient, then aged 17, had been seriously injured in a major disaster.[31] His lungs had been crushed and punctured and the supply of oxygen to his brain was interrupted. As a result, Anthony Bland sustained catastrophic and irreversible damage to the higher centres of his brain which had left him in a condition known as a persistent vegetative state (PVS). The medical opinion of all who had been consulted about his case was unanimous in the diagnosis, and all were agreed on the prognosis that there was no hope of improvement in his condition.

At no time prior to the disaster, however, had the patient indicated his wishes if he should find himself in such a condition. His father, in evidence, was of the opinion that his son would not "*want to be left like that.*" With the concurrence of his parents and the consultant in charge of his case, together with the support of independent physicians, the authority responsible for the hospital where he was being treated, as plaintiffs in the action, sought declarations that they might:

- (i) lawfully discontinue all life-sustaining treatment and medical support measures designed to keep the patient alive in his existing persistent vegetative state, including the termination of ventilation, nutrition and hydration by artificial means, and
- (ii) lawfully discontinue and thereafter need not furnish medical treatment to the patient except for the sole purpose of enabling the patient to end his life and die peacefully with the greatest dignity and the least pain, suffering and distress.

In the Family Division of the High Court Sir Stephen Browne P granted the declarations sought.

An appeal by the Official Solicitor was dismissed.[32]

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[29] *[1993] AC 789.* See Chapter VI on England and Wales for a more detailed analysis of this case. Blayney J in the Supreme Court Appeal, *at 144,* opined that Lynch J, in the court of first instance, had not "*blindly followed*" *Bland.*

[30] *Keown, op.cit., fn. 11 supra.*

[31] At the Hillsborough football ground on 15th April, 1989.

[32] Heard before Lords Keith, Goff, Lowry, Browne-Wilkinson and Mustill. The grounds for dismissal were "*that the object of medical treatment and care was to benefit the patient, but since a large body of informed and responsible medical opinion was of the view that existence in the persistent vegetative*

Counsel for Bland had argued that stopping treatment and feeding would be murder or at least manslaughter. It was accepted by three of the five Law Lords that the doctor's *"intention would be to kill his patient."* As a matter of logic, therefore, the question as to whether this would constitute murder arose.

Lord Browne-Wilkinson was unequivocal in his view that the element of intention was present: *"the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland."*[33] However, that it was not considered to be an act of unlawful killing was explained by Lord Goff. Stopping treatment and feeding was not to be regarded as a positive act. Rather it was an omission[34] Withdrawing life-support is no different from withholding it in the first instance. In doing so the doctor is merely allowing the patient to die as a result of his pre-existing condition, or *"allowing nature to take its course."*

In perhaps the most controversial aspect of the judgment, and of particular significance to the subsequent reasoning adopted and followed in *Re a Ward of Court*,[35] Lord Goff also categorised tube-feeding as medical treatment and averred that the doctor was under no duty to continue with such feeding in circumstances where he or she believed that it was not in the patient's *"best interest"* to do so.[36]

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state was not a benefit to the patient, the principle of the sanctity of life, which was not absolute, was not violated by ceasing to give medical treatment and care involving invasive manipulation of the patient's body, to which he had not consented and which conferred no benefit upon him, having been in that state for over three years; that the doctors responsible for the patient's treatment were neither under a duty nor (as per Lord Browne-Wilkinson) entitled to continue such medical care; that since the time had come when the patient had no further interest in being kept alive the necessity to do so, created by his inability to make a choice, and the justification for the invasive care and treatment had gone, the omission to perform what had previously been a duty would no longer be unlawful." Similarly, it was held, by Lords Keith, Goff and Browne-Wilkinson, that in the interests of the protection of patients and their doctors, and for the reassurance of both patients' families and the public, until a body of experience and practice had built up, *"application should be made to the Family Division on any case where it is considered by the medical practitioners in charge of a PVS patient that continued treatment and care no longer confer any benefit upon him."*

[33] *[1993] AC 789 at 876.* Lord Mustill, agreeing, stated at 887:*"Murder consists of causing the death of another with intent to do so. What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death. As the element of intention ...in my judgment there can be no real doubt that it is present in this case..."*

[34] Ibid.

[35] *(No.2)[1996] 2 IR 79.*

[36] In *Re F [1990] 2 AC 1* it had been decided that a doctor could treat an incompetent patient only if it was in the patient's *"best interests"* to do so. In *Bland* this criterion was extended to include the withdrawal of treatment: *"As continued feeding was no longer in the patient's interests, the doctor was under no duty to continue it."* See *Keown, J, op.cit., fn.11 supra, at 218*

5. In Re. a Ward of Court

The locus classicus in respect of the withdrawal of artificial nutrition and hydration from an incompetent patient is *In re a Ward of Court (withholding medical treatment) (No.2).*[37] *Airedale NHS Trust v Bland*[38] was followed.

It was submitted that by virtue of Article 41.1 of the Constitution, it was the family's prerogative, acting *bona fide* and in the interests of the ward, to decide whether the medical treatment being administered should be withdrawn. Similarly, it was contended that their decision was binding on the court pursuant to the family's inalienable and imprescriptible rights guaranteed under the Constitution.

It was submitted on behalf of the guardian *ad litem* and the Attorney General that it was for the court to decide all matters relating to ward of court, not for the family or the carers, as by virtue of Article 40.3 of the Constitution, the right to life was pre-eminent and all other fundamental rights must give way to it.

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[37] *(No.2)[1996] 2 IR 79.*The facts in the case were outlined succinctly by Lynch J at first instance. Over twenty years prior to the commencement of the action the ward, who was then 22 years old, underwent a minor gynaecological procedure under general anaesthetic, during which she suffered three cardiac arrests resulting in anoxic brain damage of a very serious nature. In the intervening period between the procedure and the court hearing she was completely dependent on others, and required total nursing care. She could not swallow, she could not speak and she was incontinent. A speech therapist had failed to elicit any means of communication. She had minimal capacity to recognise the long established nursing staff and reacted to strangers by showing distress. She also followed or tracked people with her eyes and reacted to noise. This latter was *"mainly, if not indeed wholly reflex from the brain stem and a large element of reflex eye tracking is also present in the former which, however, also has some minimal purposive content."* There was no prospect whatsoever of any improvement in her condition. Lynch J stated, *at 87,* that *"although the ward was not fully PVS, she is very nearly so and such cognitive capacity as she possesses is extremely minimal."* He had earlier adopted Sir Thomas Bingham's description in *Airedale NHS Trust v Bland [1993] AC 789, at 238,* of how a fully PVS person *"cannot feel pain and has no capacity for pleasure or displeasure even though they may groan or grimace or cry, especially in response to painful stimuli, nor have they any realisation whatever of their tragic situation."* Lynch J averred that *"this is probably the ward's state but if such minimal cognition as she has includes an inkling of her catastrophic condition, then I am satisfied that that would be a terrible torment to her and her situation would be worse than if she were fully PVS," at 88.* It appears odd that the judge would specifically qualify the ward's condition to the extent that he considered her to retain some cognition, however residual, and that, notwithstanding this reality, he would grant the application of the committee to have her artificial nutrition and hydration withdrawn in the full and sure knowledge that, while it would not be the immediate cause of death, it would, nonetheless, contribute to its acceleration. On appeal to the Supreme Court Egan J was the sole dissenting voice on this point. He was adamantly of the view that as there was some cognitive function present withdrawal of treatment was not justified. *"This is not a case of no cognitive function. Such function is present, however minimal and however close to PVS. If slightly more cognitive function existed would a right to withdraw sustenance still be claimed to be permissible? Where would the line be drawn? Cognition in a human being is something which is either present or absent and should, in my opinion, be so recognised and treated. Any effort to measure its value would be dangerous."* At 136-37.

[38] *[1993] AC 789.* See Chapter VI on England and Wales.

Counsel on behalf of the institution where the ward was being cared for submitted that as the ward had limited cognitive functions and was not in a persistent vegetative state, nor terminally ill, the treatment being afforded her should continue in order to prolong her life.

In issue was *"not the morality or otherwise of the course sought to be followed by the committee of the ward, and her family, but the lawfulness or otherwise of that course under the Constitution and the laws of this State."*[39]

Consonant with the non-vitalist approach, the State's interest in the preservation of life was not absolute, *"in the sense that life must be preserved and prolonged at all costs and no matter what the circumstances."*[40] The individual had a right to a natural death[41] and the principle of *self-determination*, specifically regarding the right to refuse medical treatment, was acknowledged.[42]

However, the precise legal position regarding the withdrawal of the artificial nourishment being provided fell to be decided. In order to enable judicial assent to its withdrawal such nourishment required classification as medical treatment.[43] Absent such classification, withdrawal would be tantamount to unlawful killing. Because nourishment by gastrostomy tube *"is an abnormal artificial way of receiving nourishment,"* Lynch J concluded, without further explication, that it *"[is] a form of medical treatment."*[44]

There were *"no difference in principle between the artificial provision of air by a ventilator and the artificial provision of nourishment by a tube."*[45]While undoubtedly of considerable

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[39] *[1996] 2 IR 79, at 91.* Lynch J did accept that the evidence of moral theologians was of relevance, for two reasons: *"Firstly, as showing that in proposing the course which they do propose the ward's family are not contravening their own ethic."* In this regard he invoked *In re Quinlan [1976] 355 A.2d.647.* Secondly, *"the matter being res integra, the views of the theologians of various faiths are of assistance in that they endeavour to apply right reason to the problems for decision by the Court and analogous problems."* He found comfort in the fact that *"the judgments in many of the cases [cited], including Airedale NHS Trust v Bland [1993] AC 789...discuss the moral and ethical issues raised by this sort of case with a view to ascertaining what the law ought to be, and thus to assist in declaring what is indeed the law of the land."*

[40] Ibid.

[41] *"Death is a natural part of life. All humanity is mortal and death comes in the ordinary course of nature and this aspect of nature must be respected as well as its life-giving aspect. Not infrequently, death is welcomed and desired by the patient and there is nothing legally or morally wrong in such an attitude. A person has a right to be allowed to die in accordance with nature and with all such palliative care as is necessary to ensure a peaceful and dignified death," at 94.*

[42] *"..despite the fact that the right to life ranks first in the hierarchy of personal rights, it may nevertheless be subjected to the citizen's right of autonomy or self-determination or privacy or dignity, call it what you will, whether exercised by himself, if competent, or on his behalf by agreement between carers and family all acting bona fide in the patient's best interests." Ibid.*

[43] As had been decided, per Lord Goff, *in Airedale NHS Trust v Bland [1993] AC 789.*

[44] At 96.

[45] At 97.

pragmatic application this averment is something of a dubious proposition.[46] Its invocation, however, underscored an existential judicial determination to buttress the granting of the application by calling in aid such support as was deemed appropriate.

The Court, faced as it was with the task of deciding the balance or proportionality of the benefits to the burdens invoked the "*the proper and most satisfactory test*", that of *'best interests.'*[47] In essence, this entailed a choice as to whether it was in the *best interest* of the ward that her life, "*such as it is at present*", should be prolonged by the continuation of the abnormal artificial means of nourishment, or, whether she should be allowed to slip away naturally by the withdrawal of such abnormal artificial means which would happen, *"I am satisfied on the evidence, within two weeks or so and without pain or distress."*[48]

What the judge noticeably failed to say, however, was that "*slipping away naturally*" would occur as a result of either starvation or of dehydration or both.

In deciding what course should be adopted the Court approached the totality of the issues before it *"from the standpoint of a prudent, good and loving parent."*[49] The benefit to the ward of sustaining her life by abnormal artificial means of nourishment was far outweighed by the burdens of sustaining life with absolutely no prospect of any improvement in her condition.

Accordingly, it was in the *"best interest"* of the ward that the abnormal artificial nourishment be terminated, *"thus ceasing to artificially prolong her life to no useful purpose and allowing her to die in accordance with nature with all such palliative care and medication as is necessary to ensure a peaceful and pain-free death."*[50] Such withdrawal and termination would be lawful. The non-treatment of infections or other pathological conditions which

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[46] In *Airedale NHS Trust v Bland [1993] AC 789* Lord Goff had drawn an analogy between tube-feeding and mechanical ventilation. This may well be the source of Lynch J's comparison. However, the analogy is unpersuasive. Ventilation is standardly part of a therapeutic attempt to stabilise, treat and cure; tube-feeding is not. *"Moreover, ventilation replaces the patient's capacity to breathe whereas a tube does not replace the capacity to digest and merely delivers the food to the stomach."* See *Keown,* op.cit, fn.11, supra, at 220. Similarly, it could reasonably be argued that a feeding-tube by which liquid is delivered to the patient's stomach is no more medical treatment than a catheter by which it is drained from the patient's bladder.

[47] While *'best interest'* was deemed the acid test Lynch J stated that he thought he "*could take into account what would be her own wishes if she could be granted a momentary lucid and articulate period in which to express them and if, despite what I have already said, I can form a view on the matter."* He was of the view that it was highly probable – "*and I find the evidence of the family on this aspect of the case to be clear and convincing*" – that the ward would choose to refuse the continuance of her treatment regime. Its ceasing would result in an *"immediate reduction of bodily functions and their attendant dignities and a peaceful death in accordance with nature within two weeks or so," at 98-99.*

[48] At 98.

[49] At 99.

[50] At 99.

might affect the ward, save in a palliative way to avoid pain and suffering, was also declared lawful.[51]

Appeal to the Supreme Court

The Attorney General, the institution in which the ward of court was being cared for, and the guardian ad litem appealed the decision to the Supreme Court.

Specifically, by notice to vary the guardian *ad litem* sought to have the High Court orders varied in respect of the standard of proof which had been applied, that of "*clear and convincing*" evidence.[52]

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[51] As it had been in *Airedale NHS Trust v Bland [1993] AC 789.* In summary the High Court held that:

- *The ward was not fully in a persistent vegetative state but was nearly so and had minimal cognitive capacity.*
- *The standard of proof to be applied was that the evidence should be clear and convincing.*
- *As the ward was a ward of court, it was for the Court to decide all matters relating to the ward by virtue of the jurisprudence conferred on the Court, although the views of the family and careers were factors to be taken into consideration. In re D [1987] IR 449 was followed.*
- *In determining the matter the Court was exercising the parens patriae jurisdiction which had been formally exercised by the Lord Chancellors of Ireland prior to 1922 and which had been vested in the President of the High Court or, at his discretion, in an ordinary judge of the High Court.*
- *Although the State had an interest in preserving life this interest was not absolute in the sense that life must be preserved and prolonged at all costs and no matter what the circumstances.*
- *Despite the fact that the right to life ranked first in the hierarchy of personal rights, it might nevertheless be subject to the citizen's tight of autonomy, self-determination, privacy or dignity, when exercised by a competent citizen or on their behalf.*
- *The nourishment by gastrostomy tube being afforded to the ward was an abnormal, artificial way of receiving nourishment and constituted a form of medical treatment.*
- *The test to be applied by the Court in determining the issue was whether it was in the best interests of the ward that her life should be prolonged by the continuance of the abnormal, artificial means of nourishment, or, whether the medical treatment should be withdrawn. Airedale NHS Trust v Bland [1993] AC 789 was followed.*

Other than the qualification that the ward was not fully in a persistent vegetative state, but was "*nearly so*", both the facts and the holding are the same as in *Bland.*

[52] Lynch J did not deem it appropriate to apply a higher standard: "*The Court should not require for itself a high standard of proof as might effectively preclude the Court from reaching a decision in a matter brought before the courts specifically for its directions. In finding the facts as already set out in this judgment, I am satisfied that the evidence in support of such facts is clear and convincing*", at 92. It was submitted that the application of a standard of proof requiring evidence to be "*clear and convincing*" before medical treatment was discontinued was not in accordance with law and in particular was at variance with the standard applied in civil law of a balance or probability; it was also at variance with the standard which, on the evidence adduced by medical practitioners on behalf of the family and the committee of the ward, was applied to decisions of this kind. It was contended that the correct standard of proof was not one beyond a probability.

While the Attorney General submitted that the Court had no jurisdiction to authorise the removal of the gastrostomy tube, the guardian ad litem submitted that, notwithstanding the Court jurisdiction in the matter, nonetheless it would be a breach of the ward's constitutional rights to do so. Likewise, the ward's right to life under Article 40.3.1 would be breached if consent was given for the removal of the tube.

Counsel on behalf of the institution submitted that the trial judge had been wrong in law in holding that the provision of nourishment to the ward by means of a gastrostomy tube was a form of medical

Hamilton CJ held that specific provisions of the Constitution were relevant to the issues raised in the appeal.[53]

While the Chief Justice did not refer to Article 40.3.3 which guarantees the right of the unborn with due regard being given to the right to life of the mother,[54] he did invoke the dicta of Finlay CJ in *Attorney General v X*[55] in respect of his interpretation of the doctrine of harmonious interpretation of the Constitution. This involved a consideration of the constitutional rights and obligations of the mother with those of others.[56]

He averred that if there was such an interaction of constitutional rights in the case before the Court, and one *"which I was not capable of harmonising....the right to life would take precedence over any other rights."*[57]

However, identifying the circumstances in which the strong presumption in favour of taking all steps capable of preserving life was no longer applicable was problematic.

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treatment and was abnormal. The institution also laid considerable stress on the fact that the ward had some, however minimal, cognitive capacity. This, it was said, put the ward's case in a radically different category to the case of *Airedale NHS Trust v Bland* where the patient was completely devoid of cognitive capacity.

[53] Article 40.1*: "All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function."*
Article 40.3.1*: "The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen."*
Article 40.3.2*: "The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."*
Article 41.1.1: *"The State recognises the family as the natural primary and fundamental unit group of society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law."*
Article 41.1.2: *"The State, therefore guarantees to protect the family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State."*
See Hamilton CJ's article, 'Matters of Life and Death', 65 Fordham L. Rev. 543 (1996-1997*)* which is an adaptation from the text delivered on March 28, 1996, as part of the John F Sonnett Memorial Lecture Series at Fordham University School of Law.

[54] In *Attorney General v X [1992] IR 1* a majority of the Supreme Court held that this article allowed for pregnancy termination where there is a real and substantial risk to the life, as distinct from the health, of the mother, and which can be avoided only by such termination.

[55] *[1992] IR 1.*

[56] This led him to conclude that "*the Court must, amongst the matters to be so regarded, concern itself with the position of the mother within a family group, with persons on whom she is dependent, with, in other instances, persons who are dependent upon her and her interaction with other citizens and members of society in the areas in which her activities occur," at 53.* In applying the doctrine of harmonious interpretation to Article 40.3.3, he stated: "*the proper test to be applied is that if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother, which can only be avoided by the termination of her pregnancy, such termination is permissible, having regard to the true interpretation of Article 40, s.3, sub-s.3 of the Constitution",* at 52-3.

[57] Ibid at 57.

"The definition of such circumstances must, of necessity, involve a determination of the nature of the right to life acknowledged by the Constitution."[58]

Personal constitutional rights[59] were neither absolute nor unqualified: *"They may be subject to the constitutional rights of others and to the requirements of the common good.....[but] they [do], however, spring from the right to life which is recognised in the Constitution."*[60]

Having established the jurisprudential territory on which he could, with some degree of judicial confidence, approach the question of whether the withdrawal of artificial nutrition and hydration from a person in a nearly persistent vegetative person would impinge disproportionately on that person's constitutional rights, irrespective of whether the person concerned had, or had not, retained capacity, Hamilton CJ turned to that right which, he averred, all citizens possess, namely *"to die a natural death"* and not have life maintained by artificial nourishment. The right to life and the right to die a natural death were inextricably linked.[61]

However, the issues before the court were *"not about euthanasia and are not about putting down the old and the infirm, the mentally defective or the physically infirm...."*

"It is important to emphasise that the court can never sanction steps to terminate life.....any course of action or treatment aimed at terminating life or accelerating death is unlawful....."

"No person has the right to terminated or to have terminated his or her life, or to accelerate or have accelerated his or her death."[62]

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[58] Ibid. Hamilton CJ reprised the dicta of Walsh J in *G v An Bord Uchtala [1980] IR 32,* at 69: *"The right to life necessarily implies the right to be born, to the right to preserve and defend (and to have preserved and defended) that life, and the right to maintain that life at a proper human standard in matters of food, clothing and habitation"* and later, *".....natural rights spring primarily from the natural right of every individual to life."*

[59] Including the right to live life to its fullest content, to enjoy the support and comfort of family, to social contact with peers, to education, to the practice of religion, to work, to marry, to privacy, to bodily integrity and to self-determination.

[60] At 124.

[61] *"As the process of dying is part, and an ultimate, inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life,"* ibid.

[62] Dicta of *Sir Thomas Bingham MR, Airedale NHS Trust v Bland [1993] AC 789, at 808.* O'Flaherty J, at 130, was equally anxious to dispel the notion that euthanasia was in issue: *"Our decision should not be regarded as authority for anything wider than the case with which we are confronted. This case is not about euthanasia; euthanasia in the strict and proper sense relates to the termination of life by a positive act. The declarations sought in this case concern the withdrawal of invasive medical treatment in order to allow nature to take its course."* For the avoidance of doubt O'Flaherty later, at 131, stated that the case was *"not about terminating a life but only to allow nature to take its course which would*

The question arose, however, as to how the wishes of the ward with regard to the continuance, or not, of artificial nourishment could be ascertained, and having been ascertained how implemented, and by whom? By virtue of her mental incapacity she was unable to exercise the right to voluntarily express her desires, one way or another, as to her treatment.[63]

It was held that, as per the provisions of Article 40.1 of the Constitution neither the requirements of the common good nor public order or morality, in the circumstances of the particular case, required that the exercise of the ward's constitutional rights should be restricted.[64]

The stumbling block, however, to this apparently logical jurisprudential progression was whether artificial nourishment could be classified, credibly – both from a medical point of view and from the perspective of the law – as more than mere medical care. If it fell within the category of medical treatment, then its withdrawal would be perfectly legal. If not, it would amount to an act of unlawful killing.

In satisfying himself that the treatment being afforded the ward constituted medical treatment and not merely medical care the Chief Justice noticeably failed to offer anything by way of substantive jurisprudential evidence to sustain this conclusion. He merely reprised the statement of Sir Stephen Brown, at first instance, in *Airedale NHS Trust v Bland* that *"the provision of artificial feeding by means of a nasogastric tube is 'medical treatment',"*[65] and in something of a giant jurisprudential leap, averred that there was no conflict between the exercise of the ward's rights and the right to life:

*"**Her right to die**[66] necessarily implies the right to die a natural death."*

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have happened even a short number of years ago and still does in places where medical technology has nor advanced as far as it has in this country, for example."

[63] The appellants, including the Attorney General, submitted that having regard to the right to life of the ward, *"it was not open to any person or persons to exercise such right on her behalf."* In the event that this submission was deemed to be correct, the ward, arising from her incapacity, would be deprived of the opportunity to exercise, or have exercised on her behalf, a right enjoyed by other citizens of the State.

[64] The loss by an individual of his/her mental capacity did not result in any diminution of his/her personal rights – the rights to life, to bodily integrity, to privacy, including self-determination and the right to refuse medical treatment, recognised by the Constitution.

[65] *Airedale NHS Trust v Bland [1993] AC 789, at 894.*

[66] At no stage in his judgment did the Chief Justice identify the source of a so-called *'right to die'*. Kamisar has rightly stated that few cries or slogans are more appealing or seductive that the 'right to die'. *"But few are more fuzzy, more misleading, or more misunderstood. The phrase has been used loosely by many people"*, including senior judges, it would appear, *"to embrace at least four different rights:*

1. the right to reject or top terminate unwanted medical procedures, including life-saving treatment;

As per the dicta of Lord Hailsham in *In re B,*[67] the paramount consideration confronting the judge in the High Court had been the ward's well-being, welfare or interests. As in Re J[68] the appropriate test was her *"best interests".* In applying this test, however, the court had been obliged to have regard to the constitutional rights of the ward.[69]

Consequently, Lynch J had arrived at the proper conclusion that it was in the best interest of the ward, and would be lawful, to withdraw the artificial nourishment.

The appeal, therefore, was dismissed.

Patently, the members of the Supreme Court were acutely conscious of the potential for future precedential invocation of their determination, particularly in cases concerning the legality of otherwise of assistance with death. A confirmatory declaration that the withdrawal of artificial nourishment from an incapacitated person, albeit in circumstances which, arising from the status of the patient as a ward of court, were governed specifically by the jurisdiction vested in the President of the High Court,[70] was lawful, might be of inestimable value to those who argue that a facility for earlier than natural death, particularly assistance with suicide, should be available to those who wish to accelerate death but are unable to do so because of a physical incapacity.

In this regard, O'Flaherty J stated that the issue with which the Court was confronted was one which depended solely on its own facts. *"Allowing nature to take its course"*[71] was the

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2. the right to commit suicide or, as some call it, the right to 'rational' suicide;
3.the right to assisted suicide, that is, the right to obtain another's help in committing suicide; and
4.the right to active voluntary euthanasia, that is, the right to authorise another to kill you intentionally and directly."
Neither *Re. Quinlan 70 NJ 10, 355 A.2d 747 (1976)* nor *Cruzan v Director, Missouri Department of Health, 497 US 261 (1980)* had established an absolute or general *'right to die'* – a right to end one's life in any manner one sees fit. *"The only right or liberty that the Quinlan Court established and the Cruzan Court recognised is the right under certain circumstances to refuse or to reject life-sustaining medical treatment or, as many have called it, the right to die a natural death."* See Kamisar, Y, *'Physician–Assisted Suicide: The last bridge to active voluntary euthanasia', in Keown, J (ed)., 'Euthanasia Examined: Ethical, clinical and legal perspectives',* Cambridge University Press, 1995, at 225.

[67] *(A Minor)(Wardship: Sterilisation)[1988] WC 199, at 202.*

[68] *(A Minor)(Wardship: Medical Treatment) [1991] Fam.33.*

[69] In considering *"whether it was in the best interests of the ward that her life should be prolonged by continuance of the particular medical treatment which she was receiving"* the proper test had been applied and the approach, *"from the standpoint of a prudent, good and loving parent",* had required *"clear and convincing"* proof of all relevant matters before reaching "an awesome decision"..... *"The true cause of the ward's death will not be the withdrawal of such nourishment but the injuries which she sustained on 26th April, 1972,"* the date on which she had suffered anoxic brain damage during the performance of a minor gynaecological procedure.

[70] *Section 9 of the Courts (Supplemental Provisions) Act, 1961.*

[71] The phrase *"in order to allow nature take its course"*, and the jurisprudential philosophy underpinning it, first made an appearance in the United States of America. See *In the matter of Claire*

governing criterion. In doing so, however, *"we are not ... going down any slippery slope or stepping into any abyss."*[72]

Indubitably, the boundaries of the dilemma facing the Supreme Court in the matter of choice on behalf of the ward were stark[73] and a credible legal formula which would enable it achieve a balance between the recognised constitutional rights of the ward and which, simultaneously, would not adversely affect the duty of the state to uphold life, was required.

Not for the first time in striving to make a finding in a hard case the Irish Supreme Court turned to American jurisprudence for the requisite guidance and support. A trans-Atlantic dimension had the added advantage of taking the edge off any criticism that the Supreme Court was following English jurisprudence blindly.[74]

In re Fiori[75] Popovich J had listed the fifty or more cases[76] in the United States in which the legality or otherwise of the withdrawal of artificial nutrition had already been addressed.[77]

Conroy 91985) 486 A 2d 1209, at 1224; Bouvia v Superior Court (1986) 225 Cal Rptr 297 (Cal CA), at 306. Having been endorsed by the English Supreme Court in *Airedale NHS Trust v Bland [1983] AC 789,* and applied subsequently in a number of cases where the non-treatment or withdrawal of treatment of neonates was in issue, it was incorporated into Irish law in *Re a Ward of Court (withholding of medical treatment)(No.2)[1996] 2 IR 79.*

[72] O'Flaherty J also averred, at 130, that the personal constitutional rights of bodily integrity were not lost by the ward by reason of her mental incapacity. A finding in this regard would be *"an invidious discrimination between the well and the infirm."* See also *O'Brien v Keogh [1972] IR 144.* O'Flaherty J was anxious to ensure that the circumstances of the case be seen as clearly distinguishable from the position of a mentally handicapped person who was conscious of his/her situation and was capable of obtaining pleasure and enjoyment from life: *"It is fanciful to attempt to equate the position of the ward in this case with that of a person whose life has been impaired by handicap. The analogy is both false and misleading; the quality of the ward's life was never in issue; she is not living in any meaningful sense. We are concerned here only with allowing nature to take its course and for the ward to die with dignity*", at 131. It is not clear from the logic of his reasoning why O'Flaherty J thought it necessary to reject any comparison between the condition of the ward and that of a mentally handicapped person. There was no submission to this effect by any of the applicants. It is likely, however, that he found it necessary to do so in order to pre-empt potential criticism of a finding that the withdrawal of artificial nourishment from an incapacitated patient who was not terminally ill was lawful as the start of a downward spiral, which would eventuate in the involuntary killing of incompetents who could no longer express a wish to continue to live. He may also have been presciently aware that his judgment, and those of his colleagues, could face evisceration by a jurist of the stature of John Keown. Keown is scathing in his critique of the reasoning adopted and followed in the Supreme Court. See his '*Death in Dublin*', (1996) Cam. Law Jour. 55:6. See also his '*Euthanasia, Ethics and Policy'*, op.cit., fn. 11 supra.

[73] *"...given the sanctity of life; given the right to self-determination and given an incompetent who cannot herself make a choice, since I hold that an incompetent does not lose the constitutional right of self-determination she would otherwise have had, how should the court exercise the choice for her because, as already indicated, a choice has to be made one way or the other,"* at 132.

[74] See fn.29 supra.

[75] *(1995) 652 A.R.2d.1350.*

[76] *See, inter alia: In re Quinlan (1976) 355 A.2d 647; Belcherstown State School (Superintendent of) v Saikewicz (1977) 370N.E. 2d 417; In re the application of Lydia E. Hall Hospital (1982) 455 N.Y.S 2d 706. In re the Application Barber v Superior Court of the State of California (1983) 195 Cal.Rptr.484; In re Hier (1984) 464 N.E.2d 959: In re Conroy (1985) 486 A.2d 1209; In re Visbeck (1986) 510 A.2d125; Vogel v Forman (1986) 512 N.Y.S.2d 622;In re Clark (1986) 510 A.2d 136; In re Westchester County Medical*

Consequently, "*near judicial unanimity*"[78] had been attained in the United States "*to permit a course similar to that sanctioned by the learned trial judge in this case*" - the clear implication being that if the decision by the court at first instance accorded with contemporaneous jurisprudential practice in the United States, it was therefore acceptable at Irish law.

The applicability of the '*substituted judgment*' criterion – prevalent in US jurisprudence, and alluded to in *In re Fiori* - at Irish law was disavowed. The '*best interest*' test was preferred. Inevitably, this entailed a choice between allowing life to continue and allowing "*nature to take its course*".

The corollary of the "*right of complete immunity to be let alone*", referred to *Union Pacific Railway Co v Botsford,*[79] and reprised in *In re Conroy,*[80]was founded, in Irish law, both on the common law and on the un-enumerated, but judicially identified, constitutional rights of '*bodily integrity*'[81] and '*privacy*'.[82]

The "*powerful dissent*" of Justice Stevens in *Cruzan v Director Missouri Department of Health*[83]was deemed to be of relevance. The reasoning that death is a natural part of life and

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Centre (1988) 531 N.E. 2d 607; Brophy v New England Sinai Hospital Inc.(1986) 497 N.E. 2d 626; Corbett v D'Alessandro (1986) 487 So.2d 368; Bouvia v Superior Court (Glenchur.)(1986) 225 Cal.Rptr.297; Workman's Circle Home and Infirmary for the Aged v Fink (1987) 514 N.Y.S.2d 893; Delio v Westchester County Medical Centre (1987) 516 N.Y.S.2d 677; Couture v Couture (1989) 549 N.E. 2d 571; In re estate of Longeway (1989) 549 N.E. 2d 292; Cruzan v Director, Missouri Department of Health (1990) 110 S.Ct.2841; Fosmire v Nicoleau (1990) 551 N.E. 2d 77; In re Guardianship of Doe (Jane) (1992) 583 N.E. 2d 1263.

[77] Popovich elaborated on the methods that had been invoked by American courts in dealing with these issues: *"Absent the existence of a statute on the subject, the various legal precepts relied upon to authorise the withdrawal of sustenance from a person in a persistent vegetative state have been reduced to a 'best interest analysis', 'substituted judgment' criterion or a 'clear and convincing' standard of proof which draw their strengths from the federal or state constitutional rights of privacy. Equally applicable to the right of an individual to forego life-sustaining medical treatment is the common law right to freedom from unwanted interference with bodily integrity."* Ibid. *See 'In re Quinlan Revisited: The Judicial Role in Protecting the Privacy Right of Dying Incompetents', (1988) 15 Hast.Cnst. L.Q.479.*

[78] *Per O'Flaherty J.*

[79] *(1891) 141 US 250: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law....'The right to one's person may be said to be a right of complete immunity to be let alone'."*

[80] *(1985) 98 NJ 321. In re Conroy* is one of the cases cited by Keown as an example of the accommodation (or one where at the very least it was reasonably open to the interpretation of accommodating) the notions that the supposed '*worth*' of a patient's life can be a justifiable reason for withdrawing life-saving treatment or tube-feeding, and that patients have an absolute right to refuse treatment or tube-feeding even with the intent to commit suicide. See Keown, *op.cit., fn. 11 supra, at 237.*

[81] *Ryan v Attorney General [1965] IR 294.*

[82] *Kennedy v Attorney General [1987] IR 587.*

[83] *(1990) 497 US 261: "it is perhaps predictable that courts might undervalue the liberty at stake here. Because death is so profoundly personal, public reflection upon it is unusual. As this sad case shows, however, such reflection must become more common if we are to deal responsibly with the modern*

that a person has a right to be allowed to die in accordance with nature and with all such palliative care as is necessary to ensure peaceful and dignified death was affirmed.

O'Flaherty J concluded that the '*best interest*' of the ward was that nature should be allowed take its course without artificial means of preserving *"what technically is life, but life without purpose, meaning or dignity."*

The most thought-provoking judgment, as well as the most comprehensive – albeit one that accorded with the majority view - was that of Denham J, as she then was.[84]

The substantive aspects of Denham J's judgment related to consent, bodily integrity, medical treatment, equality, the right to life, the right to privacy, dignity and the factors which the court had to consider in arriving at a decision in a case of this nature.

In the matter of the right to life the judge stated that this was the pre-eminent personal right. The State had guaranteed in its laws to respect this right, and *"the respect is absolute."*[85]

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circumstances of death. Medical advances have altered the physiological conditions of death in ways that may be alarming. Highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than as its continuation. But these same advances, and the reorganisation of medical care accompanying the new science and technology, have also transformed the political and social conditions of death. People are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions. When the institution is a state hospital, as it is in this case, the government itself becomes involved."

[84] It is a matter of passing interest to note that as Chief Justice Denham CJ presided over the appeal in the decision in *Fleming v Ireland [2013] IEHC 2.* She is the only member of the Supreme Court to have sat in *In re a Ward of Court.* A similar situation arises in Canada. The current Chief Justice, McLachlan CJ is the only remaining member of the Supreme Court who, having sat in *Rodriguez v British Columbia (Attorney General)[1993]3 SCR 51,* will preside over the appeal of the decision by the British Columbia Supreme Court in *Carter v Canada [2012] BCSC 886* which held that assisted suicide was permissible under the Canadian Charter of Rights and Freedoms. One of the principal reasons enabling the decision in *Carter* was what was described as *"new evidence"* from other jurisdictions where the law had been relaxed which had not been available when the decision in *Rodriguez* was made. In *Rodriguez* Sopinka J held that the prohibition of assisted suicide has *"a clearly pressing and substantial legislative objective grounded in the respect for and the desire to protect human life, a fundamental Charter value."* While the Court in *Fleming* did not invoke *"new evidence"* (it disagreed fundamentally with the premise underpinning the reasoning adopted by Smith J in *Carter*) it did introduce a radical proposal in respect of the factors which the Director of Public Prosecutions might take into account when deciding whether or not to prosecute in a case of assisted suicide. Prior to the hearing of the appeal in *Fleming* it would not have been unreasonable to expect that while upholding the correctness of the finding by the lower court that section 2(2) of the Criminal Law (Suicide) Act, 1993, was constitutionally valid and ECHR compatible, it would avail of the opportunity to demur as to the validity of the suggestion that the DPP should invoke the guidelines of the English Crown Prosecution Service when deciding whether or not to prosecute in a case of assisted suicide. In the event the Supreme Court was silent on this matter. See Chapter VIII on Canada and Chapter IX Ireland.

[85] At 160.

However, the requirement to defend and vindicate life *"as far as practicable"* was not an absolute requirement. *"Life itself is not an absolute."*[86] It is a qualified right.

Making no decision in the case of the ward *"would not be to respect her life [and] would be to refuse her the rights given to other persons.* In effect *"it would be to regard her life as less worthy of decision. Therefore, in order to respect her life a decision should be made."*[87]

However, it was for the applicant, namely the committee of the ward - to establish, on the balance of probabilities, that the life of the ward was best respected, protected and vindicated by the Court acceding to the application.

The view that life must be preserved at all costs *"does not sanctify life." "Life has a sacred value, an intrinsic worth"* but any analysis of the right to life must devote attention to other rights, those of *'privacy'*, *'autonomy'* and *'bodily integrity'*. Similarly, the common good, and the interest of the community in the protection of life, had to be considered.

As with the right to life the right to *'privacy'* was not absolute. It had to be balanced against the State's duty to protect and vindicate life. Nonetheless, the individual's right to privacy grows as the degree of bodily invasion increases[88]and *"a constituent of the right....is the right to die naturally, with dignity and with minimum suffering. This right is not lost to a person if they become incapacitated or insentient."*[89]

Feeding the ward *"a formula through a gastrostomy or nasogastric tube is a form of medical treatment,"*[90] which could be withdrawn without incurring a criminal penalty, and *"if the Court determines that the order of the High Court be upheld then, those acts so ordered being lawful,* ***the ward would die shortly as a result of the medical catastrophe which occurred 23 years ago."***[91]

However, *"this fact must not now cloud the decision to be made by the Court."*[92]

Denham J noticeably avoided the phrase *"allowing nature to take its course."* Nonetheless, she concurred with the other members of the Court, other than Egan J, that death would be as a result of the injury received almost a quarter of a century previously and not as a result

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[86] Ibid.
[87] Ibid.
[88] See *In re Quinlan (1976) 355 A. 2d. 647.*
[89] At 163.
[90] At 158.
[91] Author's emphasis.
[92] At 165.

of the withdrawal of artificial feeding from an incompetent, albeit not terminally ill, ward of court.

Therefore, notwithstanding the use of more emollient language than that employed by her judicial colleagues, Denham J accepted that the pragmatic jurisprudence governing the classification of artificial feed as medical treatment, was applicable at Irish law irrespective of the rights, both explicit and un-enumerated, including the right to life, identified and guaranteed in the Constitution.

By majority decision, therefore, the Supreme Court upheld the finding of the High Court for the following reasons:

- *In the exercise of its jurisdiction the court's prime and paramount consideration must be the 'best interests' of the ward; Airedale NHS Trust v Bland [1993] AC 789 followed;*
- *Although the views of the committee of the ward and her family were factors to be taken into consideration, they did not prevail over the court's views as to what was in the 'best interests' of the ward;*
- *The care and treatment being afforded to the ward constituted medical treatment and not merely medical care;*
- *If the ward was mentally competent she would have had the right to forego or discontinue her treatment and the exercise of that right would be lawful in pursuance of her constitutional right to self-determination which was implicit in her right to bodily integrity and privacy. However, this right did not include the right to have life terminated or death accelerated, and was confined to the natural process of dying;*
- *The loss by the ward of her mental capacity did not result in any diminution of her personal rights recognised by the Constitution, including the right to life.*
- *Neither the requirements of the common good nor pubic order or morality required the exercise of the ward's constitutional rights to be restricted as there was no conflict between the exercise of the ward's rights and the right to life;*
- *The trial judge had adopted the proper test having required* ***"clear and convincing"*** *proof of all relevant matters before reaching his decision.*

6. Jurisprudential Critique of Airedale NHS Trust v Bland and In re a Ward of Court

Prior to an analysis of the reasoning adopted and followed in *Fleming v Ireland* it is of benefit to review the critical assessment, most particularly that of John Keown,[93] of the jurisprudential underpinning of both *Bland* and *In re a Ward of Court*.

The finding in *Bland* - "*and as the decision of the Irish Supreme Court illustrates*" - was but one of several leading cases in common law jurisdictions[94] that could be used "*to illustrate*

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[93] Keown is not alone in his criticism of the reasoning in both cases. See Finnis, '*Bland*: *Crossing the Rubicon'*, LQR Vol 109, July 1993, 329-337. Keown's critical stance has been rejected by David Price, see fn. 113 below. The virulence of Keown's criticism of the reasoning in *Bland* was not diminished in his critique of that employed in *Re a Ward of Court*: "*The Law Lords*" – in *Bland* –"*took one step on the slippery slope; the Irish Supreme Court has taken the next, and on the basis of reasoning which could easily justify further steps. If this is the sort of reasoning a written constitution produces, long may we remain without one.*" See '*Life and Death in Dublin', case note,* Cambridge Law Journal (1996) 55, at 6. His criticism of the manner in which key questions had been skated over by the Irish superior courts was equally relentless: "*Lacking a rigorous analysis of the duty to care, it is hardly surprising that the judgments should skate over key questions. Why was tube-feeding held to be medical treatment rather than the ordinary care which ought normally to be provided? What were the burdens which outweighed the benefits of tube-feeding? And, even if the right to life includes a right to die naturally, why was the ward thought to be dying? Given that she could have lived for another twenty years, the court's glib references to 'letting nature take its course' invite Lord Mustill's criticism that they serve merely to conceal the ethical and legal issues.*" Ibid. Lord Mustill was one of the Law Lords who heard the appeal in *Bland.*

[94] *Keown, J,* op.cit., fn.11 supra, at 237-238. Examples of cases in the United States of America which "*accommodate (or at the very least are reasonably open to the interpretation of accommodating) the notions that the supposed 'worth' of a patient's life can be a justifiable reason for withdrawing life-saving treatment or tube-feeding, and that patients have an absolute right to refuse treatment or tube-feeding even with intent to commit suicide*" include *In the matter of Claire Conroy (1985) 486 A 2d 1209* and *Bouvia v Superior Court (1986) 225 Cal Rptr 297 (Cal CA).* In *Conroy,* the New Jersey Supreme Court held (at 1229) that treatment or tube-feeding could lawfully be withdrawn from an incompetent patient when it was clear that the patient would have refused it in the circumstances. It said (at 1224) that refusing treatment '*may not properly be viewed as an attempt to commit suicide. Refusing medical intervention* **'merely allows the disease to take it natural course'** and added that patients who refuse life-sustaining treatment '*may not harbour a specific intent to die.*' Keown, however, argues that "*equally, of course, they may, and the court evaded the question of why refusals with such intent would not be suicidal. It is obviously no answer to say that they are merely letting nature take its course since death is hastened by, and is intended to be hastened by, the decision to refuse treatment. If a diabetic refuses insulin in order to kill himself so his wife can claim his life insurance, why is this not suicide? If a father intentionally starves his baby to death, would the court acquit him on the ground that he was 'merely letting nature take its course'?*"
The court went on to state that, in the absence of any evidence that the patient would have refused it, treatment or tube-feeding could still lawfully be withheld or withdrawn if the "*net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that patient derives from life*" (at 1232).
In Bouvia, the California Court of Appeal allowed a 28 year old quadriplegic patient with severe cerebral palsy to demand withdrawal of tube-feeding. The court rejected the hospital's argument that she intended thereby to commit suicide. Despite a finding to the contrary by the trial judge, the court, echoing the court in *Conroy*, concluded (at 306) that she merely wanted '*to allow nature to take its course.*" Similarly evading the importance of intention, the court in *Bouvia*, in a question-begging criticism of the trial judge's finding, stated: "*If a right exists, it matters not what motivates its exercise.*" By contrast, the concurring opinion of Justice Compton squarely addressed the issue, and in so doing, illustrates the extent to which some judges have rejected the inviolability principle. The judge said (at

the tendency of judges across the Western World to undermine the traditional ethic," that is, of the sanctity of life.[95]

It is suggested that these are not criticisms that can be viewed either lightly or with complacency. It is of some significance, however, to note that what, by any established standards, either previously or since, were unequivocally provocative charges against the judicial reasoning engaged in by Irish Superior Courts – albeit the charges, on occasion, were couched in unembellished value-laden language and frequently displayed an over-arching righteousness – have never been rebutted by Irish jurists.[96]

This absence of juristic engagement is, frankly, inexplicable. It could be interpreted as indicative, if not of implicit agreement with the incisive logic employed by Keown, of an uncharacteristic intellectual pusillanimity to engage cogently, combatively and dispassionately with an issue of profound moral and ethical importance and one which has the potential to affect, directly or indirectly, every citizen.

Traditionally, Irish jurisprudence has shown itself more than capable of defending statutory provisions of moral and ethical magnitude. The issues of divorce and abortion spring to mind. The issue of same-sex marriage, the subject of pending legislation, undoubtedly will attract equally robust jurisprudential exchanges.

It is something of a mystery, therefore, why there has not been a comparable engagement with the issue of third party assistance with death? If the beginning of life, and the possibility

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307): "*I have no doubt that Elizabeth Bouvia wants to die; and if she had the full use of even one hand, could probably find a way to end her life – in a word – commit suicide. In order to seek the assistance which she needs in ending her life by the only means she sees available – starvation – she has to stultify her position before this court by disavowing her desire to end her life in such a fashion and proclaiming that she will eat all that she can physically tolerate. Even the majority opinion here must necessarily 'dance' around the issue.*"
Justice Compton added: "*Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision.*" The judge continued: "*The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.*" In Keown's view this decision, together with those of the Federal Courts of Appeal for the Second and Ninth Circuits, in *Quill* and *Glucksberg* respectively, indicate just how far, and how fast, some courts were in the USA had moved from a situation in which the inviolability of life was sacrosanct to one in which the quality of life pre-dominated. However, the decision in both *Quill* and *Glucksberg* were overturned by the Supreme Court in *Washington v Glucksberg 521 US 207 (1997).*

[95] "*Judges, often regarded as one of the most conservative arms of the state, are, it could reasonably be argued, playing a role no less significant than legislatures in subverting that ethic by converting a right not to be killed into a duty to kill and a right to self-determination into a right to self-termination.*"

[96] Keown's views in respect of the reasoning in *Bland* have been subjected to severe criticism by Price. See fn.113 post.

of its legitimate cessation in defined circumstances, can arouse an intensity of passion and emotion, repeatedly evidenced since the decision in *Attorney General v X,*[97] why has not assistance with earlier than natural death, of whatever form, not engendered a similar robust exchange of views?

The excuse that, other than *In Re a Ward of Court*, there has not been a consistent line of case law is, frankly, unconvincing. While the recent decision in *Fleming*[98] has aroused some peripheral jurisprudential interest no attempt of any substance has been made, either curially, extra-judicially or academically, to address the issues raised by Keown. In circumstances where it remains unchallenged, it is to be presumed that it has continued, if inconvenient, relevance.

Keown portrayed the apparently illogical character of the finding in *Bland* in startling terms. What, for example, was the basis for the decision that continued artificial nutrition was no longer in the patient's *'best interests'*? The answer provided by the Law Lords themselves was that such treatment was *"futile"* - why continue to treat a patient who is unconscious and for whom there is no prospect of any improvement in his condition?

Bolam[99] provided the template for ascertaining *'futility'*. A doctor must act in accordance with a responsible body of medical opinion. In an action for medical negligence, the appropriate test is whether a doctor has fallen below the standard of care required by the law.[100]

However, this essentially is a procedural criterion and conveniently avoids the fundamental question - why medical treatment was considered futile in *Bland*?

"Was it because it would do nothing to restore Anthony Bland to the condition towards which medical practice and procedures are directed",[101] namely, some level of health? Or was it rather, because *Bland's* ***life*** was thought futile? If the latter, it would be legitimate, in the absence of evidence to the contrary, to conclude that the decision in *Bland* condoned the withdrawal of tube-feeding because the patient's ***life,*** rather that the ***treatment***, was futile.

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[97] *[1992] 1 IR 1.*
[98] *[2013] IEHC 2.*
[99] *Bolam v Friern HMC [1957] 1 WLR 582.*
[100] Ibid.
[101] Keown, op.cit., fn.11 supra, at 220.

The importance, in *Bland*, of disabusing both the jurisprudential and the wider community of such an interpretation can be readily appreciated.

Similarly, both the significance and the convenience of the Law Lords' robust disavowal of an inference that intentional killing could be condoned was not lost on Lynch J at first instance in *In re a Ward of Court* when he found that the withdrawal of artificial nutrition from an incompetent ward was legal. Nor indeed was it lost on the judges of the Supreme Court who affirmed the decision. Had the Law Lords not underpinned their finding with credible jurisprudence - a matter disputed vigorously by Keown – the courts in Ireland would, of necessity, have been obliged to devise an exclusively indigenous resolution to the dilemma with which they were confronted. It is not in doubt that they would have done so. Undoubtedly, American jurisprudence would have been called in aid. However, notwithstanding the potential for accusations of imitative reasoning, not to avail of a ready-made finding in a UK case of similar facts would have been equivalent to looking a jurisprudential gift-horse in the mouth!

At its core, Keown's argument is that the Law Lords, and by implication superior Irish court judges, misunderstood the principle of the sanctity of life. Notwithstanding the potential for jurisprudential discomfort – arising from his claim - he contends that the view that the lives of certain patients are no longer worth living is not only pronounced in the various judgments in *Bland* but is also one which is probative of a judicial endorsement of dualism – the notion that human beings comprise two separate entities: a body and a person, *"the former being of merely instrumental value as a vehicle for the latter."*[102]

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[102] Ibid, at 221. There would appear to be some truth in this assertion. In the High Court Sir Stephen Brown described Anthony Bland as a person whose *"spirit has left him and all that remains is the shell of his body...[which is] kept functioning as a biological unit." Airedale NHS Trust v Bland [1993] AC 789,* at 804. Lord Justice Hoffman in the Court of Appeal stated: *"His body is alive, but he has no life in the sense that even the most pitifully handicapped but conscious human being has a life", Ibid at 825.* (Lord Hoffmann did admit that he had been influenced by reading the manuscript of Ronald Dworkin's *'Life's Dominion'* in which, Keown contends, the author espouses dualism). He went on to add that Bland was *"grotesquely alive."* For similar sentiments see Lord Browne-Wilkinson, *at 879*, and Lord Mustill, *at 897*. In *Re a Ward of Court, at 131*, O'Flaherty J stated that the quality of the ward's life was never in issue: *"she is not living a life in any meaningful sense."*
That dualistic reasoning was engaged in uncritically by some of the judges, and that it was the patient's life, and not his tube-feeding, that was adjudged worthless, is apparent. See, for example, the comments of Lord Keith. Lord Goff, while averring that the principle of the sanctity of life was fundamental, it was *"not absolute."* Notwithstanding the truth or otherwise, however, of Keown's claim that Lord Goff misunderstood the principle (Op.cit., fn.30 supra, at 224) it is indisputable that conventional jurisprudence is on his side. His sentiments pervade and underpin the various judgments – other than that of Egan J – in the Supreme Court *in Re a Ward of Court.* Egan J, dissenting, stated, at 136: *"the removal of the tube would, as already stated, result in death within a short period of time. It matters not how euphemistically it is worded. The inevitable result of removal would be to kill a human*

Keown may have struck a sensitive cord in the matter of English jurisprudence surrounding the sanctity, of life principle. In *Re J (A Minor),*[103] the *locus classicus* on withholding/withdrawing medical treatment prior to *Bland,* the question was whether a disabled baby, who had been made a ward of court, should be artificially ventilated. Two alternative submissions were made by counsel for the Official Solicitor. The first was of an absolute or vitalist character – *"a court is never justified in withholding consent to treatment which would enable a child to survive a life-threatening condition, whatever the pain or other side-effects inherent in the treatment, and whatever the quality of the life which it would experience thereafter."*[104]

It was submitted also that a court could withhold consent to treatment only if it was certain that the quality of the child's life would be *"intolerable"* to the child.

The court therefore was presented with only two alternatives: Lord Justice Taylor had to decide between ***vitalism*** or *a* ***quality of life*** argument which accepted that certain lives are of no benefit and may be lawfully terminated intentionally. The latter was preferred.[105]

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being. In view of the constitutional guarantees it would require (and I deem the right to life to be the highest in the hierarchy if rights) a strong and cogent reason to justify the taking of life."
It would appear, therefore that in Bland inviolability was confused with vitalism, which holds that human life is an absolute moral value. Because of its absolute worth, it is wrong either to shorten the life of a patient or to fail to strive to lengthen it. In short, the vitalist school of thought requires human life to be preserved at all costs.
John Harris states that most accounts of the criteria for personhood follow John Locke in identifying self-consciousness coupled with fairly rudimentary intelligence as the most important features. *"My own account uses these, but argues that they are important because they permit the individual to value her own existence. The important feature of this account of what it takes to be a person, namely that a person is a creature capable of valuing its own existence, is that it also makes plausible an explanation of the nature of the wrong done to such a being when it is deprived of existence. Persons who want to live are wronged by being killed because they are thereby deprived of something they value. Persons who do not want to live are no on this account wronged by having their wish to die granted, through voluntary euthanasia for example. Non-persons or potential persons cannot be wronged in this way because death does not deprive them of anything they can value. If they cannot wish to live, they cannot have that wish frustrated by being killed. Creatures other than persons can, of course, be harmed in other ways, by being caused gratuitous suffering for example, but not by being painlessly killed.....The life-cycle of a given individual passes through a number of stages of different moral significance. The individual can be said to have come into existence when the egg is first differentiated or the sperm that will fertilise that egg is first formed. This individual will gradually move from being a potential or a pre-person into an actual person when she becomes capable of valuing her own existence. And if, eventually, she permanently loses this capacity, she will have ceased to be a person."*
See *'Euthanasia and the value of life',* in Keown (ed), *'Euthanasia Examined: Ethical, Clinical and Legal Perspectives',* Cambridge University Press, 1995, p.9.

[103] *Re J (A Minor)(Wardship: Medical Treatment) [1991] Fam LR 366.* See Chapter VI on England.

[104] Ibid., at 370-1.

[105] However, the perspective of the child was *"paramount." "The correct approach is for the court to judge the quality of life the child would have to endure if given the treatment, and decide whether in all*

The contention, therefore, that it is probable that the sanctity of life argument may not have been heard, or at least may not have been persuasively presented, in either *Re J (A Minor)* or in *Bland* would appear to have some substance.[106] The correct interpretation of the sanctity of life argument, when submitted, can, in Keown's view, receive a fair hearing. This was evidenced in the conjoined twins case[107]where the presiding judge in the Court of Appeal, Lord Justice Ward, criticised the view of the judge below that the life of the weaker twin was a harm rather than a benefit and also expressly approved the sanctity principle.[108]

Indisputably, Keown's analysis gives rise to some disturbing conclusions which would not appear to be capable of easy dismissal. Their relevance to the reasoning followed in *In re a Ward of Court* is self-evident.

First, he contends that *Bland* represented *"a swerve towards Quality of life, accepting that certain lives are of no benefit and may lawfully be intentionally terminated by starvation and dehydration."*[109]

Second, accentuating this swerve was a shift from a traditional understanding of the value of autonomy – one enabling individuals to participate in decisions which respect objective moral norms and promote the flourishing of the decision-maker and others – *"to an essentially self-justificatory understanding of autonomy in which choices merit respect simply by virtue of being choices."*[110]

Third, Bland has left the law in a *"morally and intellectually misshapen"* state. The law prohibits doctors caring for patients in PVS from actively killing them but permits (if not

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the circumstances such a life would be so afflicted as to be intolerable to that child. I say 'to that child' because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable." Ibid.,at 383-4. Commenting on this Keown rightly observes that given that the child had never been capable of making any judgment, *"asking what the child would decide is something of a fiction. It is remarkable that the courts should import 'substituted judgment' in the case of a child who has never been competent and reject it in the case of an adult like Tony Bland who once was. If the court had applied substituted judgment in Bland, and declared that the feeding should be stopped because Tony would have chosen to be starved to death rather than live in PVS, and if the court endorsed this choice as reasonable, it would still have been endorsing a Quality of life approach."* See op.cit., fn.11, at 231-232.

[106] In *Bland* Lord Mustill had observed that *"it was a great pity that the Attorney General had not appeared to represent the interests of the state in maintaining citizens' lives."*

[107] *Re A (Children) [2000] 4 All ER 961.* Lord Justice Ward's views are at 997-1004.

[108] As understood by Keown, that is, and as outlined in his *'Euthanasia, Ethics and Policy'*, op.cit., fn.11 supra.

[109] Ibid, at 235.

[110] Ibid, at 235-236.

requires) them to kill by omission. *Bland* also suggests that, while doctors may not actively assist competent patients to commit suicide, they may assist them to do so by omission – by intentionally assisting suicidal refusals of treatment.[111]

Fourth, given that the Law Lords had embraced the Quality of life principle and effectively delegated the judgment as to which lives are of no benefit to medical opinion, *"there is little reason to expect that judgment to be confined to patients in PVS."* The ramifications of the courts' adoption of an individualist and amoral understanding of autonomy *"may also prove profound, not least in its potentially corrosive effect on the legal prohibition of assisted suicide and consensual murder."*[112]

Fifth, the Law Lords' rejection of the sanctity principle and their apparent endorsement of an amoral concept of autonomy appear to have been based on a misunderstanding of the traditional ethic.

Sixth, the decision whether to withdraw treatment and tube-feeding from a patient in PVS *"should be based on an evaluation of the worthwhileness of the treatment, not the supposed worthwhileness of the patient."*[113]

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[111] *"The significance of Bland is profound: although the House of Lords Select Committee reaffirmed that intentional killing by an act, even on request, should not be made lawful, the Law Lords have decided that intentional killing by omission, even without request, already is. The making of such a fundamental change in the law seems, moreover, difficult to reconcile with the guidelines for judicial development of the law laid down by Lord Lowry in the case of C v DPP,"* op.cit., fn.11, at 236. In *C v DPP [1995] 2 All ER 43* Lord Lowry, *at 52*, stated: *"(i) if the solution is doubtful, the judges should beware of imposing their own remedy; (ii) caution should prevail if Parliament has rejected opportunities of clearing up a known difficulty or has legislated while leaving the difficulty untouched; (iii) disputed matters of social policy are less suitable areas for judicial intervention than purely legal problems; (iv) fundamental legal doctrines should not be lightly set aside; (v) judges should not make a change unless they can achieve finality and certainty."* It would seem that these dicta were not considered to be of appropriate application in *Fleming v Ireland [2013] IEHC 2* where the High Court suggested that the DPP, notwithstanding the absence of statutory authority to do so, might avail of prosecutorial policies in use in other jurisdictions when deciding whether to prosecute in a case of assisted suicide. See Section on *Fleming v Ireland below.*

[112] Ibid.

[113] Ibid. *"While there appears to be something approaching a consensus that it is proper to withdraw treatment in such a case, there is a good argument that tube-feeding constitutes basic care and that it should, at least presumptively, be provided. Even if it were the better view that tube-feeding may properly be withdrawn, this should be because it, and not the patient, is judged futile."*
In the aftermath of the publication of guidance by the British Medical Association in 1999 (revised in 2001) on withholding and withdrawing life-prolonging treatment Keown argued that they were fundamentally at odds with the sanctity of life doctrine as properly understood. See his *'Beyond Bland: A critique of the BMA guidance on withholding and withdrawing medical treatment',* Legal Studies (2000) 20 LS 66. His thesis was not any different to that which he propounded subsequently in his *'Euthanasia, Ethics and Public Policy',* Cambridge University Press, published in 2002. In summary he contended that the guidance endorsed *"the withholding/withdrawal of tube-delivered food and water*

In the final analysis Keown concluded that *Bland* rendered the law *"... hypocritical rather than Hippocratic"* and the decision in *Re a Ward of Court* was an illustration of *"the tendency of judges across the western world to undermine the traditional ethic."*[114]

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not only from patients in PVS but also from other non-terminally ill patients, such as those with severe dementia or serious stroke. The underlying justification appears (as in Bland) to be that such lives lack worth." There were three major criticisms of the guidance: (*i) the argument that tube-feeding is medical treatment rather than basic care was weak; (ii) its reasons for not treating or tube-feeding undermined the BMA's long-standing opposition to active euthanasia and active assisted suicide and (iii) it relied heavily on legal precedent at the expense of ethical reasoning.* David Price, Professor of Medical Law, De Montfort University, Leicester, replied to Keown. See *Price, D, 'Fairly Bland: an alternative view of a supposed new 'Death Ethic' and the BMA guidelines', (*2001) 21 (4) Legal Studies 618. Price argued that even Keown's *"modified"* version of the doctrine of the sanctity of life *"cannot support a defensible moral or legal standard for decision-making here, being founded upon an excessive emphasis on the mental state of the clinician and an inappropriately narrow focus on the effects of the proposed treatment on the 'health' of the patient, as opposed to being primarily driven by the (best) interests of the patient. The attempt to divorce treatment decisions from broader evaluations of the net benefit to be attained by the patient from such treatment, including the taking into account of the individual's handicapped state, accordingly fails. Acceptance of such reality is, at the least, the first step toward a common language for further dialogue even between those with polar opposite opinions in this sphere."* Notwithstanding a robust reply by Keown to the effect that Price had wrongly caricatured the sanctity of life position which he supported and which continued to illuminate the proper decision-making path in relation to the withdrawal or withholding of life-sustaining medical treatment, Price, in a further article (see *Price, D, 'My view of the sanctity of life: a rebuttal of John Keown's critique', Legal Studies, Vol. 25 No.4, December, 2007, pp.549-565)* contended that Keown's riposte was misconceived and disguised *"the true nature of the sanctity of life stance, which both rests upon unconvincing premises and tends towards unacceptable repercussions, thus leading to its inevitable and rightful rejection."*

In the immediate aftermath of the decision in *Airedale NHS Trust v Bland* John Finnis, in *'Bland: Crossing the Rubicon?'* LQR Vol.109, July 1993, 329-337) had written *"The judges had identified Bland as a case in which sanctity of human life should yield to self-determination or best interests. Regrettably, no judgment attempted to state the much mentioned 'principle of sanctity of life.' A principle is a proposition which can guide deliberation, and any plausible articulation of this principle would exclude all choices intended to terminate (innocent) human life. The 'principle of self-determination' in giving or withholding consent to medical care was, however, often stated, in the quasi-absolute form canonised in Sidaway [1985] AC 871 at pp.904-905 which conspicuously fails to address the case where a refusal is known to be suicidal (e.g. motivated exclusively by concerns to ensure payment of term life insurance benefits; or pursuant to an open suicide pact). Lord Goff alone adverted to suicide, but quite ambiguously. And he approved Hoffmann LJ's dictum that suicide's decriminalisation "was recognition that the principle of self-determination should in that case [suicide] prevail over the sanctity of life."* The sponsors of the *Suicide Act 1961* repudiated rather than recognised the *'principle of self-determination'*, see, e.g. *H.C. Debates, July 19, 1961, cols. 1425-1426. "Indeed, the Act's severe penalties for complicity in suicide entail a rejection of the supposed primacy of self-determination and attest the law's acceptance, hitherto, that civilised relationships should have no truck with choices intended to terminate the lives of innocent people."* It can be seen from this that Keown is not alone in his criticism of the reasoning adopted and followed in both *Bland* and *In re a Ward of Court.*

[114] Op. cit., fn.11 supra, at 237. *"Judges, often regarded as one of the most conservative arms of the state, are, it could be reasonably argued, playing a role no less significant than legislatures I n subverting that ethic by converting a right not to be killed into a duty to kill and a right to self-determination into a rights to self-termination."* Ibid. In support of his contention Keown cited Professor Larry Gostin who had written (see *'A moment in Human Development: Legal Protection, Ethical Standards and Social Policy on the Selective Non-Treatment of Handicapped Neonates'* 1985, 11 Am J Law Med 32, at 39-40) that the term *'quality of life'* had entered Anglo-American jurisprudence to justify withholding of medically indicated treatment from severely handicapped infants *"whose life would be so bereft of enjoyment as not to be worth living."* He had added that it was difficult to argue

Therefore, the inherently arbitrary nature of the judicial findings in both cases, wittingly or unwittingly, shifted the law from its axis of sanctity of life towards an axis of what he refers to as the **Q**uality of life[115]which is not concerned only with assessing the worthwhileness of the treatment which a patient might receive but also with the worthwhileness of the patient's life.

Such a viewpoint is predicated on a belief that the lives of certain patients fall below a quality threshold, whether because of disease, injury or disability. *"This valuation of human life grounds the principle that, because certain lives are not worth living, it is right intentionally to end them, whether by act or by deliberate omission."*[116] **Q**uality of life judgments purport to judge the worthwhileness of the patient's life whereas the doctrine of the sanctity of life opposes such attempts and merely takes the patient's condition into account in deciding on the worthwhileness of a proposed medical treatment.

Is Keown's analysis correct?

It is unarguable that the High Court in In *Re a Ward of Court* followed the finding in *Bland.*[117] This stance was affirmed by the Supreme Court.

Is this probative, however, of the contention that a further step was taken on the slippery slope, or that the common law in end-of-life matters has been subverted?

While it is not possible to come to a definitive conclusion in the matter, nonetheless it is suggested that a credible argument can be made that R*e a Ward of Court*, albeit not in isolation from other cases in which the right to life was examined in the superior courts and averments made as to its imprescriptible character, marks the beginning of a process in which the traditional Irish jurisprudential approach to the sanctity of life evidenced tentative, but nonetheless discernible, deconstructive tendencies in favour of a more pluralist model, and one which apportions a greater weighting in the matter of individual *'autonomy'* and *'self-determination'*, particularly where voluntary decisions regarding the manner and timing of death are concerned, in the balance of rights provided for in the Constitution.

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with the premise underlying the *'quality of life'* position as there must come a point when life is *"so devoid of meaning and contentment that it is not worth living."*

[115] The capital **Q** is used by Keown to distinguish his categorisation from the ordinary meaning attributed to the phrase *"quality of life"*, e.g. comfort, pleasant surroundings, freedom from interference from others, etc.

[116] Op.cit, fn.11 supra, at 43-44.

[117] It did so by affirming that the right to life might not be absolute and might be subject to the citizen's rights of autonomy, self-determination, privacy and dignity, when exercised by a competent person or on their behalf; (b) nourishment by gastrostomy tube constituted a form of medical treatment and (c) the appropriate test to be applied was that of *'best interests'*.

If one is disposed to accept that the conventional jurisprudential wisdom, irrespective of provenance, and notwithstanding the infusion of an indisputable pragmatic element into the curial resolution of harrowingly difficult human situations, that medical treatment encompasses artificial nutrition, and if it is further accepted, as it must surely be, that all persons have the right to refuse treatment – a right not lost due to either mental or physical incapacitation - it would appear logical, at first sight, to conclude that Keown is in error.

This, however, is by no means conclusive. The core accusation underpinning Keown's analysis, baldly stated, is that judges, in order to arrive at closure in hard cases, either deliberately or inadvertently, have irredeemably altered traditional jurisprudence in the matter of the sanctity of life, or in more secular terms, the inviolability of life.

In effect, the charge is that Western jurisprudence has witnessed, and condoned, a shift of emphasis which relegates the worthwhileness of life to the utilitarian division.

7. *Fleming v Ireland* – the High Court:

The application[118] in *Fleming* sought a declaration that an exception be provided for the de-criminalisation of assisted suicide in cases of terminally ill persons who wish to choose the timing of their death, most particularly in circumstances when they no longer possess the capacity to kill themselves by their own hand.

The claim was grounded in the contention that the law is inequitable, infringes disproportionately on the dignity of the individual and his or her right to bodily integrity and, in confining the de-criminalisation of the act of suicide, in effect, to those physically capable of doing so, forces those confronted by a medical prognosis of future incapacity either to consider committing suicide earlier than they might wish or to resign themselves to unbearable suffering in advance of a natural death. The case was heard before a three member division of the High Court.[119]

In the event that the Court did not deem it appropriate, on criminal law grounds, to facilitate this request the Director of Public Prosecutions should be requested to issue policy

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[118] *[2013] IEHC 2.* The applicant, a 59-year old woman suffering from multiple sclerosis, asked the court for orders allowing her to be lawfully helped to take her own life at a time of her choosing so as to avoid what she feared would be a distressing and undignified death. She argued that, in her particular circumstances, the blanket ban on assisted suicide contained in Section 2(2) of the Criminal Law (Suicide) Act, 1993, breached her personal rights under both the Constitution and the European Convention in Human Rights.

[119] The High Court's dismissal of the appellant's claims was appealed to the Supreme Court. In the event the Supreme Court upheld the decision of the High Court. The treatment of the matter by the Supreme Court is addressed later in this chapter.

guidelines, similar to those published by the English Crown Prosecution Service following the decision of the Appellate Committee of the House of Lords in *R (on the application of Purdy) v Director of Public Prosecutions,*[120] which would clarify what her position was as to the factors that she regards as relevant for and against prosecution in cases of encouraging and assisting suicide.[121]

The jurisprudential logic invoked in support of the application was no different to that employed in previous applications in other common law jurisdictions.[122]

Prior to addressing the constitutional and ECHR issues which had been raised in the plaintiff's claim the Court heard evidence form the plaintiff herself and from a number of professional witnesses,[123] one of whom, Professor Margaret Battin had co-authored a study, in 2007, on legal physician-assisted dying in the state of Oregon and the Netherlands.[124] This had

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[120] *[2009] UKHL 45.* See fn. 183 et seq. in Chapter VI on England and Wales.

[121] In February, 2010, the DPP for England and Wales published the Crown Prosecution Service's policy on encouraging or assisting suicide. It provides guidance to prosecutors on the public interest factors to be taken in to account in reaching decisions in cases of encouraging or assisting suicide. In a statement accompanying the publication of the guidelines the DPP stated: *"The policy is now more focussed on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia. It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not. Assessing whether a case should go to court is not simply a question of adding up the public interest factors for and against prosecution and seeing which has the greater number. It is not a tick box exercise. Each case has to be considered on its own facts and merits."* See Chapter VI on England and Wales.

[122] With the exception of Canada attempts to decriminalise assisted dying in instances where suicide is the preferred method of dying of a physically incapacitated person who, no longer capable of committing the act him/herself, requires the help of a third party to do so, and at a time chosen by the person wishing to die in order to prevent further unnecessary suffering, have proved unsuccessful. The decision in *Carter v Canada [2012] BCSC 886* is currently on appeal to the Canadian Supreme Court. See Chapter VIII on Canada. In *Washington v Glucksberg 521 US 207 (1997)* it was held that the provisions of the US Constitution did not encompass such a right. See Chapter VII on America. Assisted suicide has been legalised in both the Netherlands (*The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002*) and Belgium *(Law on Euthanasia, 2002*). See Chapters II and III on the Netherlands and Belgium. As a result of voter initiatives in the American states of Oregon and Washington physician-assisted suicide is legally permissible. Since May, 2013 It is also lawful in Vermont. While juristic interpretations vary it is probable, as matters stand, that assisted suicide is no longer a criminal offence in Montana following the decision by that state's Supreme Court in *Baxter v Montana*. See Chapter VII on America.

[123] Including Professor Margaret Pabst Battin, Professor of Philosophy at the University of Utah in the United States of America, who was called by the plaintiffs; Dr Tony O'Brien, consultant physician in Palliative Care and former chair of the Council of Europe Expert Committee on Palliative Care and Professor Robert George, consultant physician in Guy's and St Thomas' Hospital in London and Professor of Palliative Care at Cicely Saunders Institute, both of whom were called by the State.

[124] Battin et al, *'Legal Physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable groups"',* Journal of Medical Ethics (2007) 33: 591-7.

concluded that there was not a disproportionate impact on vulnerable persons where assisted dying was legalised.[125]

Her analysis of the *Death with Dignity Act* in Oregon,[126]and the roughly analogous legislation in the Netherlands,[127]indicated that sufficient safeguards in relation to assisted dying were in place to ensure that abuse did not occur.[128] She identified two forms of abuse – procedural and substantive – and while she acknowledged that the possibility of abuse did exist nonetheless there was no empirically probative evidence of wholesale abuse.[129]

In her view the assumption that the legalisation of assisted dying brings extra-legal practices into being was "*backwards*". Rather, its actual effect was to bring these practices out into the open and allow them to be regulated and controlled much more carefully. Citing the Netherlands she claimed that as legislation became more robust, life-ending acts without a current explicit request were shown to decline.[130] However, this latter claim - one which would be vehemently contested by anti-euthanasist jurists[131]- did not impress the Court.

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[125] Her findings drew peer criticism. See fn.129 below.

[126] *See Chapter on America.*

[127] *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002.*

[128] Professor Battin did suggest that there could be added safeguards such as antecedent consultation with the Director of Public Prosecutions.

[129]Professor Battin stated that where there is procedural abuse it was declining and she was not aware of substantive abuse cases. In her study ten vulnerable groups were identified including elderly women, people without insurance, people with stigmatised illnesses, the poor, people with low educational status and those with disabilities. One of the criticisms made of the methodology employed by Battin and her co-author, Linda Ganzini, was the fact that the groups selected were categorised by reference to certain socio-economic groups instead of by reference to emotional vulnerability or personality type. (See Finlay & George, *'Legal physician-assisted suicide in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups'*, Journal of Medical Ethics (2010) doi. 10.1136). Battin responded that the study was looking for identifiable objective indicators not at the motivation of the particular mechanics of peoples' choices. She acknowledged that the understanding of those who criticised her selection as to what counts as *"vulnerable"* was different to that employed in her study. However, she expressed confidence the conclusions reached on the basis that the categories had been drawn from statements originating from various expert bodies such as the American College of Physicians and the British Medical Association.

[130] She further asserted that not every request for assisted suicide was acted upon and that assisted dying had not been extended to an ever widening circle. Overall, she claimed, incidents of assisted dying are extremely low. In Oregon, for example, she stated that only **0.2%** of people who die avail of this option. Similarly, in the Netherlands the proportion was also small – about **3%** of those who die. She stated that the vast majority of people do not die by assisted suicide. In relation to any issue of coercion she said that this could be detected by a number of techniques such as conducting interviews with patients, family member, or physicians. Her study avoided conjecture as to why people chose this route and she went on to state that her 2007 paper was not saying that coercion could not conceivably occur but rather that it could serve as an index as to whether coercion did occur.

[131] See Keown, J, (ed)., *'Euthanasia Examined: Ethical, clinical and legal perspectives'*, Cambridge University Press, 1995*; Euthanasia, Ethics and Public Policy: An Argument Against Legalisation'*, Cambridge University Press, 2002. See also debate in Legal Studies between Keown and David Price in the immediate aftermath of the publication by the British Medical Association in 1999 (revised in 2001) of guidelines in respect of withholding and withdrawing life-prolonging treatment: *Keown: 'Beyond Bland: a critiques of the BMA guidance on withholding and withdrawing medical treatment'*, Legal

Instead it invoked Keown's view in respect of an *"almost total lack of control on the administration of euthanasia"* in the Netherlands to bolster its finding that in an environment in which assistance with death is permitted *"the risk of complacency with regard to the maintenance of statutory safeguards.....could not be discounted as negligible."*[132]

Dr. O'Brien and Professor George stated that the explicit ban on assisted suicide was necessary and should be retained. A change in the law would result in people opting for assisted suicide in the belief that they had become an excessive burden to those around them.

In addition, it would be *"entirely radical for a physician to attempt to kill the pain by killing the patient"*.[133]

To condone deliberate intervention in the process of dying would completely reclassify the traditionally accepted role of medicine in society. Distinguishing assistance from suicide would have an effect on the ambient view as to what was normal resulting in a paradigm shift in society. The legalisation of assisted dying would result in a much more hazardous environment for the vulnerable. The Netherlands template demonstrated that what began as *"voluntary"* euthanasia became *"non-voluntary"* for people who were incapable. Once assisted suicide entered the domain of treatment economic utility became a consideration.[134]

The narrow exception requested by the plaintiff would not be less of a worry as no matter how narrowly the argument was construed, it would remain a paradigm shift. *"If there is one person who is considered legitimate or justified in making a claim then the territory changes*

Studies (2000) 20 LS 66; *Price, 'Fairly Bland: an alternative view of a supposed new 'Death Ethic' and the BMA guidelines',* Legal Studies (2001) 21 (4) LS 618; *Keown, 'Restoring the sanctity of life and replacing the caricature: a reply to David Price',* Legal Studies (2006) 26 (1) LS 109; *Price, 'My View of the Sanctity of Life: a rebuttal of John Keown's critique',* Legal Studiers (2007) 27 (4) LS 549. See fn. 114 supra.

[132] *[2013] IEHC 2, at para 67.*

[133] Ibid, at para 34. Dr O'Brien was fearful that a change in the law would result in people opting for assisted suicide in the belief that they had become an excessive burden to those around them. Likewise, the whole issue of persons with impaired competence would be enormously difficult and the situation would be impossible. If patients symptoms and fears were appropriately managed through palliative care they would die mush more peacefully and in must less distress. He rejected the assertion that sedatives were never administered as a primary purpose of shortening life but agreed that it is sometimes occurs knowing that this is what will happen.

[134] Evidence of Professor George, cited at para. 42. He cited the example provided in the *Remmelink Report* in the Netherlands where a patient had been euthanised non-voluntarily in order to free up a hospital bed.

by the very fact of the acceptance of that claim."[135] In summary, allowing for the narrow exception that the plaintiff requested would lead to a *"categorical change"*.[136]

In the event, the Court preferred the evidence offered by the State. It viewed the submission[137] that relaxing the ban on assisted suicide would bring about a paradigm shift with unforeseeable (and perhaps uncontrollable) changes in societal attitudes and behaviour to assisted suicide as *"compelling and deeply worrying."*[138] It was *"more convincing that than tendered by Professor Battin."*[139] The views of the State's witnesses were *"rooted in their solid clinical experience of dealing with literally thousands of terminally ill patients."*[140]

(a) Constitutional Invalidity:

The application for declarations of constitutional invalidity and ECHR incompatibility was firmly rooted in the contention that the criminal proscription of assisted suicide impairs a terminally ill person's constitutional and human rights on the basis that such rights, particularly those of privacy and bodily integrity, encompass an imprescriptible right to self-

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[135] Ibid, at para 44.

[136] Ibid. He cited the situation in the American state of Oregon where assisted suicide is narrowly defined and tightly controlled. In the first year of the operation of the *Death with Dignity Act*, **15%** of patients said being a burden on their family was a contributing factor in their decision to opt for assisted suicide. By year seven this had risen to **32%** and the median figure runs at about **42%**. *"It is, I suggest, important to be clear about the risks emanating from legalisation of these practices. The application of overt pressure on individuals to seek to end their own lives is likely to be uncommon – though it would be foolish to deny that it exists or that its presence can be easily detected. Much more common are the signals that relatives and others can send, albeit unconsciously, to a seriously-ill family member the he or she is becoming a burden on the family of that family life is being disrupted by the illness. There is such a thing as care-fatigue and as a clinician treating patients in the final stages of their lives I have come across it in the most loving family environment. It is easy in such circumstances for seriously ill people to feel a sense of obligation to remove themselves from the scene,"* at para.66.

[137] Of Dr.O'Brien and Professor George.

[138] At para. 67.

[139] Ibid. Not least because of the somewhat limited nature of the study carried out by Professor Battin and her colleague Professor Ganzini. The Court could not overlook the fact that, in a later survey, Professor Ganzini, had herself expressed concerns about the absence of appropriate safeguards in the Oregon law. See *Ganzini et al, 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying'. British Medical Journal 2008: 337: at 1682*. In his evidence Professor George had stated that in Oregon in 2011 the specialist psychiatric referral evaluation rate was just **1.4%.** He was of the view that *"in some cases depression is missed or overlooked."* Ganzini had concluded that *"most patients who request aid in dying do not have a depressive disorder. However, the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legalised aid in dying are needed."* Of equal significance for the Court was the fact that the Battin study did not directly address the concerns expressed by Dr O'Brien and Professor George. They had evinced deep concerns in respect of potentially vulnerable groups. They also worried that under a relaxed regime certain categories of patients with no visible signs of depression, or other mental health issues, and who did not belong to any of the traditional categories of vulnerable groups who would place themselves under pressure to hasten their death in this fashion in a subtle manner that might often elude detection.

[140] Ibid. Also, Dr.O'Brien and Professor George *"both gave their evidence in a manner which greatly impressed the Court."*

determination which should include a right to decide the manner and timing of an individual's own death.

The Court held unanimously, however, that the absolute ban on assisted suicide was justified on the grounds that it protected vulnerable others from involuntary death and did not breach the applicant's personal autonomy and equality rights under either Bunreacht na hEireann or the European Convention on Human Rights.

A *"real risk"* of removing the ban was that, even with rigorous safeguards, it *"would be impossible to ensure that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromise and emotionally vulnerable would not avail of the option in order to avoid a sense of being a burden on their family and society."*[141]

Kearns J, the President of the High Court, in delivering the unanimous judgment, averred that *"if the court could tailor-make a solution which would suit the needs of Ms Fleming alone without any possible implications for third parties or society at large, there might be a good deal to be said for her Article 40.3.2 case [relating to personal autonomy]. But this court cannot be so satisfied."*[142]

The very fact that a senior Irish judge found it appropriate to opine that in circumstances where the Court was convinced that there would be no adverse consequences to granting the relief sought by the plaintiff, the right to personal autonomy which lies at the core of the protection of the person contained in *Article 40.3.2,* would be engaged *"in principle"*,[143] while not indicative of jurisprudential doubt as to the pertinency of the law in respect of the ban on assisted suicide, does demonstrate an underlying empathetic dimension which will not be lost on those who wish to push the boundaries of the law on this issue further.

However, on its own admission the Court chose the words *"in principle"* advisedly. There were powerful countervailing considerations which fully justified the Oireachtas enacting legislation, such as the 1993 Act, making assisted suicide a criminal offence. The Court addressed these matters at a later stage and in the context of its invocation of the reasoning adopted and followed by the Chief Justice of the United States in *Washington v Glucksberg*.[144]

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[141] At para. 76.

[142] At para. 55.The invocation of the classic Millean principle that the individual is entitled, within reason, to behave in a manner which does not adversely affect or injure a third party, or society at large, is not uncommon in cases such as that of *Fleming*. It is the defence usually employed where a claim of an inherent right to select the manner and timing of one's death is alleged not to be negatively impactful either on other individuals or on society as a whole.

[143] At para. 52.

[144] *521 U.S. 702 (1997).* See Chapter VII on America.

The Court affirmed that it was not legally available to the Director of Public Prosecutions to issue guidelines setting out the particular facts she would consider in deciding whether to prosecute cases of assisted suicide. Only the Oireachtas could change the law and it would be unconstitutional for the DPP to effect a change in the law by issuing guidelines which would have the effect of specific provisions of the criminal law not being enforced.

Surprisingly, however, the Court went on to add, that if there was *"reliable evidence"*[145] after an assisted suicide of compliance with guidelines such as those set out by the English Director of Public Prosecutions in relation to assisted suicide prosecutions, it believed the DPP in Ireland would exercise her discretion *"in this of all cases"* in a *"humane and sensitive fashion."*

The judges, however, did not expand on what they meant by *"reliable evidence"*.[146]

The judgment in *Fleming* displayed a re-assuring robustness in finding that the criminal prohibition of assisted suicide was not unconstitutional. Had it done otherwise it would have signified an unprecedented recalibration of existing jurisprudence. As is the conventional norm, the judges availed of the opportunity to reprise the reasoning adopted and followed by their colleagues in similar cases in other jurisdictions. In this instance the Court relied heavily on the reasoning followed in *Washington v Glucksberg* where a claimed constitutional right to assisted suicide was dismissed.

In its consideration of the challenge to the constitutionality of the assisted suicide ban contained in s. 2(2) of the Criminal Law (Suicide) Act, 1993, the court stated that it was only in the event that the challenge failed that it would have jurisdiction – should the matter arise – to issue a declaration of incompatibility under s.5 (1) of the European Convention of Human Rights Act, 2003.[147]

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[145] *[2013] IEHC 2, at para 75.*

[146] It is to be presumed that, in the context of their allusion to the English guidelines that the judges intended that the criteria employed to discern what is and what is not *"reliable evidence"* in cases of assisted suicide in that jurisdiction would be transferred unquestioningly into Irish prosecutorial policy.

[147] In the proceedings the plaintiff claimed in the alternative to a finding of constitutionality and compatibility with the European Convention on Human Rights that an order be made directing the third named defendant, the Director of Public prosecutions, within such time as the Court shall seem just and appropriate, to promulgate guidelines stating the factors that will be taken into account in deciding, pursuant to section 2, sub-section (4) of the Criminal Law (Suicide) Act, 1993, whether to prosecute or to consent to the prosecution of any particular person in circumstances such as those that will affect a person who assists the plaintiff in ending her life.

The defence delivered on behalf of the State denied that s.2 (2) infringed any specific or un-enumerated constitutional right enjoyed by the plaintiff in the matter pleaded and further denied that Bunreacht na hEireann confers upon any citizen a right to die.[148]

The statutory provision was necessary in the interests of the common good and that the public interest in its continuance without qualification or exception outweighed any alleged rights which the plaintiff might claim to have in terms of obtaining the assistance of another person for the purposes of terminating her own life. The Criminal Law (Suicide) Act, 1993, was a law of general application which was designed to cover the many circumstances in which one person might aid, abet, counsel or procure the suicide or attempted suicide of another.

The defence also contended that s.2 (2) admitted of no qualification or exception to the offence of aiding, abetting, counselling or procuring the suicide or assisted suicide of another. The statutory provision did not, however, exclude the application of any general defences available at common law.

In addition, it was denied that the statutory provision was incompatible with the State's obligations under the European Convention on Human Rights or any provision thereof. The plaintiff was not entitled to seek a remedy directly from the High Court on the basis of a claim that there had been an alleged breach of her rights by reference to the provisions of the European Convention on Human Rights. In the State's view the European Convention on Human Rights Act 2003 did not give direct effect in Irish law to the European Convention on Human Rights.[149]

The Court averred that the plaintiff's contention that inasmuch as Article 40.3.2 of the Constitution protected her person this also necessarily embraced decisions concerning her personal welfare, including medical treatment, was at the heart of the case. However, the protection of the person was juxtaposed with other rights which were crucial to the fundamental freedom of the individual – liberty, good name and the protection of property.[150]

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[148] See fn.66 supra.

[149] The Human Rights Commission submitted that a person has a right, flowing from their personal autonomy rights, to take their own life in *"defined and extreme"* circumstances. The Commission invited the Court to consider whether the absolute ban on assisted suicide under Irish law is justified having regard to the extent of interference with the personal rights of a terminally ill, disabled and mentally competent person such as the plaintiff. The Court was invited to consider that it could be achieved in less absolute terms.

[150] *"To this may be added the Preamble's commitment to the dignity and freedom of the individual as a fundamental constitutional objective and the recognition by Article 44.1 of freedom of individual*

There were, however, profound and different moral, ethical, philosophical and religious views on the question of end-of-life decisions. It could not be doubted that, inasmuch as the plaintiff advanced a conscientious and considered decision to seek the assistance of others to take active steps to end her own life, such a decision was "*in principle*" engaged by the right to personal autonomy which lies at the core of Article 40.3.2.[151]

The court relied on the real and defining difference between a competent adult patient making the decision not to continue medical treatment on the one hand – even of death is the natural, imminent and foreseeable consequence of that decision – and the taking of active steps by another to bring about the end of that life of the other, which Rehnquist CJ had identified as of crucial importance in *Washington v Glucksberg*.[152]

Of necessity, the judges in *Fleming* had to tread cautiously so as not to infer that the reasoning in *Glucksberg* was applicable in its totality to the case before it. In stating, correctly, that the US Supreme Court had rejected the suggestion that the right to assisted suicide was immanent in the liberty interest protected by the 14th Amendment of the US

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conscience. For good measure, one might here also include similar and over-lapping rights such as the right to bodily integrity and personal privacy which have been judicially held to be protected as implied personal rights for the purposes of *Article 40.3.1."* The State, however, cannot prescribe "*an orthodoxy in respect of life choices of this fundamental nature and, moreover, that individual choices of this kind taken by competent adults must normally be respected absent compelling reasons to the contrary,*" at paras. 49-50. See also dicta of Henchy J in *Norris v Attorney General [1984] IR 36,* at 71-72, as emblematic of judicial consensus in respect of the individual rights: *"...there is necessarily given to the citizen, within the required social, political and moral framework, such a range of personal freedoms or immunities as are necessary to ensure his dignity and freedom as an individual in the type of society envisaged. The essence of those rights is that they inhere in the individual personality of the citizen in his capacity as a vital human component of the social, political and moral order posited by the Constitution....It is sufficient to say that there are [personal rights of this nature] which fall within a secluded area of activity or non-activity which may be claimed as necessary for the expression of individual personality, for purposes not always necessarily moral or commendable, but meriting recognition in circumstances which do not engender considerations such as State security, public order or morality, or other essential components of the common good."*

[151] Such a decision, however, was not really properly to be regarded as either an implied constitutional right in its own right or a right derived from an implied constitutional right in the manner discussed, and rejected, by the US Supreme Court in *Washington v Glucksberg, 521 US 207 (1997).* Rather it was a facet of that personal autonomy which "*is necessarily protected by the express words of Article 40.3.2 with regard to the protection of the person,*" at para. 52.

[152] See Chapter VII on America. Rehnquist CJ reasoned that the distinction between refusing care and assisting suicide was justified, inter alia, on grounds of intent, and noted that "*the law has long used actors' intent or purpose to distinguish between two acts that may have the same result," 521 US 207 (1997)* at 802. A physician who withdraws care pursuant to an express patient demand "*purposefully intends, or may so intend, only to respect his patient's wishes*", ibid at 801. By contrast, a doctor assisting a suicide "*must, necessarily and indubitably, intend primarily that the patient be made dead*", ibid. at 802. In *Glucksberg,* the Supreme Court rejected a challenge to the constitutionality of a Washington state statute which prevented assisted suicide. In doing do it reversed a finding to the contrary by the US Court of Appeals for the 9thCircuit. The claim had been brought by a number of Washington physicians who stated that they would assist terminally ill patients to end their own lives were it not for the statutory prohibition. The majority in *Glucksberg* insisted that the 14th Amendment protected only those implied rights "*which are, objectively, deeply rooted in history and tradition."*

Constitution, it accepted nonetheless that neither it nor the Irish Supreme Court had ever held that the implied personal rights protected by Article 40.3.1 were only those with deep roots in our own legal history and tradition. Had such been the case it would never have been possible for the Supreme Court, for example, to find as it did in *McGee v Attorney General*.[153]

A lengthy passage from the US Chief Justice's practical justifications in *Glucksberg* for the rationality of the Washington statute banning assisted suicide, was cited with approval.[154]

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[153] *[1974] IR 284.*

[154] The relevant passage, at 731-735, reads: *"Next, the State has an interest in protecting vulnerable groups – including the poor, the elderly, and disabled persons – from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as 'ludicrous on its face' 79 F.3d, at 825. We have recognised, however, the real risk of subtle coercion and undue influence in end of life situations. Cruzan, 497 US at 281. Similarly, the New York Task Force warned that [l]egalising physician assisted suicide would pose profound risks to many individual who are ill and vulnerable.....The risk of harm is greatest for the many individuals in our society whose autonomy and wellbeing are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatised social group.' New York Task Force 120; see Compassion in Dying, 49 F.3d, at 593 ('[A]n insidious bias against the handicapped – again coupled with a cost saving mentality – makes them especially in need of Washington's statutory protection'). If physician assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end of life health care costs.*

The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'social indifference' 49 F. 3d, at 592. The State's assisted suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same as anyone else's. See New York Task Force 101-102; Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady, at 9, 20 (discussing prejudice toward the disabled and the negative messages euthanasia and assisted suicide send to handicapped patients).

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted suicide ban on 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.' 79 F. 3d, at 838. Washington insists, however, that the impact of the Court's decision will not and cannot be so limited....If suicide is protected as a matter of constitutional right, it is argued, 'every man and woman in the United States must enjoy it.' Compassion in Dying, 49 F.3d, at 591; see Kevorkian, 447 Mich., at 470, n.41, 527 N.W. 2d, at 727-728, n.41. The Court of Appeals' decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the 'decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself,' 79 F.3d, at 832, n.120; that 'in some instances the patient may be unable to self-administer the drugs and....administration by the physician....may be the only way the patient may be able to receive them,' id., at 831; and that not only physicians, but also family members and loved ones, will, inevitably participate in assisting suicide. Ibid., at 838, n.140. Thus, it turns out that what is couched as a limited right to 'physician assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. Washington's ban on assisting suicide prevents such erosion.

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as 'the deliberate termination of another's life at his request'), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found and additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. See 'Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady', at 12-013 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has

In a companion case, *Vacco v Quill*,[155] and decided simultaneously with *Washington v Glucksberg*, the *US Supreme Court* upheld the constitutionality of a New York statute banning assisted suicide. The New York prohibition was couched in similar terms to the proscription of assisted suicide in Ireland.[156]

The Court agreed with the views expressed by Rhenquist CJ in both *Glucksberg* and *Vacco* and stated that the reasoning followed was "*... not merely adequate to sustain a law on the low-intensity 'rationality review' test favoured by the US Supreme Court in cases of this kind, but would also amply justify the ban by reference to the proportionality analysis,*"[157] which it had itself conducted in the case before it.

It was held, therefore, that a competent adult patient making the decision not to continue medical treatment, even in circumstances where death is the inevitable result, generally involves "*the passive acceptance of the natural process of dying*",[158] whereas the taking of active steps by another to bring about the end of life of a person intent on committing suicide, but who, due to physical incapacity, is unable to do so, involves the active ending of the life of another – "*a totally different matter.*"[159]

This fundamental distinction reflected a particular and necessary feature of the Constitution's protection of the person in Article 40.3.2, namely that "*the competent adult cannot be compelled to accept medical treatment.*" Irish constitutional traditions had firmly "*set their*

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not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. Id., at 16-21; see generally C. Gomez, 'Regulating Death: Euthanasia and the case of the Netherlands' (1991); H. Hendin, 'Seduced by Death: Doctors, Patients, and the Dutch Cure' (1997). The New York Task Force, citing the Dutch experience, observed that "assisted suicide and euthanasia are closely linked," New York Task Force 145, and concluded that the "risk of....abuse is neither speculative nor distant," ibid., at 134. Washington, like most other States, reasonably ensures against this risk by banning, rather than regulating, assisting suicide. See United States v 12,200-ft Reels of Super 8MM film, 413 US 123, 127 (1973) ('Each step, when taken, appear[s] a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance').

We need not weigh exactingly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code 9A36.060 (1)(1994) does not violate the Fourteenth Amendment, either on its face or 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.' 79 F. 3d, at 838."

[155] *521 US 793.* See Chapter VII on America.

[156] Rehnquist CJ averred *"..we disagree with respondents' claim that the distinction between refusing life-saving medical treatment and assisted suicide is 'arbitrary' and 'irrational'."*

[157] [2013] IEHC, at para 84.

[158] Ibid, at para 53.

[159] Ibid.

face against the compulsion of the competent adult in matters of this kind"[160] and this had underpinned the rationale for the decision in *Re a Ward of Court (No.2).*

The judges, however, could not be satisfied that *"it would be possible to tailor-make a solution which would address the needs of Ms Fleming alone"* while not, at the same time, guaranteeing against *"any possible implications for third parties or society at large."* Had it be satisfied that such a solution was indeed possible *"there might be a good deal to be said in favour of her case."*[161]

Nonetheless, it *"may be possible"*[162]for the Oireachtas to conceive of a solution to the dilemmas presented by the instant case, and others like it, *"which would provide for extensive safeguards of the kind said to be found in the regulatory regime prevailing in jurisdictions such as Switzerland, the Netherlands and certain US states, such as Washington and Oregon which have liberalised the law in this area."*[163]

Irrespective, however, of the nature of any safeguards employed[164] *"serious objections and concerns remain."*[165]

The State had provided an ample evidential basis to support the view that any relaxation of the ban *"would be impossible to tailor to individual cases and would be inimical, to the public interest in protecting the most vulnerable members of society."*[166]

Prior to a comprehensive traversal of the jurisprudential approach adopted in other jurisdictions, including decisions by the Supreme Courts of England and Wales,[167] of the

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[160] Ibid, at para 54. See *North Western Health Board v H.W. [2001] 3 IR 622, 746-753, per Hardiman J and Fitzpatrick v FK [2008] IEHC 104, [2009] 2 IR 7, 18-19, per Laffoy J.*

[161] Ibid, at para 55.

[162] Ibid, at para 56.

[163] Ibid. The Court did not refer to the recent decision to legalise physician assisted suicide in Vermont.

[164] Including a requirement that the patient be terminally ill; that he/she is facing intolerable pain; that the patient has been examined by a range of physicians over a period of time and has been appropriately counselled; that steps are taken to ensure the patient is competent and not suffering from depression; that the patient has a settled will to bring about his/her end in this fashion and that the proposed course of action is reported to the appropriate authorities. At para. 57.

[165] Ibid.

[166] Ibid. It was a point of some importance that if physicians were to be permitted to hasten the end of the terminally ill at the request of the patient by taking active steps for this purpose *"this would be to compromise – perhaps in a fundamental and far-reaching way – that which is rightly regarded as an essential ingredient of a civilised society committed to the protection of human life and human dignity"*, at para 68. In the event that legislators were ever to consider the de-criminalisation of assisted suicide the Court opined that the obvious and self-evident considerations *"of preserving the traditional integrity of the medical profession as healers of the sick, and deterring suicide and anything that smacks of the normalisation of suicide"*, should be discounted.

[167] *R. (Pretty) v Director of Public Prosecutions [2001] UKHL 61, [2002] 1 AC 800; Purdy [2009] UKHL 45; (2009) WLR 403.*

United States of America,[168] of Canada[169] and of the province of British Columbia,[170] the Court turned its attention to the not unimportant issue of the proportionality.

The familiar and authoritative exposition of the means to be employed by a court in deciding whether a restriction on the exercise of rights is permitted by the Constitution by Costello J *Heaney v Ireland* was reprised.[171]

The prohibition on assisted suicide, in accordance with the first requirement of Costello's proportionality test, was rationally connected to the fundamental objective of protecting the sanctity[172] of all human life[173] and was not remotely based on arbitrary, unfair or irrational considerations.

If the Court were to unravel "*a thread of this law*" by even the most limited constitutional adjudication in favour of the plaintiff it would – or, at least might – "*open a Pandora's box which thereafter would be impossible to close*"[174] and would place the lives of others at risk.[175]

The absolute prohibition on assisted suicide also satisfied the second and third limbs of the proportionality test and the constitutional challenge insofar as it concerned the claim based on the protection of the person in Article 40.3.2 (including overlapping and ancillary rights, such as dignity and bodily integrity), was rejected.

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[168] *Washington v Glucksberg 521 US 207 (1997); Vacco v Quill 521 US 793.*

[169] *Rodriquez v Canada [1993] 3 SCR 519.*

[170] *Carter v Canada [2012] BCSC 886.*

[171] *[1994] 3 IR 593.*Costello J, invoking the reasoning in Canadian case *Chaulk v R [1990] SCR 1303, at 1335-1336,* held that courts, in deciding whether a restriction on the exercise of rights permitted by the Constitution, must apply a proportionality test. The means chosen must: *(a) be rationally connected to the objective and not be arbitrary, unfair or based on irrational considerations; (b) impair the right as little as possible, and (c) be such that their effects on rights are proportional to the objective.*

[172] The use of the word '*sanctity*' rather than the more secular term '*inviolability*' is to be noted.

[173] The Court averred that the normative statement – contained in Article 40.3.2 - in respect of the State's interest in safeguarding the sanctity of all human life "*was of profound constitutional significance, since in conjunction with the equality guarantee in Article 40.1, it commits the State to value equally the life of all persons. In the eyes of the Constitution, the last days of the life of an elderly, terminally ill and disabled patient facing death have the same value, possess the same intrinsic human dignity and naturally enjoy the same protection as the life of the healthy young person on the cusp of adulthood and in the prime of their life,"* at para 74.

[174] At para 76.

[175] The Court recognised that placing others' lives at risk was not the intention of the plaintiff. "*But such might well be the unintended effect of such a change, specifically because of the inability of even the most rigorous system of legislative checks and balances to ensure, in particular, that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromisd, and the emotionally vulnerable would not disguise their own personal preferences and elect to hasten death so as to avoid a sense of being a burden on family and society. The safeguards built into any liberalised system would, furthermore, be vulnerable to laxity and complacency and might well prove difficult or even impossible to police adequately."* Ibid.

The Constitution's commitment in respect of the *equality* guarantee contained on Article 40.1, similar to the guarantee in Article 40.3.2, was another example, in the Court's view,[176] of a normative statement of high moral value. Unlike its European Convention on Human Rights counterpart, Article 14 ECHR, Article 40.1 was *"a free-standing equality guarantee, the application of which is by no means contingent on the operation of a separate and distinct constitutional right."* The Supreme Court had pointed out in *MD v Ireland*[177] that differences of legislative treatment will generally require at least a degree of objective justification, *"even if the margin of appreciation permitted to the Oireachtas will be somewhat greater in matters of acute social controversy."*[178]

As per the decision in *DX v Buttimer,*[179] in the case of persons with disabilities, within appropriate limits of feasibility and practicality, Article 40.1 will often permit – when it does not otherwise require – separate and distinct legislative treatment of persons with disabilities so that all *"are truly held equal before the law in the real sense which the Constitution enjoins."*[180]

Inasmuch as the 1993 Criminal Law (Suicide)Act failed to make separate provision for persons in the plaintiff's position by not creating an exception to take account of the physical disability which prevented her taking steps which an able bodied person could take, the Court was prepared to allow that the precept of equality in Article 40.1 was engaged. However, as per the reasons which it had given in respect of the provisions of Article 40.3.2, such differential treatment was deemed to be amply justified by the range of factors bearing on the necessity to safeguard the lives of others which it had already set out at some length.[181]

(b) Compatibility with the European Convention on Human Rights:

In the matter of the claim for a declaration of incompatibility under s.5 (1) of the European Convention on Human Rights Act, 2003 it was abundantly clear, following the findings in both *Pretty v United Kingdom*[182] and *Haas v Switzerland*[183] that the plaintiff's right to private life under Article 8(1) ECHR was engaged.[184]

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[176] It is suspected that this collective view was reflective of the opinion of Hogan J.
[177] *[2012] IESC 10, [2012] 2 ILRM 305.*
[178] At para 121.
[179] *[2012] IEHC 175.*
[180] Ibid.
[181] *"There is, moreover, as we have already noted, a profound difference between the law permitting an adult to take their own life on the one hand and sanctioning another to assist that person to that end on the other,"* at para 122. This was true even if the very disability under which the plaintiff laboured was the very reason she needed assistance of others to accomplish such a task.
[182] *(2002) 35 EHRR 1.* See Chapter VI on England and Wales.

In the *Purdy*[185] case the applicant suffered from primary progressive multiple sclerosis for which there was no known cure. Her case was that she anticipated that there would come a time when she would find her continuing existence as unbearable and that she would desire to bring about an end to her life. She intended to travel to Switzerland for this purpose. Her husband was willing to assist her to make that journey, but she was concerned that he would be prosecuted under the applicable legislation in England were this to occur.

The applicant sought information from the English Director of Public Prosecutions as to the factors which he would take into account in determining whether there ought to be a prosecution were she to be accompanied to Switzerland by her husband, he having made all the necessary arrangements. The Director of Public Prosecutions declined to comply with this request. The judicial review application which the claimant brought was specifically in respect of this one issue. In his judgment Lord Hope agreed that notwithstanding possible ambiguities in the ECtHR judgment in *Pretty*[186] the right to private life was engaged by decisions of this kind. He stressed that legal certainty was a core question to be addressed in considering

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[183] *(2011) 53 EHRR 33.* See Chapter IV on Switzerland. The ECtHR repeated its view that a ban on assisted suicide will always be justifiable by reference to Article 8(2) inasmuch a contracting States are entitled to adopt the position that such a ban is necessary to prevent abuse and the exploitation of the vulnerable. The decision of the Swiss authorities to refuse the applicant access to sodium-pentobarbital – a prescribed drug – so that he could commit suicide was amply justified by the provisions of Article 8(2). [The Court] *" is of the opinion that the regulations in place by the Swiss authorities....pursue, inter alia, the legitimate aims of protecting everybody from hasty decisions and preventing abuse, and, in particular, ensuring that a patient lacking discernment does not obtain a fatal dose of sodium pentobarbital..."* Ibid, at para 56. Interestingly, the Court stated, at para 57, that *"such regulations are all the more necessary in respect of a country such as Switzerland, where the legislation and practice allow for relatively easy access to assisted suicide. Where a country adopts a liberal approach in this matter, appropriate implementation measures for such an approach and preventive measures are necessary. The introduction of such measures is also intended to prevent organisations which provide assistance with suicide from acting unlawfully and in secret, with significant risks of abuse."*

[184] As to the engagement of Article 8 the ECtHR had stated in *Pretty:*

- *65. The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or of advanced physical or mental decrepitude which conflicts with strongly held ideas of self and personal identity...*
- *67. The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life.* ***The Court is not prepared to exclude*** *that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention. It considers below whether this interference conforms with the requirement of the second paragraph of Article 8."*

[185] *[2009] 2 WLR 403.* See Chapter VI on England and Wales.

[186] *[2001] UKHL 61.* See Chapter VI on England and Wales.

whether any restrictions on the right to family life were proportionate and *"prescribed by law"* in the manner provided by Article 8 (2).[187]

While Lord Hope was of the view that the statutory prohibition of assisted suicide would apply to Ms. Purdy's husband he held nonetheless that the Director's guidelines did not address this issue with sufficient particularity. He also held that the Code for Crown Prosecutors which the Director was required to issue pursuant to s.10 of the (UK) Prosecution of Offences Act 1985, must be treated as the equivalent of a *"law"* for Article 8 (2) purposes.[188]

Consequent on these findings the application was successful.

The essence of the judgment in *Purdy,* therefore, was that end-of-life issues were engaged by Article 8(1) ECHR and any restrictions on the right to family and private life required justification in accordance with Article 8(2) ECHR.

Given that the ban on assisted suicide at Irish law was rationally connected to a legitimate state interest pressing in a democratic society, namely, the protection of the *right to life*,[189] and especially that of the vulnerable, it *"is a proportionate measure designed to promote those interests and the objective it serves cannot be achieved in any less intrusive fashion."*[190]

Consequently, the claim to a declaration of incompatibility under s.5(1) of the European Convention on Human Rights Act, 2003, was rejected.

In advance of its examination of the request that an order be made directing the DPP to promulgate those factors governing decisions to prosecute, or not, in cases of assisted suicide, the decision in *Rodriguez v Canada*[191] was declared to be of *"considerable assistance*

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[187] *"The requirement of foreseeability will be satisfied where the person concerned is able to foresee, if need be with appropriate legal advice, the consequences which a given action may entail. A law which confers a discretion is not in itself inconsistent with this requirement, provided the scope of the discretion and the manner of its existence are indicated with sufficient clarity to give the individual protection against interference which is arbitrary..."* Ibid, at 418.

[188] *"Section 10 of that Act provides that the Director shall issue a code for Crown Prosecutors giving guidance on general principles to be applied by them in determining, in any case, among other things whether proceedings for an offence should be instituted and that he may from time to time make alterations to the Code. This document is available to the public. In my opinion the Code is to be regarded, for the purposes of Article 8(2) of the Convention, as forming part of the law in accordance with which an interference with the right to respect for private life may be held to be justified. The question is whether the requirements of accessibility and foreseeability where the question is whether, in an exceptional case such as that which Ms. Purdy's circumstances are likely to give rise to, it is in the public interest that proceedings under s.2(1)[of the Suicide Act, 1961] should be instituted against those who have rendered assistance,"* Ibid.

[189] As provided for in Article 40.3.2 of the Constitution.

[190] At para 124.

[191] *[1993] 3 SCR 519.* See Chapter VII on Canada.

and interest, not least given that the actual language of s.7[192]*of the Canadian Charter of Rights is very similar to that of Article 40.3.2 of Bunreacht na hEireann."*[193]

It is unnecessary here to reprise either the facts of the case or the reasoning followed in *Rodriguez*.[194]It is sufficient for present purposes to note that while the Canadian Supreme Court held that the applicant's right to the protection of the person under the s.7 of the Charter was engaged by the absolute prohibition of assisted suicide,[195] the majority held that the prohibition nonetheless was justified on proportionality grounds.

The invocation of *Rodriguez* led inevitably to consideration of the reasoning followed in *Carter v Canada,*[196] the most recent expression of the law in Canada in respect of assistance with suicide.[197] In *Carter* the ban on assisted suicide was held to be unconstitutional[198]specifically on grounds of *"disproportionality."*

In reviewing the regulatory and safeguard mechanisms employed in those jurisdictions that permitted third party assistance with death Smith J has expressed the view that any potential for risk attaching to the legalisation of assisted suicide could be minimalised.

It would have been a matter of considerable surprise had the Court found that the evidence before it, and that which had been submitted in *Carter,* regarding contemporary practice in

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[192] *"Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."*

[193] At para. 85.

[194] An analysis of the reasoning adopted and followed in *Rodriguez v Canada* is contained in the Chapter VII on Canada. Sopinka J stated that the prohibition has *"a clearly pressing and substantial legislative objective grounded in the respect for and the desire to protect human life, a fundamental Charter value."* In the matter of proportionality he averred that *"there is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose....is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be* stripped *from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death."*

[195] Contained in s.241 (b) of the Canadian Criminal Code.

[196] *[2012] BCSC 886.* See Chapter VII on Canada. The action was brought by two plaintiffs with debilitating and degenerative diseases, as well as by the husband of one of the plaintiffs and a family doctor.

[197] Now on appeal. In as far as can be ascertained *Fleming v Ireland* is the first curial evaluation, albeit summary in nature, which has so far been recorded.

[198] Evidence was heard from a wide spectrum of expert witnesses, some of whom had given evidence, or were referred to independently in *Fleming v Ireland*. They included Professors Battin, Ganzini, Keown and van Delden, together with Baroness Finlay and Dr. Hendin. Much of the evidence focussed on the experience of liberalisation of the law prohibiting assisted dying in jurisdictions such as the American state of Oregon, the Netherlands and Belgium and on the risks involved were the prohibition to be relaxed.

both the Netherlands and Belgium, was anything as encouraging or satisfactory as that expressed by Lynn Smyth J.[199]

It was not a surprise that the reasoning of Sopinka J in *Rodriguez* was preferred to that of Lynn Smith J in *Carter.*[200]

(c) The issue of the role of the Director of Public Prosecutions

The remaining issue for the Court was the plaintiff's claim that an order be made directing that the Director of Public Prosecutions, within such time as the Court shall seem just and appropriate, *"to promulgate guidelines stating the factors that will be taken into account in deciding, pursuant to section 2, sub-section(4) of the Criminal Law (Suicide) Act, 1993, whether to prosecute or to consent to the prosecution of any particular person in circumstances such as those that will affect a person who assists the plaintiff in ending her life."*

The Prosecution of Offences Act, 1974 – the Act which established the office of the DPP - provides for the prohibition of certain communications with the Director in relation to criminal proceedings.[201] However, the particular provision in section 10 of the UK Prosecution of Offences Act, 1985, whereby the DPP in that jurisdiction is obliged to issue a code of

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[199] *"It might well be said that this is altogether too sanguine a view and that the fact such a strikingly high level of legally assisted deaths without explicit request occurs in countries such as Belgium, the Netherlands and Switzerland without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation,"* at para 104. The fact that it was not in dispute that in 2005 in the Netherlands 560 patients (some 0.4% of all deaths) were euthanised without having given their explicit consent was conclusive proof – for the Court in *Fleming* at least – that despite reporting procedures and regulatory mechanisms vulnerable groups continued to be at risk in circumstances where assisted death had been legalised. *"This practices acknowledged to be unlawful, although the application of legally assisted deaths without explicit request to certain categories of incompetent patients (such as, for example, seriously disabled neonates) is apparently lawful in the Netherlands",* at para 102.

[200] Frankly, those who might have given some prior thought as to the precedents on which the court in *Fleming* would base its finding of constitutionality of s.2(2) of the Criminal Law (Suicide) Act, 1993, the decision in *Carter* would not have impacted immediately. It would not be unduly prescient, therefore, to predict that the likelihood is that the Supreme Court in Canada will reverse *Carter*, and in doing so may well cite – with justification – the analysis conducted of that case in *Fleming.*

[201] Section 6 of the Act provides that it shall not be lawful to communicate with the Director in his official capacity for the purpose of influencing the making of a decision to withdraw or not to initiate criminal proceedings or any particular charge in criminal proceedings. This provision, however, does not apply to communications made by a person who is a defendant or a complainant in criminal proceedings or believes that he is likely to be a defendant in criminal proceedings, or communications made by a person involved in the matter either personally or as a legal or medical advisor to a person involved in the matter or as a social worker or a member of the family of a person involved in the matter. The term *'member of the family'* is given a wide definition and includes *'wife, husband, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother, half-sister or a person in respect of whom an adoption order has been made.'* The Court was prepared to assume that the plaintiff's long-term partner, Mr. Curran, would come within the terms of this statutory definition.

guidance, for the benefit of Crown Prosecutors, on general principles to be applied in determining whether, in any case, proceedings for an offence should be instituted, discontinued, or the nature of the charges to be preferred, is not an option permitted to the DPP in Ireland.

However, general guidelines, but not offence-specific, have been issued from time to time by the DPP, the latest being in November, 2010. To allow for a proper appreciation of why the plaintiff considered it to be potentially beneficial for her to make a claim that, notwithstanding their general character, these guidelines should allow for greater clarity as to specific circumstances in which a person who assisted her to commit suicide might be prosecuted, the Court availed of the opportunity reprise the relevant sections, and in particular, those contained in Part 4.[202]

Cognizant of the nature and content of the guidelines lawyers for the plaintiff wrote to the Director of Public Prosecutions indicating that their client felt strongly that her life would

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[202] Sections 4.4-4.8 of the Guidelines address the issue of public interest. While there is a clear public interest in ensuring that crime is prosecuted and that the wrongdoer is convicted and punished nonetheless there may be some countervailing public interest reason not to prosecute. In assessing whether the public interest lies in commencing or continuing with the prosecution, a prosecutor should exercise particular care whether the is information to suggest that the suspect is a victim. Section 4.8 states: *"factors which should be considered in assessing whether to commence or continue with the prosecution include (i) the relative seriousness of any offence allegedly committed by the suspect and of any offence of which the suspect is believed to be ta victim; (ii) whether there is any information that coercion or duress was exercised against the suspect; (iii) whether there are allegations that the suspect was subjected to duress whether it is alleged that this included violence of threats of violence or the use of force, deceit or fraud, or an abuse of authority or exploitation of a position of vulnerability, and (iv) whether the suspect has co-operated with the authorities in relation to any offences believed to have been committed against the suspect."*
However, in addressing the issue as to whether there are cases where there may be a public interest reason not to prosecute, the guidelines state as follows:
"It is not the rule that all offences for which there is sufficient evidence must automatically be prosecuted" (Sec.4.18).
At 4.22 the guidelines deal with "other matters which may arise when considering whether the public interest requires a prosecution" and which, inter alia, include the following:
"(a) the availability and efficacy of an alternative to prosecution;
(b) the prevalence of offences of the nature of that alleged and the need for deterrents, both generally and in relation to the particular circumstances of the offender;
(c) the need to maintain the rule of law and public confidence in the criminal justice system;
(d) whether the consequences of a prosecution or a conviction would be disproportionately harsh or oppressive in the particular circumstances of the offender;
(e) the attitude of the victim or the family of a victim of the alleged offence to a prosecution;
(f) the likely effect on the victim or the family of a victim of a decision to prosecute or not to prosecute."
The weight to be attached to these and other factors *"will depend on the particular circumstances of each case."*
Section 4.23 states*: "Fairness and consistency are of particular importance. However, fairness need not mean weakness and consistency need not mean rigidity. The criteria for the exercise of the discretion not to prosecute on public interest grounds cannot be reduced to something akin to a mathematical formula; indeed it would be undesirable to attempt to do so. The breadth of the factors to be considered in exercising this discretion reflects the need to apply general principles to individual cases."*

soon be unbearable and that she would wish to terminate it. The client, however, would be unable to do so of her own accord and would require assistance. Her partner had promised her that he would be willing to help her if she decided the time had come to die.[203]

In reply the DPP stated that no guidelines of the kind mentioned in the applicant's letter had been issued. Decisions as to whether there should be a prosecution under s.2 of the Criminal Law (Suicide) Act, 1993, would continue be decided on the basis of the facts of any individual case. Having regard to the constitutional separation of powers and the roles designated to the Oireachtas and the Courts under the Constitution, there were significant legal impediments to the publication of guidelines of the type requested. Subject to any guidance or direction that the Superior Courts might give her, the Director did not believe that it would be appropriate for her to issue any such guidelines.

It was argued that failure to publish guidelines would be contrary to the provisions of the Human Rights Act, 2003, and would intrude unnecessarily on the plaintiff's right to privacy. Similarly, it was contended that it was unusual that a criminal provision should infringe the rights of those protected and for the class of those protected of whom the plaintiff happened to belong.

Counsel for the Director submitted that

(i) she would be "*aiding a crime*" if she were to grant the plaintiff's request. So to do would constitute a "*road map*" under which a person might more safely commit a crime and avoid prosecution;

(ii) she has no power to adopt a policy that prosecutions would not occur in certain cases. She could not legislate in a way that was not permitted under the Prosecution of Offences Act, 1974 and, more particularly, under the Constitution.

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[203] In relevant part the letter, dated August, 2012, read: "*In Regina (Purdy) v DPP [2010] 1 QAC 345, the Judicial Committee of the House of Lords ruled that the lack of a published policy of the (UK) Director in relation to prosecutions under equivalent provisions of UK law rendered the relevant law insufficiently clear, accessible and precise to permit a person potentially affected by it to know the degree to which it would affect his or her actions and that this amounted to an unjustified intrusion into the private life of a person in a very similar position to that of her client.....We have advised our clients that similar arguments to those advanced by Ms Purdy in the UK are available to the in this jurisdiction if no clear policy is available that would allow Mr Curran (and Ms Fleming) to know whether or not and in what circumstances, Mr Curran might be prosecuted for assisting Ms Fleming in terminating her life. A key factor is that Ms Fleming may be denied the right or power to end her life by the lack of clarity as to the circumstances in which a person who assists her might be prosecuted under s.2 of the Act of 1993....In those circumstances, the purpose of this letter is to ask you whether or not any privacy has been or is about to be adopted by your office in relation to the prosecution of offences under s.2 of the Criminal Law (Suicide) Act, 1993, and if so, to publish, at the very least to our clients, the terms of that policy.*"

(iii) even if the logic underpinning the decision in *Purdy* was applied there was *"no express power conferred on her [the DPP] to do what was ordered in the United Kingdom."* On the contrary, it would amount to forcing her into adopting a role which would in effect override statutory measures laid down by the Oireachtas.

(iv) her discretion is *ex post facto* in relation to the facts of any incidents brought to her notice. Only under s. 8(4) of the Garda Siochana Act, 2005, has the Director been empowered to *"give, vary or rescind directions concerning the institution and conduct of prosecutions by members of the Garda Siochana."*

(v) Section 3 (1) of the European Convention of Human Rights Act 2003 did not provide a basis for the plaintiff to invoke the application of the Convention to a matter such as the issuance of guidelines. This section did not purport to create functions to be exercised by organs of the State but merely described the manner in which functions elsewhere given were to be exercised. An obligation to make guidelines as argued for the plaintiff could not be rooted, therefore, in s. 3(1) of that Act. Furthermore, any obligation on an organ of State placed by s. 3(1) was expressed to be subject to *"any statutory provision (other than this Act) or rule of law."*[204]

It was confirmed for the Court that while the DPP could not, in advance of an act of assisted suicide, give any undertaking or indication as to whether or not a prosecution would follow, a communication with the Director either by the person who intended to commit suicide or by a member of her family, was not precluded under the 1974 Act establishing the office.

When questioned as to the Director's attitude to the submission of a file by a member of the plaintiff's family indicating, for example, *"that all the factors outlined in guidelines introduced in the UK following the Purdy decision had been complied with in advance of a proposed assisted suicide"*,[205] counsel stated that such a course would be legally permissible.[206]

Following confirmation by counsel for both the DPP and the State that the Director was obliged to take into account all relevant considerations when exercising her discretion the

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[204] A non-exhaustive list of statutes which would exclude a requirement to make guidelines included: (a) Article 15.2 of the Constitution; (b) Article 30.3 of the Constitution; (c) *The Prosecution of Offences Act, 1974,* and (d) The Criminal Law (Suicide) Act, 1993.

[205] At para. 156. A summary of the UK guidelines is provided at fn.202 supra.

[206] Such an action, however, would put the Director on notice of an intended criminal offence and as a result she *"might feel obliged to communicate with some other authority so as to ensure that a criminal offence, which at that point in time might be preventable, did not occur."* This is precisely what occurred in the *'X'* case in 1992. See *Attorney General v X [1992] 1 IR.* Having been notified in advance that a crime might be about to be committed the Attorney General of the day initiated proceedings with a view to prevent such an eventuality.

Court, somewhat elliptically, averred that *"such a course would undoubtedly greatly narrow down the risk of any ex post facto prosecution."*[207]

This, however, is a far cry from establishing a *"requirement"* that the *DPP* issue guidelines which would include factors determinative, or not, of a prosecution.

The Court in *Fleming* was satisfied that the decision in *Purdy* had limited relevance to the question of whether the *DPP* could be directed to issue guidelines on assisted suicide.[208] The Court appeared to contradict itself at a later point when it stated that *"the decision in Purdy is.....one of significant value."*[209]

Nonetheless, it considered it appropriate to observe that the DPP could find the prosecutorial guidelines issued by the UK Crown Prosecution Service to be of *"considerable assistance,"*[210] if an event of assisted suicide were to occur in her jurisdiction. That the Court did so notwithstanding its undoubted awareness of constitutional restraints – alluded to by the DPP herself in her reply to the plaintiff's letter - preventing the issuance of similar guidelines in this jurisdiction is, frankly, astonishing.[211]

So much for the view that the decision in *Purdy* had limited relevance in the Irish jurisdiction!!

The Court also found it appropriate to cite a list of factors – in support of public interest considerations which would tend towards non-prosecution in the case of an assisted suicide – which had been identified in the Canadian case *Carter v Canada.*[212] It alluded to these factors, *"to the extent that they add value to the exercise of the Director's discretion, and may also be taken into account by her in this jurisdiction."*[213]

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[207] At para. 157.

[208] See para. 158. It is not unreasonable to suggest, however, that, in so stating, the Court was trying to have it both ways. By virtue of the fact that the plaintiff had specifically relied on its finding, most especially on it recommendations that the Crown Prosecution Service publish guidelines in respect of the factors it would take into account in deciding whether to initiate criminal proceedings in a case of assisted suicide, to claim that the DPP in Ireland should be obliged to do likewise, the Court, of necessity, had to address the reasoning in *Purdy.*

[209] Ibid.

[210] At para. 168.

[211] It would also appear to indicate a softening of judicial attitudes in the application of the prohibition of assisted dying. The creation of an *'exception'* to the ban on assisted suicide in circumstances similar to that of the plaintiff may have been initiated in *Fleming.*

[212] *[2012] BCSC 886.* In the context of its stated disagreement with the finding in that case this too is something of a surprise. The impression created is that however jurisprudentially unpalatable the three judge Court found the decision in *Carter* it did, nonetheless, have the convenient merit of providing a readymade template of factors which might be of assistance to the DPP in Ireland in carrying out her statutory duties.

[213] At para. 172.

In dispelling the notion that an invocation of the Human Rights Act 2003 had relevance to the case under consideration the Court averred that the form of incorporation of the Convention on Human Rights in Ireland did not have direct effect. What was required - and no more - was that a court, at a sub-constitutional level, shall *"insofar as is possible, subject to the rules of law relating to such interpretation and application"* interpret a statutory provision or rule of law in a manner compatible with the Convention.[214]

Quite clearly, *"it would be impermissible for any court in this jurisdiction to apply a Convention principle when to do so would bring the court into conflict with the rule of law as prescribed by the Constitution and, in particular, Article 15.2 thereof."*[215]

The Court, therefore, stated that it *"seems clear"*[216] that the effect of any direction requiring the Director to issue guidelines of the kind sought by the plaintiff *"would infringe these basic constitutional principles."*[217]

Whatever the stated objective of seeking guidelines might be, the Court had no doubt but that the intended effect of obtaining such relief would be to permit an assisted suicide without fear of prosecution.

"No amount of forensic legerdemain can alter that fact."[218]

Nonetheless, having repeated its view that it was not within its powers to direct the DPP to issue offence-specific guidelines in the matter before it, *"because we share a similar system"* -

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[214] At para. 161. *"There must therefore be a statute or rule of law to which the Convention principles may be said to attach. The Convention does not operate in a free standing way, nor can it override the provisions of the Constitution. Further, in interpreting or applying such provision or rule of law, the court is necessarily circumscribed by existing rules of law relating to such interpretation and application," at para 162.* The dicta of Denham CJ in MD (Minor) v Ireland, AG & DPP [1012] IESC, [2012] ILRM 305 was invoked. The appellant had included in his claim an assertion that s.3 of the Criminal Law (Sexual Offences) Act, 2006, was *"in breach"* of certain articles of the Convention. The Chief Justice stated*: "That formulation is not acceptable. It treats the Convention as if it had direct effect and presumes that the Court has the power to grant a declaration that a section is in breach of the Convention. It is clear from the judgments of this Court in McD v L [2012] 2 IR 199 that the European Convention on Human Rights Act, 2003, did not give direct effect in Irish law to the European Convention on Human Rights. As Murray CJ stated at page 248, 'the Convention does not of itself provide a remedy at national level for victims whose rights have been breached by reference to the provisions of the Convention.'" [2012] ILRM 305, at 324*

[215] Article 15.2 provides: "1.*The sole and exclusive power of making laws for the State is hereby vested in the Oireachtas.....no other legislative authority has power to make laws for the State. 2. Provision may however be made by law for the creation or recognition of subordinate legislatures and for the powers and functions of these legislatures."*

[216] At para.166.

[217] Ibid.

[218] Ibid. The use of the pejorative term *"legerdemain"* is, to say the least, unusual and is particularly so in a case as sensitive as the one on which the Court was called to adjudicate. It is not a word that would normally be associated with the vocabulary of either the President of the High Court or of Mr Justice Carney.

to that of the UK - *"for the initiation of criminal proceedings"*,[219] and because the discretion exercisable by the Directors in both jurisdictions was *"not focused exclusively on evidential matters"*,[220] the UK guidelines *"provide considerable assistance"*[221] in the prosecutorial approach to a case of assisted suicide. This was particularly so when the wording of the offence in the English Suicide Act, 1961, was virtually identical to that of the Criminal Law (Suicide) Act, 1993, in Ireland.[222]

In an attempt, in effect, to change the law by stealth – the word is used advisedly - the court averred that in the instant case, and in future cases of assisted suicide, the very existence of the UK guidelines *"must surely inform any exercise of discretion by the DPP in this jurisdiction."*[223]

The assuredness of this averment is devoid of both logic and legal rationality. It is unclear what criterion was employed to permit the statement that *"without being compelled in an impermissible way under our law to issue offence-specific guidelines, the Director in this jurisdiction is nonetheless in as good a position as the Director in the UK* ***as an incidental beneficiary of what happened in that jurisdiction."***[224]

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[219] At para. 168.

[220] In the matter of the principle that there is no automatic prosecution based on evidence alone the Court cited *Smedleys Ltd v Breed [1974] AC 839* where the issue was addressed by Viscount Dilhorne.: *"In 1952 the question was raised whether it was not a basic of the rule of law that the operation of the law is automatic where an offence is known or suspected. The then Attorney General, Sir Hartley Shawcross, said: 'It has never been the rule in this country - I hope it never will be – that criminal offences must automatically be the subject of prosecution.' He pointed out that the Attorney General and the Director of Public Prosecutions only intervene to direct a prosecution when they consider it in the public interest to do so and he cited a statement made by Lord Simon in 1952 when he said: '...there is no greater nonsense talked about the Attorney General's duty than the suggestion that in all cases the Attorney General ought to decide to prosecute merely because he thinks there is what the lawyers call a case. It is not true and no one who has held the office of Attorney general supposes it is' Sir Hartley Shawcross's statement was endorsed, I think, by more than one of his successors."* In *The State (McCormack) v Curran [1987] ILRM 225* Finlay CJ, in a similar vein, stated, *at 237*: *"In regard to the DPP I reject also the submission that he has only got a discretion as to whether to prosecute or not to prosecute in any particular case related exclusively to the probative value of the evidence laid before him. Again, I am satisfied that there are many other factors which may be appropriate and proper for him to take into consideration."* The Court in *Fleming* believed the final part of this citation to be of such importance to the task facing it that it gave it added emphasis.

[221] At para. 168.

[222] The logic underpinning this statement is unclear. That the wording of an Irish statute is similar to, or merely a replication of, a UK statute would not appear to be a good jurisprudential reason for suggesting that prosecutorial policies in the one should be imitated in the other.

[223] At para. 171.

[224] Author's emphasis. Since when has the law in Ireland been formulated on the basis that its jurisprudence is an incidental beneficiary of what occurs in the UK? Unquestionably, this is not good law and, absent a speedy clarification by the Supreme Court, it has the potential to incubate unpleasant viruses which, quicker than might be imagined, may attack and destroy indigenous jurisprudential values.

"Because of their importance in the overall context of this part of the case" the Court availed of the opportunity to set out the UK guidelines in some detail.

It is troublesome that an Irish Court, having clearly established - arising from both a constitutional prescript and an absence of legislative authority - that it is not within the remit of an arm of the State to issue offence-specific guidelines, and having fulsomely endorsed that position,[225] nevertheless, and in a clearly permissive tone, virtually enjoined the Director of Public Prosecutions not alone to use the guidelines of another jurisdiction as a template in arriving at a decision whether to prosecute a case of assisted suicide but to allow herself also to be guided by factors identified, but which are not operational, by a court in Canada.

To put it no more bluntly, there is a disturbing element of active judicial legislative endeavour evident throughout this unanimous judgment and one which does not do any credit to either the reputation of the justice system as a whole in matters as fundamental as those with which the Court grappled, or to that of the justices involved.

Were the Director to heed this judicial advice, and were it to become know that she had done so, it is not unreasonable to suggest that unless a person who was physically unable to fulfil his or her intention to commit suicide, and who required the assistance of another person to do so, was a complete and utter fool, careful observance of the readily available English guidelines, or those identified by the Supreme Court of British Columbia in *Carter v Canada*, it would be likely that the Irish Director of Public Prosecutions would spend considerably more time than heretofore exercising her discretion not to prosecute cases of assisted suicide, and would do so in the knowledge that she had the endorsement of no less an institution than that of the High Court.

While it may be a matter of some consolation to those who continue to believe that the function of the courts is to uphold the law, and not to instigate jurisprudential rebellion, that the Director of Public Prosecutions is unlikely, of her own volition, to heed the enjoinment of the High Court in this matter, it would have been of even greater comfort had the Supreme Court, in exercising its appellate authority, discouraged those who, as a result of an

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[225] At para. 174 the Court stated: *"Most, if not all of the difficulties in this case, insofar as they relate to the issue of guidelines, derives from the fact that it is sought to require the Director to issue offence-specific guidelines* ***in advance*** *of the event which might trigger a prosecution. The Court has detailed the various reasons why it believes that this is impermissible under Irish law, and the Court accepts the submissions advanced on behalf of the Director that to apprise her of an intention to commit a criminal act in advance may place her in an invidious, if not impossible, position. To be made aware of an intended criminal offence might well, as outlined by counsel for the Director, oblige the Director to consult band liaise with other public authorities with a view to restraining the commission of an offence such as occurred in the "X" case in this country in 1992 (Attorney General v X [1992] 1 IR 1. This objection is one not lightly to be discounted."*

unprecedented display of judicial hubris, believe that assisted suicide may, in the future, be carried out with impunity. In the event, however, the Supreme Court did not address the role of the Director of Public Prosecutions and confined itself to the issues of the claimed unconstitutionality of section 2, sub-section (2) of the Criminal Law (Suicide) Act, 1993 and its alleged incompatibility with the State's obligations under the European Convention on the Protections of Human Rights and Fundamental Freedoms.

8. *Fleming v Ireland* – the Supreme Court:

Denham CJ delivered the judgment of the Supreme Court, upholding the earlier decision of the High Court, on 29 May, 2013.[226] The Court considered carefully the decisions in *Rodriguez v British Columbia,*[227] *Washington v Glucksberg et al,*[228] *R (Pretty) v DPP*[229], *Carter v Canada,*[230] together with the findings by the European Court of Human Rights in *Pretty v United Kingdom* and *Haas v Switzerland*.

As mentioned earlier each of these cases, and *Carter v Canada* in particular, was traversed in considerable detail by the High Court. The Supreme Court was acutely mindful, however, of the fact that the decision in *Carter* was that of a trial court, and one which was under appeal. While the decision was grounded on the Canadian Charter of Rights and Freedoms - not the Irish Constitution - and a development of the principle of proportionality, and new evidence, underpinned the judgment, it was not consistent with many determinations from the supreme and constitutional courts of other nations. The Court found it significant that a claim to a right to assisted suicide *"has come before many common law and Convention bound courts, including those of the United Kingdom, the United States of America, Canada, and the European Court of Human Rights, without having succeeded in any of those Superior Courts."*[231]

The specific issue which the Court had to address was whether the right sought by the appellant was provided under the Constitution.

The matter of *locus standi* required resolution prior to any consideration of the substantive questions involved in the case. Notwithstanding the fact that it would

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[226] *[2013] IESC 19.*
[227] *[1993] 3 S.C.R 519.*
[228] *521 U.S.702.*
[229] *[2001] UKHL 61.*
[230] *[2012] BCSC 886.*
[231] *At para 75.*

only be in very special circumstances that a plaintiff would have *locus standi* in a hypothetical situation the Court held that the appellant had such standing[232] where a direct effect on her had been established by the facts of the case. *"A plaintiff must show a real and significant effect of the statute concerned on him or her, by reference to the facts of his or her case, and by reference to the constitutional rights with which he or she asserts have been interfered. In this case the appellant's circumstances are within the parameters permissible. While her circumstances are hypothetical, in the limited sense that no one has actually assisted her, they are very real."*[233]

However, the Court was adamantly of the view that was no explicit right to commit suicide, or to determine the time of one's death, in the Constitution. Consequently, any such right as was argued by the appellant had to be found as part of another expressed right or in an un-enumerated right. It was a matter for the appellant to identify the constitutional right which she alleged had been breached by s. 2(2) of the Act of 1993, and it was only after the Court was satisfied that a constitutional right exists, that the principle of proportionality would arise.

In her submission the appellant had referred to several rights under the Constitution, and had placed particular stress on Article 40.3 which *"guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen,"* and on Article 40.3.2 which states that *"the State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name and property rights of every citizen."*

The appellant, therefore, had laid the foundation of her case on the express right to life in Article 40.3.2. *"However, that right to life does not import a right to die."* The Court cited the familiar dicta of Hamilton CJ in *Re a Ward of Court (withholding treatment) (No.2)*:[234]

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[232] *"In the special circumstances of this case, which include the fact that the appellant has a terminal illness and is facing imminent death, and that she asserts a right to be assisted to commit suicide, which she submits she cannot do because of s. 2(2) of the Act of 1993, the Court is satisfied that the appellant has locus standi."* See para 91.

[233] *At para 88.*

[234] *[1996] 2 IR 79 at 124.*

"As the process of dying is part of, and an ultimate inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life. This right, as so defined, does not include the right to have life terminated or death accelerated and is confined to the natural process of dying. No person has the right to terminate or to have terminated his or her life or to accelerate or have accelerated his or her life."

The Court averred that it may well be that as part of its obligation to vindicate the right to life, *"the State is required to seek to discourage suicide generally and to adopt measures designed to that end."*[235]

"It does not, however, necessarily follow that the State has an obligation to use all of the means at its disposal to seek to prevent a person in a position such as that of the appellant from bringing her own life to an end."[236]

The problem presented by the facts in *Fleming* was that it would be impossible for the State to consider the position of the appellant without also having regard to the position of other persons, not necessarily in exactly the same position, whose right to life may also have to be taken into account. Consequently, difficult questions of policy involving complex issues of both principle and practicality arose which were matters exclusively for the legislature.

"Nothing in this judgment should be taken as necessarily implying that it would not be open to the State, in the event that the Oireachtas were satisfied that measures with appropriate safeguards could be introduced, to legislate to deal with a case such as that of the appellant. If such legislation was introduced it would be for the courts to determine whether the balancing by the Oireachtas of any legitimate concerns was within the boundaries of what was constitutionally permissible. Any such consideration would, necessarily, have to pay appropriate regard to the assessment

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[235] *At para 107.*
[236] *Ibid.*

made by the Oireachtas both of any competing interests and the practicability of any measures thus introduced." [237]

The Court was in no doubt that the Constitution recognises, respects and protects the general values of autonomy, self-determination and dignity. It did not follow, however - and it was not claimed by the appellant that it did - that every law which impinges on the life of individuals *"is even prima facie inconsistent with the Constitution."* Whether, therefore, values of autonomy, self-determination and dignity, as they found expression in the rights guaranteed by the Constitution, *"provide constitutional protection for the performance of specific acts depends on a concrete analysis of the impact of any law which is impugned in a particular case on the life of the individual, and a careful consideration of the provisions of the Constitution and the values it protects in the rights it guarantees."*[238]

In the absence of a specific authority the appellant's arguments depended on general principle only:[239]

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[237] *At para 108.*

[238] *At para 110.*

[239] Most notably the appellant relied on the iconic passage in the dissenting judgment of Henchy J in *Norris v Attorney General [1984] IR 36*. That case involved a challenge to the provisions of s.61 and s.62 of the Offences against the Person Act 1861 which had the effect of making criminal sexual acts carried out between consenting male adults. A principal round of challenge was the assertion that the provisions were an impermissible invasion of a personal right to privacy. Henchy J's dicta, at pp. 71 to 72 of the judgment, merit repetition:

"That a right of privacy inheres in each citizen by virtue of his human personality, and that such rights is constitutionally guaranteed as one of the unspecified personal rights comprehended by Article 40, s.3, are propositions that are well attested by previous decisions of this Court. What requires to be decided – and this seems to me to be the essence of this case – is whether that right of privacy, construed in the context of the Constitution as a whole and given its true evaluation or standing n the hierarchy of constitutional priorities, excludes as constitutionally inconsistent the impugned statutory provisions. Having regard to the purposive Christian ethos of the Constitution, particularly as set out in the preamble ('to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations'), to the denomination of the State as 'sovereign, independent, democratic' in Article 5, and to the recognition, expressly or by necessary implication, of particular personal; rights, such recognition being frequently hedged in by overriding requirements such as 'public order and morality' or 'the authority of the State' or 'the exigencies of the common good', there is necessarily given to the citizen, within the required social, political and moral framework, such a range of personal freedoms or immunities as are necessary to ensure his dignity and freedom as an individual in the type of society envisaged. The essence of those rights is that they inhere in the individual personality of the citizen in his capacity as a vital human component of the social, political and moral order posited by the Constitution.

Amongst those basic personal rights is a complex of rights which vary in nature, purpose and range (each necessarily being a factor of the citizen's core of individuality within the constitutional order) and which may be compendiously referred to as the right of privacy. An express recognition of such a right

"The right to life which the State is obliged to vindicate, is a right which implies that a citizen is living as a vita human component in the social, political and moral order posited by the Constitution. While it may be said that it is of the essence of certain types of rights, such as that of the right to associate, that they logically apply as a corollary a right to dissociate, that reasoning cannot be applied to all rights guaranteed by the Constitution. In particular the protection of the right to life cannot necessarily or logically entail a right, which the State must also respect and vindicate, to terminate that life or have it terminated. In the social order contemplated by the Constitution, and the values reflected in it, that would be the antithesis of the right rather than a logical consequence of it."[240]

The Court concluded, therefore, that there was no constitutional right which the State, including the courts, must protect and vindicate either to commit suicide, or to arrange for the termination of one's life at a time of one's choosing. It did not accept the submission that there exists a constitutional right for a limited class of persons, which would include the appellant, deducible from their particular personal circumstances. While the Court was not unsympathetic to the tragic plight of the appellant nonetheless it could not resile from the protection of rights anchored in the Constitution.

It was understandable that the appellant relied on her very distressing situation as giving rise to a right in her very particular situation to have assistance in the termination of her life. *"That reasoning reverses, however, the process of identification of the extent of rights of general application and risks converting the question of the identification of rights and correlative duties, into an ad hoc decision on the individual case. It had not generally been the jurisprudence of the Irish*

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is the guarantee in Article 16, s.1, sub-s.4, that voting in elections for Dail Eireann shall be by secret ballot. A constitutional right to marital privacy was recognised and implemented by this Court in McGee v The Attorney General [1974] IR 284; the right there claimed and recognised being, in effect, the right of a married woman to use contraceptives, which is something which at present is declared to be morally wrong according to the official teaching of the Church to which about 95% of the citizens belong. There are many other aspects of the right of privacy, some yet to be given judicial recognition. It is unnecessary for the purpose of this case to explore them. It is sufficient to say that they would all appear to all within a secluded area of activity or non-activity which may be claimed as necessary for the expression of an individual personality, for purposes not always necessarily moral or commendable, but meriting recognition in circumstances which do not engender considerations such as State security, public order or morality, or other essential components of the common good."

[240] *At para 113.*

Constitution that rights can be identified for a limited group of persons inn particular circumstances no matter how tragic and heartrending they may be."[241]

The Court concluded that the appellant had no right which may be interfered with by any disability. As there was no right to commit suicide so issues, such as discrimination, did not arise; nor did values such as dignity, equality, or any other principle under the Constitution, apply to the situation and application of the appellant.

In the matter of proportionality the Court held that as the appellant had no right to commit suicide, and no right to assistance in the commission of suicide, the issue of proportionality of any restriction of such a right did not arise for determination. It did note, however, that an argument had been advanced – derived in the main from Canadian jurisprudence – suggesting that the Court should approach the question at issue by first determining in general whether a right existed, whereupon the onus shifted to the State to justify by evidence any limitation whatsoever on the general right asserted, by reference to the principle of proportionality. Similarly, it was noted that the appellant had asserted that the Court was entitled – indeed obliged – to decide whether, on the evidence adduced on the balance of probability, there was a compelling justification for the asserted limitation.

However, the Court averred that there was no support within Irish jurisprudence for such an approach. *"Accordingly, this Court expressly reserves for a case in which the issue properly and necessarily arises, and is the subject of focussed argument and express decision in the High Court, whether the approach to proportionality urged by the appellant, whether cumulatively, or any component part thereof, is required by, or compatible with, the Constitution."*[242]

In the matter of claimed incompatibility under s. 5(1) of the European Convention on Human Rights Act, 2003, the Court reprised and upheld the arguments adduced by the High Court in its rejection of the claim. It was apparent to the Court that the appeal was similar to the case of *Pretty v United Kingdom,*[243] where it had been

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[241] *At para 115.*
[242] *At para 140.*
[243] *Application No. 2346.02.*

decided that States are entitled to regulate activities which are detrimental to the life and safety of persons. The ECtHR held that it was primarily for the States to assess the risk and likely incidence of abuse is the general prohibition on assisted suicides were relaxed, or if exceptions were to be made.

The ECtHR held that the blanket ban on assisted suicide contained in s.2 of the UK Suicide Act of 1961 was proportionate and that:

"It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence."[244]

The ECtHR concluded that the interference of the applicant's rights under Article 8 of the Convention may be justified as "*necessary in a democratic society*" for the protection of the rights of others.

This judgment of the ECtHR on the Convention and the issue of assisted suicide "*was of assistance to the Court, especially as the statutory formulation of s. 2(2) of the Act of 1993 is similar to the statutory law of the United Kingdom at that time.*"

The ECtHR finding in *Haas v Switzerland,*[245] where the alleged violation of Article 8 of the Cinvention was examined from the perspective that there was a positive obligation on Member States to take necessary measures to permit a dignified suicide, was also invoked. This, the ECtHR held, *"presupposes a weighing of the different interests at stake, an exercise in which the State is recognised as enjoying a certain margin of appreciation which varies in accordance with the nature of the issues and the importance of the interests at stake."* In this regard, it was determined that Member States enjoy a considerable margin of appreciation and the vast majority of States attach "*more weight to the protection of the individual's life than to his or her right to terminate it.*

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[244] *Pretty v United Kingdom (Application Npo.2346/02), at para 76.*
[245] *Application No.31322/07.*

The ECtHR considered the positive obligation placed on Member States by Article 2, namely to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved. The restriction on access to the lethal substance in the *Haas* case, by the requirement to obtain a medical prescription, was found to pursue the legitimate aims of the prevention of crime and the protection of public health and safety. Further, the Court determined that the risks inherent in a system that facilitates access to assisted suicide "*should not be underestimated*" and that in such systems strict regulations are "*all the more necessary*".

It was concluded that "*having regard to the foregoing and to the margin of appreciation enjoyed by the national authorities in such a case, the Court considers that, even assuming that the States have a positive obligation to adopt measures to facilitate the act of suicide with dignity, the Swiss authorities have not failed to comply with this obligation in the instant case.*"

The Act of 2003 makes provision, under s. 5(1), for the High Court, or the Supreme Court when exercising its appellate jurisdiction, to grant a declaration of incompatibility.[246] However, in the case on appeal before it the Supreme Court was not prepared to exercise that right. Its decision not to do so was specifically influenced by the ECtHR jurisprudence in both the *Pretty* and *Haas* cases.

"*The complex issue of assisted suicide has been assessed, and the legislature has legislated on the issue in s. 2(2) of the Act of 1993. The Court would, consequently, dismiss the appeal which has been brought on the basis of s. 5 of the Act of 2003, seeking a declaration of incompatibility.*"[247]

9. Advance Healthcare Directives:

Reference has already been made to two published documents of relevance, namely the Opinion of the Irish Council for Bioethics in 2007 regarding advance healthcare directives[248]

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[246] Section 5(1) provides: "*In any proceedings, the High Court, or the Supreme Court when exercising its appellate jurisdiction, may, having regard to the provisions of section 2, on application to it in that behalf by a party, or of its own motion, and where no other legal remedy is adequate and available, make a declaration (referred to in this Act as 'a declaration of incompatibility' that a statutory provision or rule of law is incompatible with the State's obligations under the Convention provisions.*"

[247] *At paras 164 and 165.*

[248] Opinion*: 'Is it Time for Advance Healthcare Directives?',* Irish Council for Bioethics, Dublin, 2007.

and the Law Reform Commission's Consultation Paper on the same topic.[249] A brief outline of both is merited.

(a) Opinion of the Bioethics Council:

There is no specific legislation in Ireland in relation to advance directives. In its *Consultation Paper on Advance Care Directives*[250] the *Law Reform Commission* recommended that they be put on a statutory footing. To date, this has not occurred.

The *Bioethics Council* is of the opinion that competent adults should have the right to prepare an advance directive, stemming from their right to self-determination and their related rights to *bodily integrity, privacy* and *dignity*.[251]

Notwithstanding widespread interest in, and public support for, advance directives their adoption is relatively low, both in the United States and in those countries in Europe that have provided a statutory basis for them. In the United States the figures vary from **20%** to **25%**,[252] while in Germany the uptake is of the order of **15-18%**.[253]

An Irish Hospice Foundation survey conducted in 2004 suggested that the uptake of advance directives in Ireland was approximately **14%**.[254] A mere **11%** of the respondents to the public consultation process prior to the publication of the *Council for Bioethics' Opinion* indicated that they had made advance directives.

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[249] Irish Law Reform Commission: Consultation Paper*: 'Bioethics: Advance Care Directives',* LRC CP 51-2008, Dublin, 2008.

[250] Ibid.

[251] The Council takes the view that the instrument of the advance directive allows individuals to govern their future medical treatment and care, should they become incapacitated, in a way that reflects their person values and beliefs. It is cognizant of the fact that the principle of respect for autonomy restricts health care interventions to those that respect the decision-making capacity of a competent adult. However, the principle of respect for autonomy is itself limited. It is not absolute. It must be balanced against other ethical principles and values, such a s beneficence, non-maleficence, justice, integrity and solidarity, recognising the interdependency and interconnectedness of individuals within society. Ibid at 19.

[252] See Fagerlin & Schneider, *'Enough: The Failure of the Living Will',* Hastings Centre Report 34 (2), *2004, at 30-42*; Hecht & Shiel, op.cit.; Crane, MK, Wittink, M and Doukas, DJ, *'Respecting End-of-Life Treatment Preferences',* American Family Physician 72 (7): 1263-1268, 2005*; The President's Council on Bioethics,* Washington DC, 2005, at 71.

[253] See *German National Ethics Council – communication with Irish Council of Bioethics in preparation of its Opinion.*

[254] *'A nationwide survey of public attitudes and experiences regarding death and dying',* Dublin, 2004. Available at *http://www.hospice-foundation.ie/cfmdocs/pdf/survey_of_attitudes_to_death_and_dying2005pdf*

(b) Law Reform Commission Consultation Paper:

The Law Reform Commission's Consultation Paper, Bioethics: Advance Care Directives[255] was part of its Third Programme of Law Reform 2008-2014.[256]

In essence, the Consultation Paper is emblematic of the Western jurisprudential consensus that has evolved over the course of the past quarter of a century in respect of the rights of an individual to exercise personal control over his/her end-of-life treatment and whether current criminal law on homicide or suicide should be altered.

It eschewed consideration of euthanasia and stated that any steps taken to hasten death in a manner that would, under current law, amount to murder or to assisting suicide *"will not in any way be affected by the proposals being considered in the Consultation Paper."*[257]

However re-assuring this averment it is necessary, nonetheless, to contextualise a recommendation from such a reputable institution that advance care directives be placed on a statutory footing within the parameters of a legal environment which, as has been displayed by the suggestion in *Fleming v Ireland* that current prosecutorial policies might, with benefit, permit of the imitation of guidelines from other jurisdictions - which tend towards non-prosecution in cases of assisted suicide - disports a vestigial, but nonetheless discernible, propensity to give sympathetic consideration to a recalibration of the principle of the sanctity of life.

This is not to suggest that the recommendations of the Commission are not of value. Neither is it to either question or denigrate the Commission's motivations. It is, however, to issue a word of caution. The unremitting burnishment of the principles of *autonomy*, *bodily integrity*, *privacy* and *dignity,* while undoubtedly of significance in a relativist context, cannot – if not controlled - but lead to anything other than the ultimate loosening of the traditional constraints which govern third party assistance with death.

The Commission devoted considerable attention the *Quinlan*[258] *and Cruzan*[259] cases in the United States.[260] Although an advance directive was absent in *Quinlan* the case highlighted

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[255] LRC CP 51-2008.

[256] See *Report on the Third Programme of Law Reform 2008-2014 (LRC 86-2007).* Project 30 in the Third Programme committed the Commission to examine "*Legal Aspects of Bioethics*". The Commission had previously addressed the topic of advance care directives in its *Report on Vulnerable Adults and the Law,* LRC 86-2006, at para. 3.36; its Consultation Paper on Vulnerable Adults and the Law: Capacity, LRC CP 37-2005, at paras. 7.62/7.64 *and its Consultation Paper on the Law and the Elderly, LRC CP 23-2003, at paras 3.48-3.51.*

[257] Op.cit., fn.255 supra, at 4.

[258] *In re Quinlan 355 2S 647 (1976).*

the plight of the patient and her family and galvanised public interest in *"moving living wills from their shadowy existence as hortatory statements to officially recognised instructions."*[261]

In the immediate aftermath of the *Quinlan* decision advance care legislative measures began to be adopted by individual states.[262]

The Commission described the decision in *Cruzan v Director, Missouri Department of Health,*[263]as a *"powerful catalyst for legislative reform."*[264] The US Supreme Court had held that competent persons have a *"constitutionally protected liberty interest in refusing unwanted medical treatment."*[265] The Court did not draw a distinction between the withdrawal of artificial nutrition and hydration and other medical treatment.[266] It held, however, that individual states could insist on *"clear and convincing evidence"* of a patient's wishes before permitting hospitals to withdraw life support.[267] Having established the

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[259] *Cruzan v Director, Missouri Department of Health (1990) 497 US 261.*

[260] For details of each of these cases see Chapter VII on America.

[261] Capron, *'Advance Directives', in Kuhse & Singer (eds) 'A Companion to Bioethics',* Blackwell Publishing, 1998, at 264.

[262] Beginning with California's *Natural Death Act, 1976.* This first generation of *'living will'* statutes was concerned only with the refusal of life-sustaining procedures in the event of *'terminal illness'* or *'imminent death'.* Those that required that death be *'imminent'* or where the prognosis was that death would occur in a *'short time'* invited the criticism that they were substituting a time measure for the more appropriate question regarding the futility of medical treatment. See Gelfand, *'Living Will Statutes: The First Decade',* Wisconsin Law Review (1987) 737, at 744. A second generation of statutes emerged thereafter. These permitted the creation of durable powers of attorney which were specifically concerned with healthcare decisions. See *Durable Power of Attorney Health Care Act, 1983,* in California. Two more generations of statutes followed, the first combining provisions relating to loving wills with the option of appointing a proxy decision-maker, and the second vesting power members of the patient's family in circumstances where no advance directive had been made.

[263] *(1990) 497 US 261.*

[264] LRC CP 51-2008, at 44.

[265] *(1990) 487 US 261, at 278.*

[266] See Kennedy & Grubb, *'Medical Law',* 3rd ed., Butterworths, 2000, at 2047.

[267] It will be recalled that the Attorney General, the institution and the guardian ad litem of the ward appealed the High Court decision in *In Re a Ward of Court* to the Supreme Court. The committee and family of the ward applied to vary the judgment in respect of the following: *"That the application of a standard of proof requiring evidence to be clear and convincing before medical treatment is not continued is not in accordance with law and in particular is at variance with the standard applied in civil law of a balance of probability and is at variance with the standard, which on the evidence, medical practitioners called on behalf of the family and committee apply to decisions of this kind. It is submitted that the correct standard of proof is not one beyond a probability,"* per Hamilton CJ in *In re a Ward of Court (withholding medical treatment) (No.2) 2 IR, at 116.*
The *Cruzan* Court noted that written instructions – such as those provided in a living will – were persuasive evidence of an individual's *"prior expressed wishes"* regarding medical treatment. The *"informal, casual statements of friends and family remembered"* would be insufficient evidence of such wishes, at 266-268. This averment has been interpreted as implicitly establishing *"the right to engage in advance planning for incapacity."* See LRC CP 51-2008, at 15, citing Gallagher, *'Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals', (*1998) Psychol Pub Pol'y & L 746, at 796. The US *Patient Self-Determination Act, 1990,* addresses – albeit only partially – the problem of educating both patients and doctors with regard to advance planning for incapacity. It

jurisprudential acceptance of advance directives in the United States[268] – a traditionally important precedential benchmark for Irish jurisprudence – the Commission turned its attention proceeded to the recognition of directives at English common law.

The genesis of the legal force for advance directives at English common law is traceable to the dicta in respect of autonomy by Lord Donaldson MR in *Re T.*[269]

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requires health care institutions receiving federal funds to inform patients of their right to refuse life-sustaining treatments and to complete advance care directives.

[268] However, the Commission did cite assertions that the living will had failed in the United States. In particular it alluded to the claim by Fagerlin & Schneider, in their *'The Failure of the Living Will'*, (2004) Hastings Centre Report 30, that only **18%** of Americans have made living wills. However, the exact figure for Americans who have advance directives is uncertain. It will be recalled that the Irish Council for Bioethics in its 2007 *Opinion* stated that the figure vary from approximately **20%** to **25%**. In support it cited *Hecht & Shiel, 'Advance Medical Directives (Living Will, Power of Attorney and Health Care Proxy)* available at http://www.medicinenet.com/advance_medical_directives/article.htm; Crane Wittink & Doukas, *'Respecting End-of-Life Treatment Preferences' in* 72 (7) American Family Physician 1263; and The President's Council on Bioethics, *'Taking Care – Ethical Caregiving in Our Aging Society'*, Washington DC, 2005, at 71.
Empirical studies have demonstrated that the Patient Self-Determination Act has failed to generate a significant increase in the number of Americans making living wills due to a passive implementation by medical staff and a lack of physician involvement. See Yates & Glick, *'The Failed Patient Self-Determination Act and Policy Alternatives for the Right to Die'*, (1997) Journal of Aging and Social Policy 29 at 31 cited in Fagerlin & Schneider's *'The Failure of the Living Will'*, op.cit, fn 33 at 32. It has been estimated that the 1990 Act imposed a start-up cost of **$101,596,922** (omitting administration costs) on all hospitals. Fagerlin and Schneider argue that the Act should be repealed as it was *"passed with arrant and arrogant indifference to its effectiveness and its costs,"* op.cit., fn 33 at 39. They also submit that people do not know what they actually want, analysing *"their choices only superficially before placing them in a time capsule,"* ibid at 33. A meta-analysis of eleven studies found that almost one-third of preferences for life-sustaining medical treatment changed over periods as short as two years. See Coppola et al *'Are Life-Sustaining Treatment Preferences Stable over Time? An Analysis of the Literature'*, unpublished manuscript cited in Fagerlin & Schneider, op.cit., fn 33 at 34. Likewise, there is the suspicion that people cannot accurate their choices accurately. Most advance directive forms do not solve this problem as they either fail to ask all the right questions, or they ask questions in a manner that fails to elicit a clear response. See Pope, *'The Maladaptation of Miranda to Advance Directives'.* (1999) 9 (1) Journal of Law-Medicine 139 at 165-166, cited in Fagerlin & Schneider, op.cit., fn 33 at 34. Also, living wills have failed to stimulate conversation between doctor and patient about terminal treatment. In one study, doctors commonly *"did not explore the reasons for patients' preferences and merely determined whether they wanted specific interventions"* with the average discussion lasting **5.6 minutes** (physicians speaking for an average of **3.9 minutes** and patients speaking for the remaining **1.7 minutes**). See Tulsky et al., *'Opening the Black Box: How do Physicians Communicate about Advance Directives?'*, (1998) 129 Annals of Internal Medicine 441, at 444.

[269] *[1992] 4 All ER 649, at 352/53 "An adult patient...who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or choose one rather than another of the treatments being offered...This right is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."* For similar sentiments see dicta of Denham J in *Re a Ward of Court (withholding medical treatment)(No.2) 2 IR 79.*
The Court of Appeal in *Re T* had held that T's refusal of treatment was vitiated by her mother's undue influence. The Master of the Rolls, in considering the validity of a patient's anticipatory refusal of treatment, suggested that, in principle, advance decisions would be binding if three requirements were satisfied: first, the patient must be competent at the time the advance decision was made; second, the patient must have anticipated the circumstances when the advance decision would have effect and intend this decision to apply to those circumstances; finally, the patient must have reached his decision

Advance care directives were held to be valid and effective in *Re C*[270] and *Re AK.*[271]

In *Airedale NHS Trust v Bland* Lord Browne-Wilkinson had stated that he was in "*no doubt that it is for Parliament, not the courts to decide the broader issues*"[272] and the English Law Reform Commission, in its 1991 *Consultation Paper on Mentally Incapacitated Adults and Decision-Making: An Overview*, was of the view that the desirability of the piecemeal decision-making through case law was "*questionable:*" [273] Nonetheless, the *Royal Commission on Mental Incapacity*, in a Report published in 1995,[274] recommended legislation on advance directives. The consultation process which it had undertaken prior to publication had "*reflected an almost unanimous view that patients should be enabled and encouraged to exercise genuine choice about treatments and procedures.*"[275]

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without undue influence, at 664. In *Airedale NHS Trust v Bland [1993] AC 789* Lord Keith stated: "*a person is completely at liberty to decline to undergo treatment, even if the result of his doing so is that he will die. This extends to the situation where the person, in anticipation...gives clear instructions.....*" In the same case Lord Goff stated that "*....a patient of sound mind may, if properly informed, require that life support, should be discontinued....the same principle applies where the patient's refusal to five his consent has been expressed at an earlier date.*"

[270] *[1994] 1 WLR 290.* A 68 year-old man with chronic paranoid schizophrenia suffered from the delusion that he was a world famous doctor who had never lost a patient. He developed gangrene in his leg, but refused amputation despite the hospital's assessment that he would die immediately if the operation was delayed. He sought an injunction to prevent the hospital from amputating his leg in the future. Thorpe J was prepared to find him competent and granted the injunction.

[271] *[2001] 1 FLR 129.* A 19 year-old patient suffered from a progressive neuro-muscular disease causing paralysis. He informed his carers, by means of an eyelid movement, that he would wish his artificial ventilation to be stopped if he could no longer communicate., The health authority applied to the English High Court for a declaration that it would be lawful, in accordance with AK's wishes, to discontinue artificial ventilation, nutrition and hydration, two weeks after AK lost all ability to communicate. Hughes J, in granting the declaration, confirmed the "*vital nature of the principle of autonomy*" and had "*no doubt*" of AK's capacity and the validity and applicability of the directive.

[272] *[1993]1 All ER 821 at 878.*

[273] *"Decisions of the courts, particularly in sensitive areas, tend to be confined to particular facts, and there is a reluctance to give pronouncements on principles of general application. This can mean that there is no real consistency between different decisions, and can make it difficult to elicit guidelines with any real reliability."* See The Law Commission for England and Wales, *'Mentally Incapacitated Adults and Decision-Making: An Overview Consultation Paper' (*No 119) 1991, at para. 3.37.

[274] The Law Commission for England and Wales, *'Report on Mental Incapacity', (No 231) 1995.*

[275] Ibid., at para. 5.3. Green and White Papers on the matter were published in 1997 and 1999 respectively and the Mental Capacity Act was enacted in 2005. See Lord Chancellor's Department, *'Who Decides? Making Decisions on behalf of Mentally Incapacitated Adults',* Cm 3808 (1997); Lord Chancellotr's Department, *'Making Decisions: The Government's Proposals for Making Decisions on behalf of Mentally Incapacitated Adults',* Cm 4465 (1999); *Mental Capacity Act, 2005* – Code of Practice, available at www.justice.gov.uk/guidanbce/mca-code-of-practice.htm Chapter 9 deals with advance directives. Sections 24-26 codify the right of a competent individual to re=fuse medical treatment in advance. One of the five guiding principles of interpretation set out in *section 1* is that any decisions must be made in the *'best interests'* of the person concerned. However, advance directives differ from the other care provisions of the Act in that once an advance decision to refuse treatment is valid and applicable, the is no place for a *'best interests'* assessment. In essence, the *Mental Capacity Act, 2005,* incorporated the vast bulk of the recommendations of the *Law Commission.*

The Law Reform Commission also reviewed the provisions of both the European Convention on Human Rights and the Convention on Human Rights and Biomedicine with a view to ascertaining whether one or other, or both, provided a jurisprudential underpinning for its recommendation that advance directives be put on a statutory footing.[276]

A patient's right to refuse life-sustaining medical treatment can be founded on his or her right to private life in Article 8 (1) of the Convention.[277]

However, Article 8 (1) may be subject to interference that is "*necessary in a democratic society*" by virtue of Article 8 (2). Thus, a balancing exercise between the right if the individual in Article 8 (1) and the legitimate aims specified in Article 8 (2) might require a balance to be struck on an individual case by case basis. Conversely, under common law, that balance is always struck in favour of the individual's right to refuse medical treatment which is "*paramount*".[278] Therefore, it has been argued that English common law is probably "*more*

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[276] The European Convention on Human Rights does not contain any direct reference to an advance refusal of medical treatment. The 1997 European Convention on Human Rights and Biomedicine does contain an article on "*previously expressed wishes*." See Article 9. However, the right to refuse treatment in advance is only "*weakly recognised*." Nys has argued that the Convention adopted a cautious approach in this matter because of the lack of consensus in many European countries as to the validity of an advance refusal of treatment. See Nys, '*Physician Involvement in a Patient's Death: A Continental European Perspective', (*1999) 7 (2) Medical Law Review 208.
Article 3 of the Convention in Human Rights prohibits torture and inhuman or degrading treatment or punishment and *Article 8* prescribes respect for private and family life. Both of these articles have been invoked in support of advance directives. See Wicks, '*Refusal of Medical Treatment and ECHR', (*2001) 9 Medical Law Review 17.
The Royal Commission rightly pointed to the Herczegfalvy case [*Herczegfalvy v Austria (1992) Series A*] where, at para 82, the *ECtHR* held that *"a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."* If medical treatment is therapeutically necessary, therefore, it will not violate *Article 3* even if it is imposed without consent.
In *NHS Trust A v M; NHS Trust B v H [2001] 1 All ER 801* the English High Court noted that *Article 3* requires the patient to be aware of the inhuman and degrading treatment which he or she is experiencing. Therefore, as a patient who is in a permanent vegetative state has "*no feelings and no comprehension of the treatment while he or she is experiencing*", he or she cannot obtain the protection of *Article 3*, per Butler-Sloss P, at 814. In *R (Burke) v GMC [2004] EWHC 1897 (Admin)*, however, Munby J held, at *paras 149-150,* that *Article 3* could be violated even if the individual concerned was unaware of the humiliating or degrading treatment which he is experiencing. He felt that the definition of torture and degrading treatment should not be viewed from the point of view of the individual concerned, but rather should be viewed objectively, from the point of view of the reasonable bystander. This, however, was dismissed by the Court of Appeal in *R (Burke) v GMC [2005] EWCA Civ.1003; [2005]2 FLR 1223, at para 37.* The Court *"[did] not consider that there was any justification for embarking on speculation as to what the position might be when Mr Burke reaches the final stages of life."*

[277] *Pretty v United Kingdom (2002) 35 EHRR 1, at para. 63: "In the sphere of medical treatment, the refusal to accept particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 (1) of the Convention."*

[278] *Re T (adult: refusal of medical treatment) [1992] 4 All ER 649 at 661 per Lord Donaldson MR.*

robust in its recognition of a competent patient's right to refuse life-sustaining medical treatment than is the ECHR."[279]

Having found supporting jurisprudential arguments in favour of advance care directives in other jurisdictions the Law Reform Commission made a number of provisional recommendations, chief of which was that such directives should be placed on a statutory footing.[280]

10. Conclusion

As mentioned at the outset Irish case law in the matter of third party assistance with death, irrespective of type, is exceptionally jejune. Prior to *Fleming v Ireland*[281] the *locus classicus* was *Re a Ward of Court (withholding medical treatment) (No.2).*[282] Notwithstanding this paucity, however, a clearly identifiable normative jurisprudential template obtained whereby it was recognised realistically, without undue fanfare, that the principle of the sanctity of life would prevail over any endeavour to have the imprescriptible criminal prohibition of unlawful killing altered to allow for the acceleration of death in circumstances where a request to die had been expressed by a person suffering from a terminal disease. This recognition, however, did not equate remotely to a prescriptive vitalistic dynamic, where life is to be protected, and prolonged, at all costs irrespective of personal rights. The approach adopted by Ireland, while deeply redolent of an over-arching desire to preserve life, simultaneously encompassed, and continues to do so, a deep-seated respect for the un-enumerated constitutional personal rights of self-determination, autonomy, bodily integrity and dignity.

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[279] See Grubb, *'Competent Adult Patient: Right to Refuse Life-Sustaining Treatment', (*2002) 10 Medical Law Review 201 at 203.

[280] The Commission also recommended that:

(i) a set of guidelines be drawn up to complement a legislative framework;

(ii) in general, a refusal to consent to treatment on religious grounds to constitute a valid advance care directive (subject to constitutional consideration);

(iii) those making of advance care directives should be encouraged to consult with a medical professional prior to doing so. In the case of directives refusing life-sustaining medical treatment medical advice must be obtained for such directives to be valid;

(iv)there is a rebuttal presumption of capacity in favour of the maker of an advance care directive;

(v) the capacity to refuse medical treatment should be assessed on the functional test of capacity. Statutory codes of practice should be formulated to guide healthcare professionals when assessing the capacity of an individual.

[281] *[2013] IEHC2; [2013] IESC 19.*

[282] *[1996] 2 IR 79.*

Notwithstanding protestations to the contrary by Blayney J in *Re Ward of Court*, on appeal in the Supreme Court, it is beyond question that the decision in *Airedale NHS Trust v Bland*[283] provided a particularly convenient jurisprudential template for the High Court – and subsequently for the Supreme Court – in that case. The boundaries of the dilemma facing both the High Court and the Supreme Court in the matter of choice on behalf of the ward of court were undoubtedly stark and jurisprudentially unenviable. As has been stated previously, a credible legal formula which would enable them achieve a balance between the recognised constitutional rights of the ward and which, at the same time, would not adversely affect the duty of the state to uphold life, was required.

Admittedly, this was not an easily surmountable task. However, it was made somewhat less difficult, by the willingness displayed by the Irish judges, in the High Court initially, and in the Supreme Court thereafter, to embrace the jurisprudence adopted and followed in *Airedale NHS Trust v Bland,* notwithstanding the somewhat controversial categorisation of tube-feeding as medical treatment together with the averrment that a doctor was under no obligation to continue this type of feeding in circumstances where he or she believed that it was not in the patient's *"best interests"* to do so.

The task was further alleviated by the Supreme Court's jurisprudential trawl – and not for the first time - of American case law for requisite precedential support and guidance. This was particularly evident in the judgment of O'Flaherty J. Thereafter, the pragmatic underpinning of the classification of artificial nutrition as medical treatment became a canon of Irish jurisprudence and was held to accord with the rights, both explicit and un-enumerated, including the right to life, guaranteed by the Constitution.

As outlined earlier, and particularly in the context of the unchallenged critique by John Keown of the judicial reasoning adopted and followed in *Airedale NHS Trust v Bland*, and its unquestioned espousal in *Re a Ward of Court*, a credible argument can be made that the latter case marked the beginning of a process in which the traditional Irish jurisprudential approach to the sanctity of life principle appeared,

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[283] [1993] AC 789.

however tentatively, to be in the process of being dismantled. A deconstructive dynamic favouring a more pluralist dimension - and one apportioning a greater weighting in the matter of individual autonomy and self-determination regarding the manner and timing of death – began to emerge and, notwithstanding the recent findings in *Fleming v Ireland*, particularly that of the High Court in the matter of the role of the DPP and her discretion to prosecute or not in the case of an assisted suicide, have not been totally dissipated.

Whether the decision by the Supreme Court in *Re a Ward of Court* illustrates, as Keown contends, *"the tendency of judges across the Western world to undermine the traditional ethic",* that is, of the sanctity of life, is a moot point. However, the absence of Irish juristic engagement with his unequivocally provocative charge does not augur well for the continuance of the traditional conviction which heretofore underpinned the normative value attributed to both the beginning and the end of life in Irish jurisprudence.

Fleming v Ireland:

Notwithstanding its dismissal of the substantive claims by the appellant the High Court finding in *Fleming v Ireland* created uncertainty as to the factors which the Director of Public Prosecutions may invoke, in the future, when deciding whether to prosecute in an instance of assisted suicide. The three judge court observed, unanimously, that, in such circumstances, she might find the guidelines issued by the English Crown Prosecution Service to be of *"considerable assistance."*[284]

It is not unreasonable to submit, particularly in circumstances where the issue was not specifically addressed by the Supreme Court in its decision to uphold the decision of the lower court that s.2(2) of the Criminal Law (Suicide) Act, 1993, was constitutional and not incompatible with the European Convention on Human Rights, that persons in future situations similar to that of the plaintiff in *Fleming* could be forgiven for thinking that all that is now required in order to radically reduce the probability of prosecution of those providing assistance with death by suicide, is to emulate precisely those factors which the English Prosecution Service have promulgated as tending towards non-prosecution for the same offence.

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[284] At para. 168.

If the High Court in *Fleming* believed – and it is legitimate to infer, based on the ordinary meaning attributable to the language used, that it did – that the existing discretionary powers of the DPP were such as not to inhibit her from doing other than prosecuting, as the law requires that she should, those who assist with, abet or procure the suicide of another person, it might have found subtler means of transmitting this view to the legislative and prosecutorial authorities other than by suggesting that she engage unilaterally in the crude subterfuge of aping the template of another jurisdiction, and doing so in the absence of supporting statutory authority.

Clearly implicit in the High Court's attitude was the belief that similar guidelines to those published in the UK in the aftermath of the *Purdy*[285] case should be made available to the DPP in Ireland. Were this not true the reasoning adopted and unanimously followed would undoubtedly have been satisfied, as a matter of simple logic, to state unequivocally that such guidelines were contrary to existing Irish law and, as a consequence, were of no relevance to prosecutorial policy in those cases where assisted suicide was in issue.

However, in the absence of a cogent explanation of the High Court's underlying motivations in making the radical observations that it did, legitimate and rational evaluation of the particular weight the judges may have intended to be accorded their views – and that they intended some weight to be attached to them cannot be doubted - will continue unabated until such time as the suggestion itself is either discounted as impracticable or is disavowed by a higher court as a viable legal option. Surprisingly, however, the Supreme Court declined the opportunity to disavow the lower court's observations when it handed down its appeal finding. That it did not do so will do little to provide assurances to the contrary for those who believe that the highest Irish appellate court, in effect, was providing an overt indication of prior approval for any future facilitation by the legislative authorities of provisions similar to those which were made available to the UK Crown Prosecution Service subsequent to decision in the

It is to be presumed that the High Court was of the view that simply restating the law prohibiting unlawful killing – which is what assistance with suicide is - together with reprising the statutory restraints under which the Director of Public Prosecution must operate, would engender a degree of insensitivity which it did not wish to add to its already clinical, and proper, legal determination of constitutional validity and ECHR compatibility of the Criminal Law (Suicide) Act, 1993, and which would have had the potential of unjustifiably exacerbating the level of discomfort which the plaintiff was already suffering.

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[285] *R (Purdy) v Director of Public Prosecutions [2010] 1 AC 435.*

It is more than possible, indeed it is highly probable, that due to the presence on the judicial panel of a distinguished constitutional lawyer, the unanimity with which the High Court delivered its finding was arrived at after only after intense internal debate. While not wishing, Hotspur-like, to summon demons from the deep, nonetheless it may not be long before another collision between the criminal law constraints in the matter of assistance with death and constitutional personal rights evinces a new pragmatic dimension in which a compromise, such as that arrived at in the case of foetal death, is buttressed by either judicial or legislative approval, and more likely the former. As of now, however, assistance with suicide remains a criminal office and all manner of third party assistance with death, other than in those instances where it is judicially endorsed as being in an incompetent patient's "*best interests*", is proscribed.

Chapter X

Conclusion

It will be recalled that it was submitted at the outset that while there are two radically different jurisprudential approaches to the issue of third party assistance with death – the one legislative, the other judicial – the end result is identical, namely the lawful termination of life.

This thesis set out to explore the law relating to both assisted suicide and, where appropriate *'letting die'*, in those jurisdictions where there has been direct legislative overhaul of the area, particularly in the **Netherlands, Belgium, Luxembourg** and **Switzerland**. It also set out to examine those jurisdictions where the law has developed as a result of either judicial activism, such as in **Canada** and, it is argued, in the **UK**, and where there has been both judicial and legislative treatment of the question of assisted death, for example, in the **United States of America**. It was contended that it could be empirically demonstrated, by way of case law, that the changes that have occurred in the matter of assisted death at common law are clearly indicative of a pragmatic willingness on the part of the courts to accommodate novel jurisprudential criteria, such as the *'best interests'* paradigm, for the resolution of the dilemma of who should be let live and who should die or be killed.

In order to identify the genesis, development and introduction of these new legal mechanisms, as well as highlighting the differential between a strictly judicial approach and that which has been followed by jurisdictions where specific statutory provision for the killing of human persons has been enacted, it was proposed to contrast what has occurred in the four central European jurisdictions selected - the **Netherlands, Belgium, Luxembourg** and **Switzerland** - where third party assistance with death has been legalised, with the consciously nuanced recalibration of the common law in **England, the United States, Canada** and **Ireland.**

A derivative/normative methodological matrix was maintained throughout.

In essence, therefore, this thesis, as its title indicates, set out to conduct a comparative critical analysis of the constitutional, legislative and judicial strategies which have been adopted in the jurisdictions selected. As was stated in the Introduction it is not, and was not intended to be, a comprehensive jurisprudential exegesis of the normative concepts underpinning the various approaches to assisted death. Rather, it sought to assess how these concepts have been used and applied as a method of developing the law in respect of such assistance.

The approach adopted in the overhaul of the law in the **Netherlands, Belgium, Switzerland** and **Luxembourg** was examined in detail. From the analysis conducted it is palpably evident that permissible assistance with death evolved more from a pragmatic acceptance by the relevant judicial, prosecutorial and medical authorities, and ultimately by the legislators, that prolongation of life against an individual's stated wishes, in circumstances where the person was enduring unbearable pain and suffering, was unacceptable, and that death was preferable, than from any conscious disavowal of the normative criteria usually invoked in the matter of assisted death by the Western jurisprudential tradition, most especially the sanctity/inviolability of life.

Paradoxically, the fact that laws allowing for third party assistance with death have been enacted in certain jurisdictions does not mean, as those same jurisdictions would argue vehemently, and as has

been demonstrated in this study, that life is deemed to be of less value than in those countries where assisted death is specifically prohibited. Non-natural death, for example in **Switzerland** - where death tourism is prevalent – is not trivialised. Causing intentional death is legally impermissible and a guilty finding attracts a lengthy custodial sentence. Similarly, both voluntary and involuntary manslaughter are proscribed and are accorded appropriate penal sanction. In addition, suicide prevention is a stated and robust objective of the state authorities. It is clearly evident that notwithstanding its invocation of a base motive – *selfishness* – as the sole determinant of culpability in the provision of assistance with suicide, Switzerland's overall legal disposition in the matter of death, intended or otherwise, while different to other jurisdictions in its criminal categorisations, is neither whimsical nor arbitrary.

It is of value to reprise summarily the existential context in which the varying jurisprudential, prosecutorial, medical and legislative approaches to third party assistance with death in each of the jurisdictions examined has occurred to date. Within the derivative/normative matrix adopted the **Netherlands, Belgium, Switzerland** and **Luxembourg** fell within derivative parameters, while the **UK, the United States of America, Canada** and **Ireland** fell more on the normative side of the divide. As has been pointed out above, however, these are not mutually exclusive categorisations. As was clear from the examination and analysis conducted by this thesis the derivative does not necessarily entail an automatic abandonment of the normative. This is particularly evident, for example, in Belgium, **Switzerland** and **Luxembourg**

The Netherlands:

The passage of the Dutch *Termination of Life and Assisted Suicide (Review Provisions) Act, 2002*, represented the culmination of a concerted and co-ordinated approach to third party assistance with death by the Dutch judicial, prosecutorial and medical authorities over a twenty year period.

Prior to this Act, sections *293* and *294* of the *Dutch Penal Code (1896)* unequivocally proscribed both voluntary euthanasia and assisted suicide.

In essence, the 2002 Act amended these sections in order to provide a *justificatory* – not an *excusatory* – defence of *'necessity'* for doctors - and only for doctors – who perform either act.

Similarly, the 2002 law codified the *"requirements of due care"* which a doctor is obliged to observe when performing an act of euthanasia. These requirements had been formulated by the courts and the prosecutorial authorities, beginning in the early 1980s.

The *"requirements of due care"* do not include a provision that the patient be in the terminal phase of an illness or disease, or that the illness itself be a terminal one. Neither is there any restriction to suffering of somatic origin.

In addition, *the Burial and Cremation Law 1991* was amended in respect of those *"due care criteria"* which, if observed by a physician, is not deemed to be a criminal offence. Any failure to observe these criteria on the part of a doctor can result in his/her actions being adjudged *"not careful"*, and the possibility of referral to the prosecutorial authorities for a decision as to whether the matter is criminally actionable.

The law also established the *Regional Review Committees* as the principle bodies responsible for reviewing reported cases of euthanasia and assisted suicide and of deciding whether to refer the actions of the doctor involved to the prosecutorial authorities.

In short, the 2002 Act formally endorsed euthanasia, i.e. the termination a patient's life at the patient's "*voluntary*" and "*well-considered*" request, but contingent on the fulfilment of specific "*due care requirements*", together with reportage, via the municipal pathologist, to the appropriate *Regional Review Committee*. The patient must have been suffering "*unbearably*" and "*hopelessly*."

The practice of voluntary active euthanasia had been deemed legally acceptable – it was regarded as a *discrete* offence – long before it was given statutory footing. Between the Supreme Court (*Hoge Raad*) 1985 decision in *Schoonheim*,[1] which held that notwithstanding its absolute prohibition in the *Dutch Penal Code*, euthanasia by a doctor might be legally justifiable on the basis of *'necessity'*, and the enactment of the 2002 Act, the authorities did not display undue concern as to the legality of euthanasia *per se*. The *"due care requirements"* previously established by the courts and the national prosecutors obviated the need for any such concern. Rather the focus of attention was on appropriate methods for the regulation and control of the practice of assisted death by members of the medical profession.

In 1984 the *Royal Dutch Medical Association (KNMG)* expressed the view that euthanasia was acceptable when carried out by a doctor who fulfilled specific "*requirements of due care.*" In 1985 the defendant in the *Admiraal* case,[2] who was charged with ending the life of a patient suffering from multiple sclerosis, claimed he had fulfilled the "*due care requirements*" which had been identified in previous court findings and endorsed by his own professional association. In mitigation he pleaded *'necessity'*. He was acquitted.

Also in 1985 the Supreme Court held that where there was a dilemma between law and medical ethics euthanasia was justifiable.[3] It held that *"unbearable and hopeless"* suffering included *"increasing loss of personal dignity"* and *"the prospect of an undignified death."* The significance of these findings was clearly evident in the subsequent decisions in the *Chabot* [4]and *Brongersma*[5] cases and is of on-going relevance in the context of the discernibly nuanced interpretation of *"unbearable suffering"* to include a *"dignified death"*, or one that is not *"inhumane"*, which has become evident in Dutch jurisprudence generally and most particularly in the context of the Annual Reports of the *Regional Review Committees*.

In 1991 the findings of the first report of the *Remmelink* Commission,[6] which had been appointed by the Government to investigate and report on the practice by physicians of *"performing an act or omission...to terminate [the] life of a patient, with or without an explicit and serious request if the*

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[1] *Nederlandse Jurisprudentie 1985, no.106.*

[2] *Nederlandse Jurisprudentie 1985, no. 709.* Following the decisions in *Wertheim* (*Nederlandse Juriusprudentie 1982, no.63:233)* and *Admiraal* the Procurators General, the highest Dutch prosecutorial authority, with the approval of the ministry of Justice, began a review of prosecutorial policy with a view to establishing uniform guidelines in the matter of reported cases of euthanasia and assisted suicide.

[3] See fn.1 supra.

[4] *Nederlandse Jurisprudentie 1994, no.656.*

[5] District Court Haarlem, 30th.October, 2001, *no 15/035127-99*; *Tijdschrift voor Gezondheidsrecht 2001/21.*

[6] Medische beslissingen rond het levenseinde. Het onderzoek voor de Commissie onderzoek medische praktijk inzake euthanasia (1991).

patient to this end", were published. The findings in respect of the incidence of lethal drugs being administered with the express purpose of accelerating the dying process of patients in circumstances where the patient had not explicitly requested assistance with death were deeply shocking,[7] and greatly disconcerted the international jurisprudential community.

The Commission caused no little surprise by referring to the practice of accelerating death in the absence of an explicit request as "*help in dying*",[8] and averred that it was part of "*normal medical practice*." While it was patently evident from the Commission's research that such *'help'* was regarded by many doctors as part of their normal duty to dying patients its categorisation by the Commission as *"normal medical practice"* gave rise to serious political and legal concerns. The Government of the day responded by stating that such behaviour was not normal - it was deliberate "*termination of life"* and the cause of death in such instances was "*non-natural*". Under the then *Burial and Cremation Act* such a death had to be reported to the prosecutorial authorities. Historically, such reportage was extremely rare.

The truth of the matter, however, was that the putatively criminal character of the reporting procedure acted as a disincentive for doctors to acknowledge that they had helped patients to die, on request or otherwise. Hence, the establishment, by an Order in Council, of *Regional Review Committees* whose remit was to act as a buffer between doctors and prosecutors. While the principal function of these Committees was to assess notification by doctors of acts of euthanasia, they also aimed to make the process of review more acceptable to doctors, in the hope that they would be more inclined to self-report.

The role and influence of the *Committees* - which were fully operational some four years prior to the passage of the *2002 Act* - in the management and control of euthanasia and assisted suicide in the Netherlands since 1998 cannot be underestimated. The range of sanctions available to them extends beyond the bland language employed in the Act. A doctor can be asked for further information in respect of the circumstances surrounding his/her performance of euthanasia and can be called for interview by the relevant *Committee.* There have been instances where a *Committee*, while finding a doctor's behaviour "*careful*" nonetheless point to deficiencies in the actual performance of the act. A doctor found to be acting in "*good conscience*" can be found "*not careful*" as a result of a purely technical violation and *Committees* have been known to instigate a review of procedures at particular institutions where euthanasia has taken and where they consider that improvements are required.[9] The Annual Report of the *Committees* indicate that the two aspects of reported cases

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[7] The Commission found that in 1990 there were some **130,000** deaths resulting from all causes. Of these **49,000** involved *"a medical decision concerning the end of life"* – the term devised by the Commission to include *"all decisions by physicians concerning courses of actions aimed at hastening the end of life of the patient or courses of action for which the physician takes into account the probability that the end of life of the patient is hastened."* Voluntary active euthanasia occurred in about **1.8%** of **all** deaths, or about **2,300** cases, and there were about **400** cases of physician assisted suicide, about **0.3%** of **all** deaths. More than half of the doctors who were regularly involved with terminal patients had performed either voluntary active euthanasia or had provided assistance with suicide. Only **12%** of doctors said that they would never do so. The Commission also found that intentional hastening of death, either by act or omission, with or without a request by the patient, occurred in some **1000** cases, or about 0.8% of all deaths. These deaths were additional to those found in respect of voluntary active euthanasia.

[8] *"A tendentious euphemism"*, in the words of John Keown in his *'Euthanasia, Ethics & Public Policy: An Argument against Legalisation', Cambridge University Press, 2002, at 117.*

[9] See fn.185, Chapter II on the Netherlands supra.

which most often give rise to difficulties relate first, to the nature and timing of the consultation with another doctor and second, whether the patient's suffering was truly "*unbearable*". The latter issue arises most often in situations involving comatose patients. In cases where special attention is deemed necessary a conclusion that the doctor was *"careful"* is invariably found.

There is a strong view in the Netherlands that the requirement for doctors to report participation in non-natural deaths is of itself a form of prospective control. That this is the case is evidenced in the greatly increased incidence of reporting by doctors and the infrequency of "*not careful*" findings by the Regional Review Committee. Similarly the growing use of **SCEN**[10] consultants appears to be not only a form of control in advance but also functions as an institutional means of transmitting relevant information to doctors, adding a variety of other institutionalised (e.g. hospital protocols) and non-institutionalise (e.g. professional journals) ways in which they are kept informed.

The *"tired of life"* issue arose in 2000 when a court in Haarlem acquitted a doctor for assisting an 86 year-old a lawyer and former Senator, Edward Brongersma, to commit suicide. Brongersma had asked Dr Sutorious, who was a **SCEN** doctor, for assistance with death on a least eight occasions since 1986. Sutorious was prosecuted on the basis that *"aging, deterioration and fear of losing control over the end of life"* did not justify a doctor assisting with suicide. Nonetheless the court accepted Sutorious's appeal to *'necessity'*. The Court of Appeal, however, reversed the finding on the grounds that relieving suffering that does not have a medical cause is not part of the professional duty of a doctor. The Supreme Court upheld this decision and averred that a doctor who assists in suicide in a case in which the patient's suffering is not predominantly due to *"medically classified disease or disorder"*, but stems from the fact that *"life has become meaningless"*, acts outside the scope of his/her professional competence.[11]

The Van der Wal Report in 2003 defined the concept of *"tired of Life"* as one in which the patient asks for assisted suicide in the absence of a serious physical or psychiatric disorder.[12]

In 2004, the *Dijhuis* Committee of the Royal Dutch Medical Association (KNMG) published a report on norms for doctors who are confronted with requests from patients for assistance with suicide on the basis that they are *"tired of life."*[13] The Committee was of the view that such requests would increase with time. It recommended that assistance with suicide in such cases should be deemed lawful because of the *"unbearable and hopeless suffering involved."*

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[10] In 1997 the Royal Dutch Medical Association (KNMG), supported by the Ministry of Health, established an experimental programme in Amsterdam to provide a corps of consultants trained in all aspects of euthanasia who would advise family doctors as to the proper course of conduct to be followed prior to carrying out a patient's request for euthanasia,. Initially called **SCEA** it was established as a permanent fixture in 1999 and extended to the entire country. It is now known as **SCEN.** See fn.67, Chapter II on the Netherlands supra.

[11] *Nederlandse Jurisprudentie 2003, no.167.*

[12] *Medische besliutvorning an het einde van het leven: de praktijk en de toesings procedure euthanasia en het Verslag van de begeleidingcommissie van het evaluatieonalerzoek naar de medische besluiting aa het einde het leven* [Medical Decision Making at the End of Life: Medical Practice and the Assessment Procedure for Euthanasia], Utrecht, de Tijdstroom, 2003.

[13] *Norms for the behaviour of Doctors in the case of Requests for Assistance in Suicide due to Suffering from Continued Life: Report of the Dijhuis Committee, Utrecht, KNMG, 2004. http//srtsennet.nl/Publicaties/KNMGPublicatie/Op-zoek-naar-normern-joor-het-level-rapport-Commissie-Dijhuis-2004.htm*

In summary, therefore, it is beyond question that the Dutch defence of *'necessity'* is available to doctors faced with a *"conflict of duties"*(*Schoonheim*);[14] that *"help in dying"*, in principle, is available to patients, albeit in extraordinary circumstances (*Van Oijen*);[15] that *"palliative sedation"* is considered to be *"normal medical practice"* and not a form of *"termination of life"* (*Venken*);[16] that assistance with suicide is legally justifiable in the absence of *"somatic"* indices and that mental distress can amount to *"unbearable suffering"* (*Chabot*),[17] and that while the condition of being *"tired of life"* does not justify assistance by a doctor with suicide(*Brongersma*),[18] nonetheless the jury is out on the issue given the views expressed in the *Dijhuis* Committee Report.

A traversal of the developments which occurred prior to the formal legalisation of euthanasia and assisted suicide in the *2002 Termination of Life and Assisted Suicide (Review Provisions) Act* are clearly probative of the fact that the new law was the culmination of an orchestrated series of separate undertakings by official Dutch entities and professional representative bodies which, when combined, eventuated in the consensual approach to the legal performance by a doctor of acts which, in all other circumstances, continue to be criminal offences.

The new Act did not emanate from a nationwide discourse on the moral or ethical considerations attaching to the appropriateness or otherwise of legitimating assisted dying. Its sole purpose was to provide a statutory footing for the existing discrete practice of euthanasia by doctors.

Notwithstanding the carefully choreographed orchestration by the Dutch courts, the prosecutorial authorities and the medical profession in identifying the requisite *"due care requirements"* for the licit performance of third party assistance with death there is a complete absence of consensus among international jurists – as there is among some Dutch medical practitioners – as to the desirability of its legitimation.

The validity of the defence of *'necessity'*, which underpins the Act, continues to be questioned. Similarly, the effectiveness or otherwise of the statutory control mechanisms has given rise to an enormous corpus of jurisprudential commentary, the vast majority of which is negative.

The vast majority of Dutch jurists and medical practitioners, however, defend the legalisation of euthanasia and assisted suicide. They are of the view also that, while occasional adjustments may be required, the regulatory mechanisms function effectively and well. Nonetheless, a small but vociferous group, among them the noted jurist John Griffiths, who, while supporting the practice of euthanasia in principle, would like to see changes introduced to the current regulatory regime. Changes of any substance, however, are unlikely.

Belgium:

The circumstances leading to the enactment of the Belgian *Act Concerning Euthanasia,* 2002, were radically different from those which resulted in the passage of the *Termination of Life and Assisted Suicide (Review Provisions) Act, 2002,* in the Netherlands. A co-operative dynamic between the

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[14] *Jurisprudentie Nederlandse 1985, no.106.*
[15] *Jurisprudentie Nederlandse 2005, no. 217.*
[16] *LIN: AUO211, 20-000303-05.*
[17] *Jurisprudentie Nederlandse 1994, no. 656.*
[18] Jurisprudentie Nederlandse 2003, no. 167.

relevant determinative entities, similar to that which existed between the Dutch judicial, prosecutorial, medical and legislative authorities, was absent in Belgium.

The Belgian *Order of Physicians*, unlike its Dutch counterpart, the *Royal Dutch Medical Association,* did not consider legal regulation of euthanasia to be desirable. In its view the matter was best left to individual doctors. The *Order* did not appear to be unduly concerned at the putative absence of legal certainty for those of its members who did perform - albeit covertly – acts of assisted death. That such acts occurred was not in doubt. The results of studies carried out in Flanders – where 60% of the Belgian population lives – in the late 1990s and early 2000s, provided empirical proof that medical end-of-life practices included euthanasia.

The prosecutorial authorities, again unlike their Dutch counterparts, preferred a policy of non-engagement. However, this was not unusual. It accorded with a national disinclination either to acknowledge – notwithstanding evidence to the contrary – that euthanasia was practised or that normative criteria for its regulation and control were required.

The progression towards the legitimation of third party assistance with death, and specifically euthanasia, was galvanised primarily by political opportunism rather than by any deep-seated conviction as to the necessity for legal clarity. The absence for the first time in over 40 years of the Christian Democrats – opponents of any attempt to introduce of legislation which would provide a legal basis for assisted dying, including euthanasia[19] - from Government, enabled proponents of third party assistance with death to propose, and have enacted, the *Act Concerning Euthanasia, 2002.* A policy programme agreed between the Liberals, the Socialists and the Greens (who entered Government as a result of the General Election of 1999) provided tangible indications of a determination on the part of these parties to effect legal change.

The precise statutory definition of euthanasia contained in *section 2* of the *Act Concerning Euthanasia, 2002 – "the intentional life-terminating action by someone other than the person concerned, at the request of the latter"* - is in stark contrast to the complete absence of a definition in the Dutch Act.

The *Belgian Act* contains very detailed definitional, substantive and procedural provisions. Unlike the Dutch, however, the Belgian authorities did not pursue the route of amending its Penal Code. Instead they acted *de novo* and the *Act* placed greater emphasis on the rights of the individual, especially that of self-determination, than is evident in the Dutch statute.

Prior to the 2002 Law a doctor, as per *Articles 95* and *96* of the *Deontological Code*, could not intentionally cause the death of a patient or help him/her to take their own lives. Subsequent to the Act coming into force the *Code* was amended to allow for a situation in which a doctor receives a question regarding the end of life he/she has to inform the patient of all possible options and provide any medical and moral assistance required.

As defined at Belgian law *euthanasia* is not normal medical behaviour such as the refusal of treatment either by way of advance directive or in the form of a current request; the withholding or withdrawing of treatment which is deemed to be medically futile; pain relief with life-shortening

[19] See fns.27 & 28, Chapter III on Belgium supra. The Christian Democrats, in effect, exercised a veto on alternative majority solutions to ethical matters following the legalisation of abortion in 1990.

effects or palliative and terminal sedation. The Council of State affirmed that this was the case during the debate on the Bill in Parliament. There does appear, however, to be a body of opinion among some elements of the Belgian medical profession that because the performance of an act of euthanasia is specifically restricted to doctors it logically falls within the parameters of normal medical behaviour.[20]

The reasoning appears to be that regardless of the character of the medical actions taken, once performed by a doctor they should be deemed as normal and that the concept of normal medical behaviour encompasses all such behaviour irrespective of any potential criminal consequences were such actions to be carried out by non-doctors. This is not correct. On foot of a valid informed consent by the patient – and only as a result of such a consent – the *Royal Decree Concerning the Practice of Health Care Professionals*, issued in 1967, which governs those practices that fall within the general description "*normal medical behaviour*", including palliative care, make this abundantly clear.

In summary, therefore, the new *Law* creates a specific legal justification for the performance of euthanasia by a doctor - similar to the justificatory defence of '*necessity*' provided in the Dutch Act – when confronted by a conflict of duties: the duty to save life on the one hand and the duty to relieve suffering on the other. In furtherance of the principle of self-determination on which the *Law* is predicated the right to request euthanasia is recognised. But that is all. The *Law* does not recognise a right to euthanasia *per se*.

The criteria for a valid acceptance of a voluntary request for euthanasia, both by way of an advance directive and as a result of a well-considered and repeated request at a time when it is concluded that there is no reasonable alternative treatment for the patient's condition - arrived at jointly by the patient and the doctor – together with the specific protocols governing the role of the doctor who acquiesces in such a request, including consultation with an independent physician, and the mechanisms for review and control, form by far the greater portion of the provisions of the *Act.*

By way of contrast with the Dutch Act the Belgian statute does not specify what offence, if any, is committed by a doctor who fails to comply with the established criteria. Whereas the Dutch Penal Code contains a distinct offence of either euthanasia or assisted suicide, the Belgian Code does not. The legitimate question has been posed, therefore as to what offence a Belgian doctor commits if he/she performs euthanasia without meeting the conditions set down in the law. Is it manslaughter, murder, poisoning or some other offence? As Nys has pointed out the uncertainty is not in any way ameliorated by the absence of case law in the matter.[21]

The *Act on Palliative Care* was enacted in 2002 also. This *Act* specifies that every patient has the right to palliative care. This right has led to the use of what is referred to as the "*palliative filter*", a procedure adopted in Catholic hospitals in Flanders where, notwithstanding institutional concurrence in the availability of euthanasia for "*competent terminally ill patients*", care for a patient who has requested euthanasia includes an obligatory consultation with a specialised palliative care team which considers the patient's actual needs. The *Act Concerning Euthanasia*, however, does not make any reference to a "*palliative filter.*"

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[20] See fn.32, Chapter III on Belgium supra.
[21] See fn.59, Chapter III on Belgium supra.

The *Act Concerning Euthanasia* legalised the practice of euthanasia by doctors contingent on the observance of specific protocols. The Act did not legalise assistance with suicide. However, in 2003, the Belgian *Order of Physicians* decided that assisted suicide is equivalent to euthanasia as long as the provisions of the *Act Concerning Euthanasia* have been followed. Likewise the *Federal Control and Evaluation Committee*, which was established by the Act, and which reviews reported cases of euthanasia biennially, considers assisted suicide to fall within the statutory definition of *'euthanasia'* and disposes of cases accordingly.

One of the primary objectives of the establishment of the *Federal Control and Evaluation Commission* was to encourage doctors to self-report acts of euthanasia to the relevant authorities. To date there is insufficient empirical data available for a proper assessment of the success or otherwise of this aim.

In 2011, **1133** reported acts of euthanasia were performed in Belgium and at the time of writing a proposal to reduce the age of consent of a minor to an act of euthanasia from 18 to 12 is before the Senate. This matter has yet to be resolved.

In enacting the *Euthanasia Law* Belgium – a predominantly Catholic country - became only the second country in the world, after the Netherlands, where the termination of the life of a person by a doctor can be effected licitly at that person's voluntary and repeated request.

Switzerland:

The Swiss approach to assisted death is at once unique and unremarkable. Unique in that the determinative criteria it employs to ascertain the culpability arising from the requested participation by one person in the self-induced death of another is essentially *altruistic* in nature; it decriminalises all such action other than in those instances where *self-interest* is involved.

It is unremarkable in that like many other jurisdictions which are imbued, to a greater or lesser degree, by the Western jurisprudential tradition that considers life to be of inherent value, it specifically proscribes voluntary active euthanasia.

Direct active euthanasia (*sterbehilfe*) – deliberate killing in order to end the suffering of another person – is punishable as intentional homicide under *Article 111* of the Swiss *Penal Code*. Indirect active euthanasia – the use of means having unintended side-effects that may shorten life – and passive euthanasia – rejecting or discontinuing life sustaining or prolonging measures – are not treated as criminal offences at Swiss law provided certain conditions are fulfilled.

Article 115 of the *Penal Code* specifically invokes a base motive – *selfishness* – as the sole determinant of culpability in the provision of assistance with suicide. The logical and seemingly irrefutable corollary to this qualification is that in the absence of such a motive assistance with suicide is legally permissible.

The non-criminal character of assisted suicide is implicitly, rather than explicitly, stated. Assistance with suicide is not illegal if the person providing help is not motivated by *self-interest* and in most cases the permissibility of *altruistic* assisted suicide cannot be overridden by a duty to save life. There is no requirement for the involvement of a doctor. The patient need not be terminally ill. The sole criterion is that the motivation be *unselfish*. For legal validity, the mental capacity of the person

requesting assistance is also required. Absent capacity, the resultant suicide would not be deemed a voluntary and free decision and the person assisting would face prosecution for intentional killing.

From the early 1980s onwards the provisions of *Article 115* have been exploited by a number of right-to-die organisations in Switzerland. The foundations of the *'Swiss model'* of assisted death were laid by one of the commercial right-to-die organisations, *EXIT DS,* when it stated that the objective was *"not to strive primarily for greater liberalisation of active euthanasia....but rather to use the liberal legislation concerning assisted suicide to offer such assistance on request to severely ill people wishing to die."*

Over the past quarter of a century the services of Swiss private right-to-die organisations, of which there are four,[22] have been availed of extensively, both by Swiss residents and non-residents alike.[23]

The courts in Switzerland have held that, in principle, assisting in suicide is not incompatible with the rules of medical practice.[24] The precise role which a doctor plays in assisting a person to commit suicide in Switzerland is to provide the requisite prescription for the controlled drug, normally sodium pentobarbital. This drug must be prescribed, dispensed and used according to the established rules of medical practice.[25]

In 2011 the European Court of Human Rights handed down its decision in *Haas v Switzerland.*[26]The applicant had been refused permission by the Swiss public health authorities to obtain sufficient quantities of the drug sodium pentobarbital to enable him to commit suicide. His claim was dismissed by the Swiss Federal Court. He appealed to the European Court of Human Rights on the grounds that the refusal was in breach of his rights under of *Article 8* of the Convention on Human Rights. The ECtHR disagreed. It held that the decision of the Swiss public health authorities to refuse the applicant's request was amply justified by the provisions of *Article 8(2)* of the Convention.

In summary, the legal permissibility of a*ltruistic* assistance with suicide creates something of an unreal ethical atmosphere in Switzerland. The actual practice of assisted suicide there seems to obviate any need for the ventilation of the usual criteria considered essential in democratic jurisdictions for an evaluation of the putative legitimacy of a practice which involves earlier than natural death.

While the practice of assisted suicide does not receive universal endorsement in Switzerland, nonetheless there is an underlying ambivalence which appears to engender a resigned acceptance of the existential reality. This is reinforced by the comforting assurance by the relevant authorities that

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[22] See fn.22, Chapter IV on Switzerland supra.

[23] See sections 5 & 6, Chapter IV on Switzerland supra for detailed statistics.

[24] *See Schweirzerisches Bundesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006.* However, the patient's competence to decide to seek assistance with death must be ascertained prior to a prescription for the lethal cocktail being issued. See *Verwaltunsgericht des Kantons Zurich [Zurich Administrative Court], Entscheid der 3. Kammer VB Nr 99.00145, 1999; Verwaltungsgericht de Kantons Aargau [Aagau Administrative Court], Entscheid BE 2003.00354-K3, 2005.* This means the doctor must examine the patient wishing to die, in person, and assess the medical conditions giving rise to that wish.

[25] See *Article 11(1) of the Narcotics Law.*

[26] *(2011) 53 EHRR 33.* See section 7, Chapter IV on Switzerland supra.

the appropriate regulatory controls are on place and that nothing untoward, such as direct active euthanasia (*sterbehilfe*), will occur.

However, notwithstanding claims to the contrary, it is evident from the review conducted by this thesis that clear and explicit criteria for the applicability of *Article 115* of the *Penal Code* are absent. The law is applied in a relatively inconsistent manner currently. On the one hand, private right-to-die organisations that provide assistance with death require patients – or "*members*" as they are euphemistically referred to – to meet specific requirements, such as, inter alia, mental capacity, earnest and repeated requests, incurable diseases, bleak diagnosis and intolerable suffering. On the other hand, certain institutions, such as nursing homes and retirement homes, refuse to even consider request from patients or residents for assistance with suicide for the avoidance of further pain and suffering.

Right-to-die organisations continue to provide a commercial service in assisted death to the degree that death tourism is now an ineradicable characteristic of Swiss identity. These right-to-die organisations are allowed to operate with impunity because:

(i) altruism is legally endorsed as a criterion of non-culpability in the provision of assistance to a person wishing to commit suicide;
(ii) the regulatory regime in which they operate is not burdened by an excessively intrusive disposition on the part of the civil authorities;
(iii) the medical profession has succumbed to the seductive, and apparently logical proposition, that because doctors actually do not perform the final act of death – they only prescribed the means by which this can be effected by the person wishing to die – this behaviour is excluded from the possibility of critical stricture, including criminal prosecution.

Luxembourg:

When the *Law on Euthanasia and Assisted Suicide 2009* came into effect[27] Luxembourg became the third European country to permit third party assistance with death, specifically voluntary active euthanasia and assisted suicide.

However, the *Law* only decriminalises these actions when performed by a doctor; only at the repeated request of a terminally ill patient suffering constant and unbearable pain and mental anguish, and only when specific procedural protocols are observed.[28] For its valid application *"euthanasia is to be understood as the act, performed by a doctor, intentionally ending the life of a person who has expressly and voluntarily requested death. Assisted suicide is to be understood as the intentional assistance by a doctor to a person intent on committing suicide, or providing that person with the means to that end, having been expressly and voluntarily requested to do so by the person wishing to die."*[29]

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[27] On 16 March, 2009. The Law is referred to as *Loi du 16 Mars 2009 sur l'euthanasie et l'assistance du suicide.*
[28] The conditions and procedures – in respect of both doctor and patient - attaching to a request for euthanasia or assisted suicide are contained in *Articles 2* and *3* of *Chapter II* of the *Law.* See section 2, Chapter V on Luxembourg supra.
[29] Article 1: General Provisions, *Loi du 16 Mars 2009 sur l'euthanasie et l'assistance du suicide.*

Assisted dying in Luxembourg is medicalised and the Luxembourg *Criminal Code* has been amended to exclude doctors from criminal prosecution as a result of the performance of either euthanasia or assisted suicide.[30]

The 2009 *Law* does not allow for the performance of euthanasia or assisted suicide by a person other than a doctor. Both euthanasia and assisted suicide continue to be punishable offences if performed other than within the specified parameters of the new legal framework. The Luxembourg *Criminal Code* does not possess a provision comparable to *Article 115* of the Swiss *Penal Code* which permits *altruistic* suicide by members of all professions or none.

The genesis of the *Law on Euthanasia and Assisted Suicide* in Luxembourg is curious. Unlike the Dutch and Belgian euthanasia laws that of Luxembourg was neither initiated nor supported by the main government party, the Christian Socialists. Two members of the Opposition parties,[31] the Greens and the Socialists, sponsored the proposal for legislative change. Its passage was ensured when socialist ministers in the coalition government joined the opposition Liberal and Green parties in support.

Both the *Euthanasia and Assisted Suicide Bill* and the *Palliative Care Bill* were passed by the Chamber of Deputies in late 2008, the former by a small margin and the latter unanimously. Neither was given effect until 16 March 2009, however, because the Grand Duke refused to sign the *Euthanasia and Assisted Suicide Bill* on grounds of conscience. A bill passed by Parliament could not have legal effect without the Grand Duke's signature. The impasse was resolved when Parliament enacted legislation removing the Grand Duke's veto power.

A doctor who performs an act of euthanasia or provides assistance in the suicide of a patient must submit the requisite official declaration of such action, duly completed, within eight days to the *National Commission for Control and Assessment*,[32] established under the *Euthanasia Law.*

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[30] Article 397-1: "*The fact of a doctor responding to a request for euthanasia or assisted suicide shall not fall within the scope of application of the present section if the fundamental conditions of the Law of 16 March, 2009, on euthanasia and assisted suicide are met.*"

[31] Jean Huss of the Green Party and Lydie Err of the Socialist Party.

[32] The terms of reference of the Commission provide for a report to the Chamber of Deputies every two years and must include statistical data as to the number requesting, and being accommodated with, euthanasia or assisted suicide. One of its key functions is to oversee the systematic registration of end-of -life provisions. The two basic tasks which the Law requires the Commission to fulfil are : (i) to draw up an official declaration to be completed by a doctor each time he/she performs an act of euthanasia or provides assistance in the suicide of a patient; (ii) to provide the Chamber of Deputies, within two years of the Law taking effect, with (a) a statistical report; (b) a report of the description and assessment of the application of the Law and (c) where deemed necessary, recommendations likely to result in a legislative initiative and/or other measures concerning the execution of the Law. In its first Report, in March 2011, the Commission stated that five people (3 men and 2 women, all over the age of 60) had availed of euthanasia in the two year period of review since 2009.There were no recorded deaths by assisted suicide. In each case, according to the doctors involved, death was "*serene and rapid; it occurred within minutes.*" See *National Commission for Control and Assessment of the Law on Euthanasia and Assisted Suicide or 16 March 2009, First Report, Years 2009 and 2010, 16 March, 2011.* By the end of March 2011, 681 (396 women and 285 men), end-of-life declarations had been registered with the Commission outlining a variety of illnesses and disorders, physical and psychological, all of which were described as "*constant and unbearable*."

A patient's request for euthanasia or assisted suicide – known as an end-of-life provision - must be noted in writing. The document has to be drafted, dated and signed by the person personally, or, if permanently physically unable to do so, this must be noted in writing by an adult person of his/her choice. A patient may withdraw his/her request at any time, in which case the relevant document must be removed from the patient's medical file and returned to the patient. All requests for assistance with death, irrespective of number, made by a patient, as well as procedures of the treating doctor and the results, including the report(s) of consulted doctor(s), must be placed in the patient's medical file.

Shortly after the enactment of the *Law* the Ministries of Health and Social Security published an information booklet detailing the illnesses and disorders for which euthanasia or assisted suicide might be possible solutions. It also outlined the circumstances in which a patient can make a direct request for either. It defined "*unbearable suffering without prospect of improvement*" and detailed the conditions and procedures which must be followed by a doctor before he/she performs one or other act.

The Minister for Health was of the view that Luxembourg was "*one of the European countries doing all that it can to guarantee its citizens access to first class palliative care whist preserving their right to decide on the end of their life in accordance with their beliefs.*"

"*It is a matter of giving additional legislative answers aimed at providing the framework for medical practices with regard to the end of life, respecting everyone's dignity and choice.*"

According to the Luxembourg authorities the underlying ethic of the *Law on Euthanasia and Assisted Suicide 2009* is one which endeavours to encompass simultaneously respect for the freedom of conscience of a doctor and respect for the freedom of choice of a patient wishing to die an earlier than natural death.

If the intention of enacting a law on palliative care at the same time as the passage of *the Euthanasia and Assisted Suicide Law* was to reassure those who feared either that an indiscriminate regime of assisted dying would ensue or that incompetent or disabled persons would be subjected to involuntary euthanasia in the absence of an organised system of palliative care, as a calculated manoeuvre, to date at least it has been successful in that objective.

The fact that there have been no recorded instances of involuntary euthanasia, or of elderly persons being pressurised into committing suicide – in short, no record of abuses – does not mitigate the reality, however, that in the Duchy of Luxembourg euthanasia and assisted suicide are now legally permitted when performed by a doctor within specified parameters. As with Switzerland assisted death has now been added to the list of national characteristics which are invoked as evidence of a modern and sophisticated jurisdiction.

In its first report to the Chamber of Deputies the *National Commission for Control and Assessment* made a number of recommendations regarding the on-going application of the *Law,* one of which

was that there was an *"urgent need for dedicated guidelines for the medical profession."*[33] This would appear to suggest that either the medical profession as a whole had expressed concern that the information supplied by the Ministry if Health was deficient or that individual doctors were found not to be in full possession of the requisite data. However, the *Commission* did not elaborate and no empirical findings have been published to indicate that an informational deficit exists, either at the corporate medical level or in the case of individual doctors. Nonetheless the fact that the *Commission* deemed it appropriate, in its first report, to identify a need for special information brochures for doctors is indicative either of a nonchalant attitude to assisted death on the part of the medical profession as a whole or a genuine apprehension on the part of the regulatory authorities that individual doctors had failed to acquaint themselves fully with the provisions of the new *Law.*

The *Commission* also recommended that doctors involved in euthanasia *"should have free and unrestricted access to the drugs required to perform the act."*[34] The *Commission* did not give a particular reason why it considered it necessary to make this recommendation but it is to be presumed that it did so only in circumstances where difficulties in accessing the appropriate drugs for effecting a successful act of euthanasia had been brought to its attention. Whatever the reason, it is probable that such difficulties are indicative of residual opposition – on the part of pharmacists – to the provision of assisted death by a doctor.

It is to be noted that the *Specific Provisions* of *Article 15* of the *Law on Euthanasia and Assisted Suicide* do not make any mention of the freedom of conscience of a pharmacist who may, on religious, ethical or other grounds, feels unable to supply drugs in the knowledge that their use is to bring about the death of a human person.

To the dispassionate observer it would appear inconceivable that the possibility that persons other than doctors, nurses and health care providers – such as pharmacists – might be imbued with conscientious doubts as to the moral or ethical propriety of participating, albeit not directly, in the death of another person would not impinge sufficiently on the parliamentary draughtsman to allow for their exceptional inclusion in the new *Law.* The reality, however, is that such a possibility is not provided for in the *Law.*

This may well prove to be a matter for consideration by the *Commission* in future reports. At the time of writing the *Commission Report* for the years 2011 and 2012 had not been published.

England and Wales:

The thesis demonstrated that at English law a number of established principles – the medical exception, informed consent, the right of refusal of medical treatment, autonomy, self-determination, capacity/incapacity and medical futility - are inextricably interwoven with an intricate filigree of evolved legal mechanisms which are employed in the determination of the legality or otherwise of non-natural death.

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[33] See fn.32 supra.
[34] Ibid.

It was established that the principle of the inviolability/sanctity of life and the legal construct of double effect, the essence of which is the distinction drawn between intention and foresight, were of particular significance.

Similarly, the applied differential between acts and omissions was found to be of pivotal importance in an appreciation of how the lawfulness of death resulting from either medical action or inaction can be readily accommodated within the legal architecture governing the prohibition of the deliberate termination of the life of one person by another.

It was established also that the influence of these mechanisms could be clearly discerned in the judicial reasoning adopted and followed in a number of iconic cases, particularly those in which incapacity, together with a medical prognosis of futility, predominated and where the lawfulness or otherwise of the withdrawal of life-sustaining medical treatment was in issue. Both *Airedale NHS Trust v Bland*[35] and *Re A (Conjoined Twins)*[36] fell into this category.

Notwithstanding the irrefutable significance historically of these legal mechanisms within the jurisprudential matrix governing life and death issues the contention that a new philosophical orientation had emerged in the last decades of the twentieth century was examined. The defining contours of this new approach were identified as the diminution of medical paternalism and the recalibration of the concept of individual rights, particularly those of informed consent and the refusal of unwanted medical treatment, even in circumstances where death is the inevitable outcome.

A subtle but nonetheless discernible relegation of the common law principles underpinning findings as to who should be let live and who should be permitted to die was put in evidence and it was established that a more pragmatic curial estimation of whether life or death happens to be in a patient's actual *'best interests'* was identified as the new criterion.

In consequence, a *'quality of life'* benchmark was shown to have emerged as an integral and authoritative element in end-of-life decision-making at English common law. The genesis of this new criterion was traced to a line of case law, beginning in the early 1980s, in which the lawfulness or otherwise of the non-treatment, or the discontinuance of life-sustaining medical treatment of incompetent children suffering with disabilities, including those of an uncomplicated character, was in issue.

Resulting from the infusion of this new element into judicial reasoning, traditional jurisprudential criteria were subjected to a type of constructive ambiguity, resulting in the gradual discontinuance of their automatic invocation as the exclusive and unassailable reference points in the determinative matrix regarding continued life or guaranteed death.

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[35] *[1993] AC 789.*
[36] *[2001] Fam 147.*

In short, the contention that the common law as practiced is symptomatic of an innate ability to accommodate a suite of alternative and novel criteria, referred to in emollient terms as the *'best interest'* test, was amply demonstrated.

Paradoxically the common law, which proscribes the intentional killing of one person by another, has evolved to a position whereby judges - and only judges – can decide whether it is no longer in the *'best interests'* of an incompetent patient to be allowed to continue living. Likewise, based on a medical prognosis as to the unlikelihood of a future desirable *'quality of life'*, judges can decide whether he or she should die.

A clinical and forensic examination of both the substance and reach of the *'best interest'* paradigm was deemed necessary.

The methodology adopted included: (a) a review of the rare cases in which doctors have been prosecuted for the attempted murder of their patients, illustrating the efficacy attaching to the principle of double effect; (b) tracing the application of the paradigm *via* a continuum of cases in which the continued treatment, or not, of children with disabilities was in issue, beginning immediately after the unsatisfactory finding in *R v Arthur;*[37] (c) an examination of the application of the paradigm in cases involving adults who no longer possess competency and (d) a review of the findings of the *House of Lords Select Committee on Medical Ethics*[38] which was established in the aftermath of the finding in *Airedale NHS Trust v Bland,*[39] and of the *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill*, 2005, together with an analysis of the judicial reasoning applied in *Pretty,*[40] *Purdy*[41] and *Nicklinson.*[42]

The totality of the findings in the cases reviewed illustrates, it is suggested, the gradual but clearly discernible recalibration of the conditions which render non-treatment lawful, based largely on the application of the *'best interests'* test. It was established that the courts have abrogated to themselves the unilateral right, based on inherent jurisdiction,[43] to make determinations as to when, and how, incompetent children are to have life-sustaining medical treatment denied to them, notwithstanding the expressed contrary wishes of parent and guardians.

It was established also that in *Bland*[44] the House of Lords based their decision on an assessment of what was in Mr Bland's *'best interests'*. It was decided that continued life in a permanent vegetative state was not in his *'best interests'* and that it would be preferable, and lawful, to cease medical treatment, notwithstanding the fact that he was not terminally ill and could breathe independently. Other than having infections treated with antibiotics, he was not under specific therapeutic management. He was fed and hydrated intravenously. This artificial nutrition and hydration was

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[37] *(1981) 12 BMLR 1.* See fn.27 Chapter VI on England and Wales supra.
[38] *HL Paper 21-1 of 1993-4.*
[39] *[1993] AC 789*
[40] *R (Pretty) v DPP [2001] UKHL 61, [2002]1 AC 800.*
[41] *R (On the Application of Purdy) v DPP [2009] UKHL 45.*
[42] *Nicklinson v Ministry of Justice [2012] EWHC 2381 (Admin).*
[43] See dicta of Sir Stephen Brown in *Re C A Minor: Medical Treatment)[1998] Lloyd's Rep Med 1 Fam Div:* "What the court is being asked to do in this case is to exercise **its inherent jurisdiction**...."
[44] *[1993] AC 789; [1993] 1 All ER 821.*

deemed to be medical treatment and its withdrawal, in the clear knowledge that such action would accelerate death, was endorsed.[45] While *Bland* remains the leading authority on the withdrawal of treatment from an incompetent patient there have been statutory developments in the interim which impact on the treatment decisions that can now be made by others on behalf of an incompetent individual.[46]

All of the judgments delivered in *Bland* stressed that it was not a matter of it being in the *'best interests'* of the patient to die but rather that it was not in *'best interests'* to treat him so as to prolong his life in circumstances where *"no affirmative benefit"*[47] could be derived from the treatment.[48]

In its Report, published in 1994, the *House of Lords Select Committee on Medical Ethics* unanimously recommended that the law should not be relaxed to permit either voluntary active euthanasia or physician-assisted suicide.[49] Considerable attention was devoted to the issue as to whether a new offence of *'mercy killing'* should be introduced into the criminal law. The members concluded, however, that to distinguish between murder and *'mercy killing'* would be to cross the line which prohibits any intentional killing, a line which they thought it essential to preserve. Nonetheless they were of the view that the mandatory life sentence for murder should be abolished.[50]

In 2003, 2004 and 2005 Lord Joffe introduced Bills in the House of Lords to legalise not only *"medical assistance with suicide"* but also, in cases where self-administration of lethal medication was not possible, *"voluntary euthanasia."* All three Bills proved unsuccessful. A Bill proposing physician-assisted suicide for the terminally ill – *Assisted Suicide for the Terminally Ill Bill* - was introduced in the House of Lords in 2005. However, it was defeated on Second Reading in May, 2006, by 142 votes to 100.[51]

During the passage of the *Coroners and Justice Act, 2009,* Lord Falconer moved an amendment in the House of Lords which would have created an exception to section 2 of the *Suicide Act, 1961*, in the case of acts done for the purpose of enabling or assisting a person to travel to a country in which assisted suicide is lawful, subject to certain conditions. This amendment was defeated.

On 27 March, 2012, a debate was held in the House of Commons on the subject of assisted suicide. The House passed motion welcoming the *DPP's Policy Statement (2010)* in the matter of factors which would be taken into consideration in deciding whether to instigate a prosecution in an

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[45] For an exegesis of the reasoning adopted and followed in *Bland* the matter of categorising artificial nutrition and hydration as medical treatment see fn.131, Chapter VI on England and Wales supra.

[46] *Mental Capacity Act, 2005*, which came into effect in 2007.

[47] Per Lord Browne Wilkinson, *[1993] AC 789, at 883.*

[48] Lord Goff held that judicial approval should be sought in all PVS cases in which the patient's medical team believe it is in his/her *'best interests'* for artificial nutrition and hydration to be withdrawn. Ibid at 873-4. This practice was reflected in cases subsequent to *Bland*. For a list of such cases see fn. 140, Chapter VI on England and Wales supra.

[49] This recommendation was accepted by the Government. See *Government Response to the Report of the Select Committee on Medical Ethics (Cm 2553, 1994).*

[50] The Government did not accept this recommendation. It did accept, however, that there should be no change in the law relating to assisted suicide.

[51] See House of Lords, *House of Lords Annual Report 2006/7 (HL Paper 162, 2007) 1.*

instance of assisted suicide. It also encouraged further development of specialist palliative care and hospice provision. However, it rejected an amendment calling on the Government to carry out a consultation about whether to put the DPP's guidance on a statutory basis.

In *Pretty v Director of Public Prosecutions* Lord Steyn stated that the logic of the European Convention on Human Rights *"does not justify that the House must rule that a state is obliged to legalise assisted suicide."* Lord Bingham described the distinction between suicide on the one hand and assisting another to commit suicide as one which was *"deeply embedded"* in the fabric of English law. He also stressed the fundamental difference between the cessation of medical treatment on the one hand and active assistance to end life on the other. He concluded that *Article 8(1)* and *(2)* of the *European Convention* – the right to respect for private and family life - was not engaged by the prohibition on assisted suicide contained in section 2 (1) of the *Suicide Act, 1961*, but if it was, the section was not compatible with it. Counsel for *Pretty* had submitted that this article conferred a right to self-determination and cited *X and Y v Netherlands,*[52] *Rodriguez v Attorney General of Canada*[53] and *In re A (Children)(Conjoined Twins: Surgical Separation)*[54] in support.

The plaintiff claimed that the court was obliged to rule whether it could be other than disproportionate for the Director of Public Prosecutions to refuse to give the undertaking sought and, in the case if the Secretary of State, whether the interference with Ms Pretty's right to self-determination was proportionate to whatever legitimate aim the prohibition on assisted suicide pursues

Ms Pretty failed in her claim and appealed the matter to the European Court of Human Rights. The ECtHR disagreed – or at least, seems to have disagreed[55] – with the House of Lords' opinion that *Article 8* was not engaged. Critically, however, it did agree that *Article 8* was not breached. The blanket nature of the ban on assisted suicide was not disproportionate.

The jurisprudential relevance of the *Purdy* case lies in the finding that it was incumbent on the Director of Public Prosecutions *"to clarify what his position is as to the factors that he regards as relevant for and against prosecution"* in cases of encouraging and assisting suicide.

Lord Hope held that the ECtHR, in its judgment in *Pretty, "when read as a whole"* found that the right to respect for private life in *Article 8(1)* was engaged by issues of the kind which arose in *Purdy.* Similarly, he stressed that legal certainty was a core question to be addressed in considering whether any restrictions on the right to family life were proportionate and *"prescribed by law"* in the manner provided by *Article 8 (2).*

Significantly, he went on the express the view that the *Code for Crown Prosecutors*, which the Director of Public Prosecutions was required to issue pursuant to section 10 of the *(UK) Prosecution of Offences Act, 1985, "must be treated as the equivalent of a law for Article 8(2) purposes."* Holding that the guidelines in existence were inadequate, he allowed the appeal and required the DPP to

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[52] *(1985) 8 EHRR 235.*
[53] *[1994] 2 LRC 136.*
[54] *[2001] Fam 147.*
[55] See fn.179 Chapter VI on England and Wales supra.

clarify those factors which he would take into consideration when deciding whether or not to prosecute in a case of assisted suicide.

Complying with the Court's request the DPP, in February 2010, published his *Policy for Prosecutors in Respect of Cases Encouraging or Assisting Suicide*.

The case of *Nicklinson v Ministry of Justice* is the most recent judicial exposition of the law on assisted suicide in the UK. A declaration was sought that it would not be unlawful, on the grounds of the common law defence of *necessity,*[56] for the claimant's doctor, to terminate or assist in the termination of his life. The claim was that the defence was available to a charge of murder in the case of active voluntary euthanasia and/or to as charge under s.2 of the *Suicide Act, 1961*. It was also contended that the criminalisation of assisted suicide was incompatible with *Article 8* of the *European Convention on Human Rights* in that it prevented him from exercising a right to receive assistance in committing suicide.

Permission to apply for relief by way of judicial review was granted.[57]

In the event the application was refused.

In summary, it has been shown that in the case of those who either never possessed the capacity to decide whether they wished to continue to live, or to die, or of those who no longer possess such capacity, that judicial determinations in respect of life and death are contingent on an estimation of future *'life quality'*, based on a *'best interests'* test which, in turn, relies on a medical prognosis of futility.

At its core, the *'best interests'* test was found to be an interpretative one. Beginning in the late 1980s and early 1990s – after years of endorsing medical opinion – the courts adopted a much more proactive approach to *'best interests'*. This was some ten to fifteen years before the enactment of the *Mental Capacity Act, 2005.*

In truth, the *'best interests'* criterion is something of a flexible entity and is one which depends wholly on the judicial interpretative approach taken in particular cases. When applied in circumstances, for example, where the decision to be made relates to the withdrawal of artificial nutrition it is difficult not to conclude that the argument that it is the *'bests interests'* of a patient to be starved – which, in effect, is what the withdrawal of nutrition amounts to – is nothing more, or less, than a statement to the effect that it is in the patient's *'best interests'* to die. In such a context Lord Goff's statement in *Bland* that *"we are not saying that it is in your best interest to die, just that it is in your best interests not to receive essential physiological support,"*[58] is inherently contradictory. The two cannot be separated.[59] Lord Lowry, in the same case, appeared to share these reservations.[60]

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[56] See fn.197 Chapter VI on England and Wales supra.
[57] By Charles J – 12 March, 2012.
[58] *[1993] 1 All ER 821, at 896.*
[59] See Mason and McCall Smith, *'Law and Medical Ethics', 8th ed, Oxford University Press, 2011, at 602.*
[60] *[1993] 1 All ER 821, at 887.*

The recent decision in *Carter v Canada*,[61] albeit on appeal, is indicative of a jurisprudential willingness - on the part of a common law jurisdiction - to extend traditional boundaries to allow for an acceptance of the right of an individual who is terminally ill, and who wishes to avoid further pain and suffering, to avail of assistance with death from a third party in the knowledge that criminal proceedings against the person who helps with the act are unlikely to ever occur.

The disavowal of the possibility of such a development, in the absence of legislative underpinning, within the parameters of English law, evidenced in the decisions in *Pretty, Purdy* and *Nicklinson,* should not blind the dispassionate observer, however, to the historical reality that while the *'best interests'* test received statutory endorsement in the *Mental Capacity Act, 2005*, it first saw the light of day in the courts some twenty-five years earlier. Therefore, any suggestion that an expansion of the test will not involve future curial initiative would not only be foolhardy but would also be a denial of previous, empirically probative judicial activism in the matter.

Paradoxically, at English common law currently, if you are incompetent and the medical prognosis is negative you can be killed in your *'best interests'* by judicial authority; if, on the other hand, you are terminally ill and you express a voluntary and settled wish to die by suicide, albeit your physical condition does not allow you to do so, you cannot receive assistance from another person to achieve your objective.

In conclusion, it would appear that in the UK the only legal method by which those who wish to commit suicide in order to avoid further unbearable pain and suffering, but cannot do so without the assistance of another, can overcome this dilemma is to seek a declaration of incompetence and, having obtained it, submit to the judicial *'best interests'* criteria which will result in an earlier than natural death!

While this, at first sight, might appear to be an outrageous suggestion, and one incapable of actual implementation, nonetheless it does highlight the apparent lack of logic which applies to the jurisprudential approach to the totality of third party assistance with death at English common law.

United States of America:

The thesis demonstrated clearly that the jurisprudential terrain in the matter of assisted suicide in the United States of America is uneven and that the likelihood of future *as applied* challenges[62] to state statutes prohibiting such assistance cannot be discounted. The fact that such a challenge has not emerged in the fifteen years since the decision in *Washington v Glucksberg*[63] is surprising. In any event, when such a case, or cases, occur – as they are bound to do – they will undoubtedly add to the colourful – and not always commendable - history of the jurisprudential approach adopted to third party assistance with death in that jurisdiction.

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[61] *[2012] BCSC 886.*

[62] As distinct from a *facial* challenge, i.e. one in which the challenger must establish that no set of circumstances exist under which the particular Act in question would be valid. See *United States v Salerno, 481 US (1987).* An *as applied* challenge is where the narrower question – whether particular laws are unconstitutional when applied to specific individuals – arises.

[63] *521 U.S.702 (1997).*

From the detailed analysis conducted it is evident that a tension prevails between a rights-based federal constitution and the independence with which individual states apply particular laws in the matter of third party assistance with death.

It was demonstrated that while much attention has been devoted to the advocacy of the putative constitutional right of an individual to decide the manner and timing of his or her own death – and more particularly to the alleged right of an individual to receive assistance with suicide – far less attention has been paid to the ideological entanglement of end-of-life issues with the divisive cultural conflicts in America on the question of where the boundaries between personal autonomy and public authority, and between individual freedom and the notion of a common good, lie.[64]

It is legitimate to ask what jurisprudential principles are to be extracted from the reasoning adopted and followed in the Courts of Appeal in the Second and Ninth Districts, and from that applied by the Supreme Court in *Washington v Glucksberg*, in the matter of a putative right to assistance with death?

Could it be possible that a future Supreme Court will recognise as legitimate an *as applied* challenge to a state law prohibiting assistance with death? It is difficult to disagree with the reflections of Yale Kamisar on these matters.[65]

First, notwithstanding their subsequent vacation by the Supreme Court the decisions *in Compassion in Dying v Washington* and *Quill v Vacco* are deeply evocative of the rights-based philosophical and jurisprudential approach which has characterised repeated attempts to change the law in respect of the availability of assistance with suicide from the 1960s onwards and is likely to continue to inform future endeavours in that regard.

Second, notwithstanding its inherent contradictions, together with the patently disparate reasoning evident in the separate statements by a number of the justices who sat in *Washington v Glucksberg*, it is nonetheless a robust re-affirmation of the law in respect of the constitutionality of state statutes prohibiting assisted suicide.

Third, *Washington v Glucksberg* provides the currently definitive touchstone for the evaluation by lower courts of any future applications for declaratory judgments of a putative constitutional right to assisted suicide.

Fourth, *Washington v Glucksberg* affords an invaluable insight into the not always consistent invocation and application by the Supreme Court of a particular suite of criteria when identifying the constitutional status of substantive new personal rights.

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[64] In this matter see, in particular, Nuland, SB, *'How We Die: Reflections on Life's Final Chapter', Knopf, New York, 1994.*

[65] See Kamisar, Y, *'Can Glucksberg survive Lawrence? Another Look at the End of Life and Personal Autonomy', Mich.Law Review, vol.106, No.8, June 2008.*

Fifth, *Compassion in Dying v Washington, Quill v Vacco* and *Washington v Glucksberg* graphically demonstrate the particular difficulties which United States courts, at all levels, are confronted by when striving to achieve an appropriate balance between the recognition of individual personal rights, such as autonomy and privacy, and the duty of the state to preserve life.

While it is improbable that such a balance will be achieved any time soon, the possibility that the Supreme Court could, at some future date, recognise an *as applied* constitutional challenge to a state statute banning assisted suicide, is indicative of the underlying jurisprudential uncertainty attaching to the issue of the inviolability of life in that jurisdiction.

Sixth, whether the overruling of *Bowers v Hardwicke*[66] in *Lawrence v Texas*[67] will eventuate in a re-consideration of *Washington v Glucksberg* in any subsequent determination by the Supreme Court in matters of individual personal rights is a moot issue.

In *Lawrence v Texas* the Court held that *"the State cannot demean [the] existence [of homosexuals] or control their destiny by making their private sexual conduct a crime."*[68] While Bowers remained good law the likelihood of the establishment of a constitutional right to physician-assisted suicide was remote. In *Lawrence,* however, the Court not only invoked the mystery-of-life passage in *Planned Parenthood v Casey*[69] with approval but also stated that the sweeping language of the passage *"explain[s] the respect the Constitution demands for the autonomy of the person in making choices"* such as those personal decisions *"relating to marriage, procreation...family relationships and childrearing."*[70]

This is in stark contrast to the stance adopted by the Supreme Court in *Washington v Glucksberg* in its dismissal of the interpretation accorded to the same mystery-of-life passage by both the court at first instance and the Ninth Circuit Court of Appeals when they both found its exposition of *"substantive"* due process inquiries *"highly instructive."*

A reconciliation of the disparate interpretations by the Supreme Court of a single passage contained in one of its previous findings would appear impossible.

Nonetheless, a simplistic interpretation of the finding in *Washington v Glucksberg* – to the effect that any future attempt at expanding the un-enumerated substantive rights adduced by the courts to reside in the procedural language of the *Fourteenth Amendment* to include one which would allow for assistance with suicide has been permanently neutralised – would be unwarranted. While the majority concurred that assisted suicide, historically, has never been condoned at American law – quite the contrary – nevertheless a number of the judges in the case were less definitive as to the permanent exclusion of any possibility of unconstitutional applications of such laws. The narrower question of an *as applied* right was not addressed by the Court.

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[66] *478 U.S.186 (1986).* Bowers criminalised private homosexual conduct.
[67] *539 U.S.558 (2003).*
[68] *Ibid at 578.*
[69] *505 U.S.833 (1992).*
[70] *539 U.S.558 (2003), at 574.*

It is contended that the fact that individual members of the then U.S. Supreme Court availed themselves of the opportunity presented by its review of the affirmative findings in respect of the unconstitutionality of laws prohibiting assisted suicide in the states of Washington and New York respectively, to leave open the possibility that consideration to a constitutional right to assisted suicide for competent, terminally ill persons in an appropriate future case might be met with something more than expressions of sympathy is emblematic of the unremitting discord which has characterised the subject of assisted death throughout the relatively short history of the United States.

As mentioned earlier,[71] much of this discord is attributable to those endeavours which are aimed at expanding the scope of the principle of personal autonomy.

Notwithstanding trenchant disavowals by those who campaign for such an expansion of intentions other than allowing for the legal provision of assisted death for those who are terminally ill, adult, competent and who voluntarily express a clear wish to opt for death, the not completely unfounded suspicion persists that the emphasis on voluntariness is nothing more than a strategic step on the way to a more ambitious goal, namely the legalisation of active voluntary euthanasia.[72]

Assisted suicide continues to be prohibited in all states other than Oregon, Washington, Montana and Vermont. However, it is can no longer be stated with any certainty that by the time the Supreme Court is faced with an *as applied* challenge that more states will not have been added to this list.

Canada:

The traditional proscription of third party assistance with death[73] in Canada was thrown into jurisprudential confusion as a result of the recent decision by the Supreme Court of British Columbia in *Carter v Canada*[74] in which *section 241(b)* of the *Criminal Code*[75] was struck down on the grounds that it infringed *ss. 7*[76] and *15*[77] of the Canadian *Charter of Rights and Freedoms* and as a consequence was unconstitutional. This decision is currently on appeal. In summary the judge in the case held that the impugned provisions unjustifiably infringed the claimant's rights and freedoms. They were, therefore, of no force or effect, to the extent that they prevent physicians from providing assisted suicide, and voluntary euthanasia, to certain classes of persons. The ruling pertained specifically to cases of physician-assisted suicide or homicide.

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[71] See Chapter VII on America supra.

[72] See Epstein, R, *'Moral Peril: Our Inalienable Right to Health Care?', 1999.*

[73] The 1995 Report of the Special Committee of the Senate of Canada, entitled *'Of Life and Death'*, defined euthanasia as *"the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering where that act is the cause if death."*

[74] *[2012] BCSC 886.*

[75] *Section 241(b)* prohibits assistance with suicide. *Section 14* of the *Criminal Code* provides that no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

[76] *Section 7* provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[77] *Section 15(1)* provides that every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based in race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

In effect, it was concluded that the law should allow physician-assisted suicide in cases involving patients who are diagnosed with a serious illness or disability and who are experiencing *"intolerable"* physical or psychological suffering with no prospect of improvement. Likewise, it was held that a remedy to protect the vulnerable from the loss of the *section 7* right to life, liberty and security of the person could be made available by way of the imposition of legal restrictions in a regime which permits of physician-assisted suicide.

Prior to the decision in Carter the *locus classicus* in the matter of the constitutionality of the proscription of physician-assisted suicide was *Rodriguez v British Columbia*[78] in which the Supreme Court had held that *s.241(b)* of the *Criminal Code* did not infringe the appellant's rights under *ss.7* and *12* of the *Charter of Rights and Freedoms* and, although her right to security of the person was engaged, any resulting deprivation was not contrary to the principles of fundamental justice. The Court concluded similarly with respect to any liberty interest which might have been involved.

The thesis conducted a detailed analysis of the judicial reasoning adopted and followed in both *Rodriguez* and *Carter.*

It will be recalled that in delivering the decision of the majority in *Rodriguez* Sopinka J held that the appellant's liberty and security of the person interest under *s.7* of the *Charter* could not be divorced from the sanctity of life, the third value protected by *s.7.* The Court rejected the argument that for the terminally ill the choice is one of time and manner of death rather than death itself since the latter is *"inevitable"*. It was concluded that that security of the person guaranteed under *s.7* encompassed personal autonomy, at least with respect to the right to make choices regarding one's own body, control over one's physical and psychological integrity and basis human dignity. Section *241(b)* did operate to deprive the appellant of autonomy over her person and caused her physical pain and psychological stress in a manner which impinged on the security of her person. The Court was satisfied, however, that any resulting deprivation was not contrary to the principles of fundamental justice.

It was found that the blanket prohibition on assisted suicide akin to that contained in *s.241(b)* of the *Criminal Code* was the *"norm among Western democracies"* and that such prohibition had never been adjudged to be unconstitutional or contrary to fundamental human rights. The impugned provision was *"valid and desirable"* and pursued the government's objectives of *"preserving life and protecting the vulnerable."*

In *Carter* Lynn Smith J held that the prohibition on assisted suicide contained in *s.241(b)* of the *Criminal Code* to be unconstitutional because it was inconsistent with the principles of fundamental justice and was disproportionate. The impugned provision unjustifiably infringed the plaintiff's rights to life, liberty and security under *s.7*, and also her equality rights under *s.15* of the *Charter*.

In departing from the authority of the Supreme Court's decision in *Rodriguez* Lynn Smith J averred first, that proportionality analysis had been significantly developed since the decision in *Rodriguez*

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[78] *[1993] 3 SCR 519.*

and second, that new evidence from jurisdictions in which the ban on assisted suicide had been relaxed, which was not available to the Supreme Court in *Rodriguez*, had since become available.

The judge concluded that the prohibition on assisted suicide had "*more burdensome*" and "*very severe and specific deleterious*" effects on persons with physical disabilities. She rejected the argument for a distinction between the withdrawal of treatment to bring about the end of a person's life and the act of physician-assisted suicide. She was of the opinion that such a "*bright-line distinction is elusive.*" She held, therefore, that due to it unqualified nature, the impugned provision did not impair the *Charter* rights as little as possible. Rather, on the evidence before the Court, and summarising her findings in relation to her examination of the legislation she stated that:

"*Less drastic means of achieving the legislative purpose would be to keep an almost absolute prohibition in place with a stringently limited, carefully monitored system of exception allowing persons in Ms Taylor's situation – grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress – to access physician-assisted death.*"[79]

Thus, it was held, the legislation did not meet the requirement of minimal impairment, and it was found that the absolute prohibition on assisted suicide fell "*outside the bounds of constitutionality.*" *Section 241(b)* was declared invalid and struck down by the court. The operation of this declaration, however, was suspended for one year in order to afford Parliament an opportunity to amend the impugned provision accordingly. A constitutional exemption was granted to the appellant, allowing her to avail of physician-assisted suicide during the period of suspension, subject to a number of court-imposed conditions. However, the appellant passed away unexpectedly due to the contraction of an infection before any such assisted was provided.

Notwithstanding the fact that the *Carter* decision is on appeal the judicial reasoning adopted and followed in it has been invoked in a number of similar cases in other jurisdictions, most notably in *Fleming v Ireland*[80] in the Irish High Court.[81] In the event the three judge court forensically dismantled the reasoning applied by Lynn Smith J and held that it was inapplicable at Irish law. While it would be foolhardy to attempt to predict the outcome of the appeal of the *Carter* finding it would be a matter of considerable surprise if it did not concur with the analysis conducted by the Irish court.

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[79] *[2012] BCSC 886, at para. 16.*

[80] *[2013] IEHC 2.*

[81] The High Court decision not to grant an order declaring that section 2, sub-section (2) of the Criminal Law (Suicide) Act, 1993, to be invalid having regard to the provisions of the Constitution, or to grant an order declaring that the same section was incompatible with the State's obligations under the European Convention on the Protection of Human Rights and Fundamental Freedoms, or in the alternative, an order directing the Director of Public prosecutions, within such time as seem just and appropriate, to promulgate guidelines stating the factors that will be taken onto account in deciding, pursuant to section 2, sub-section (4) of the Criminal law (Suicide) Act, 1993, whether to prosecute or to consent to the prosecution of any particular person in circumstances such as those that will affect a person who assists the appellant in ending her life , was appealed to the Supreme Court. In the event the Court upheld the High Court's decision.

Shortly before the decision in *Carter* the Royal Society of Canada Expert Panel's Report '*End of Life Decision Making*'[82] stated that "*it can be inferred*", based on the results of the various surveys that have been held from the med-1990s onwards, "*that the majority of the Canadian public would support legislation permitting voluntary euthanasia and assisted suicide for people suffering from incurable physical illness.*"

In Canada, the level of public support for legalising voluntary euthanasia and assisted suicide is comparable to that in the UK, but markedly higher than that in the United States of America, according to a 2009 survey of national samples.[83] Canadians demonstrated slightly less support (**71%**) than that of Britons (**77%**) and nearly twice that of Americans (**45%**). By a measure of public support, Canada appears to be roughly equal to the Netherlands,[84] where both voluntary euthanasia and physician-assisted suicide are carried out legally.[85]

When compared with the general public, physicians in Canada, as in other jurisdictions,[86] are significantly less supportive of legalising voluntary euthanasia or assisted suicide, and many are vehemently opposed. Al though the reasons for such opposition have not been sufficiently explored among Canadian physicians, studies of American and British doctors suggest a strong association between opposition to legalising physician-assisted suicide and voluntary euthanasia and religious belief.[87]

In *Carter* the respondent – the State – submitted that notwithstanding the findings of any opinion poll or survey, whether in favour or not of an amelioration of the proscribing euthanasia and assisted suicide, methods of estimating public opinion were unreliable and were of no assistance to the Court. Similarly, lawyers for British Columbia argued that public opinion were not relevant to the determination of societal consensus and cited *Suresh v Canada (Minister of Citizenship and Immigration)*[88] in support. Rather, Canadian consensus was to be found in the refusal of successive governments and Parliaments to legalise assisted dying, in the Special Senate Committee Report[89] and in the position of the Canadian Medical Association,[90] statutory and judicial pronouncements, and the views of individual palliative care physicians. Meanwhile, international consensus was to be found in the overwhelming majority of Western democracies that prohibit the practices.

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[82] *RSC, November, 2011, 170 Waller Street, Ottawa, ON K1n Ob9, www.rsc.src.ca.*

[83] *'Britons, Canadians on the same page on legalising euthanasia.' Angus Reid Global Monitor: San Francisco, September, 2009. http://www.angus-reid.com/.*

[84] Rierjens, JA, Heide van der A, Onwuteaka-Philipsen, BD, Mass van der PJ, Wal van der G, *'A Comparison of attitudes towards end-of-life decisions: survey among the Dutch general public and physicians', Social Sciences and Medicine, 2005, October, 61(8):1723-32.*

[85] See Rietjens, JA, Heide van der A, Onwuteaka-Philipsen, BD, Maas van der PJ, Wal van der G, *'Preferences of the Dutch general public for a good death and associations with attitudes towards end-of-life decision-making', Palliative Medicine, 2006, October, 20(7): 685-92.*

[86] See fn.78 Chapter VIII on Canada supra.

[87] See fn.79 ibid.

[88] *[2002] SCC 1.*

[89] *'Of Life and Death', 1995,available at <http://www.parl.gsa.ca/content/SEN/Committee/351/euth/rep/led-tc-e.htm>*

[90] *'Euthanasia and Assisted Suicide', The Canadian Medical Association, Ottawa, 2007.*

Ireland:

Prior to 2012 Irish courts had not been asked to adjudicate on the legitimacy or otherwise of assistance which was intended to bring about an earlier than natural death in the case if a competent person who had expressed a voluntary wish to die by suicide but could only do so with the help of another.

Neither had they been asked whether the statutory prohibition of such assistance was capable of amelioration in specifically defined circumstances.

Likewise, the question whether the criminal proscription of assisted suicide was constitutionally invalid or incompatible with the European Convention on Human Rights had never previously been in issue.

This scenario changed in 2013 when proceedings in respect of a claim that *section 2(2)* of the *Criminal Law (suicide) Act, 1993,* which criminalises assisted suicide, be declared invalid having regard to the provisions of the Constitution, and incompatible with the rights of the claimant pursuant to the European Convention on Human Rights and Fundamental Freedoms, came before the High Court in *Fleming v Ireland.*[91]

The Court held that the claims of unconstitutionality and ECHR compatibility were without substance. It re-affirmed the criminal proscription of third party assistance with death, irrespective of circumstances.

The observations of the court in the matter of the future role of the Director of Public Prosecutions, and specifically whether it might be appropriate for her, in a case of assisted suicide, to give *"full and careful consideration"* to evidence of compliance with those prosecutorial policy factors invoked in other jurisdictions, particularly those of the English Crown Prosecution Service, gave rise to some jurisprudential surprise.

The implication of these observations is that while the DPP is statutorily prohibited from doing what is done elsewhere, nonetheless she could be expected, albeit in an ex post facto context, to deal with cases in a similar fashion, but based on the very guidelines she is not entitled to promulgate! While the Supreme Court, in its decision to uphold the substantive findings of the High Court's decision, did not refer to the observations made by the three judge panel in the lower court nonetheless, it was considered appropriate to subject them to examination and analysis in this thesis.

The High Court averred that the English Crown Prosecution Service guidelines *"provide considerable assistance"* in the prosecutorial approach to a case of assisted suicide. It is contended that the approach adopted by the Court, in effect, was an overt invitation to the legislative authorities to change the law in respect of the discretionary powers of the DPP in this sensitive matter. Its averment that the very existence of the UK guidelines *"must surely inform any exercise of discretion*

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[91] *[2013] IEHC 2.*

by the DPP in this jurisdiction" are not capable, it is submitted, of any other interpretation. However, the assuredness with which this *'observation'* was delivered is devoid of both logic and legal rationality. In particular, it is unclear what criterion was employed to permit the statement that *"without being compelled in an impermissible way under our law to issue offence-specific guidelines, the Director in this jurisdiction is nonetheless in as good a position* ***as the Director in the UK as an incidental beneficiary of what happened in that jurisdiction."***[92]

As stated previously,[93] it is troublesome that a superior Irish court, having clearly established that it is not within the remit of an arm of the State to issue offence-specific guidelines, and having unequivocally endorsed that position, nevertheless - and in what can only be described as a permissive tone - virtually enjoin the Director of Public Prosecutions not alone to use the guidelines of a neighbouring common law jurisdiction as a template in arriving at a decision whether to prosecute a case of assisted suicide but to allow herself also to be guided by factors identified, but which are not currently operational, by a court in another common law jurisdiction, namely Canada.[94]

There is a disturbing element of active judicial endeavour evident throughout the unanimous judgment in *Fleming v Ireland* and one which does not do any credit to either the reputation of the justice system as a whole in matters as fundamental as those with which the Court grappled, or to that of the justices involved.

Were the Director to heed this judicial advice, and were it to become known that she had done so, it is not unreasonable to suggest that unless a person who was physically unable to fulfil his or her intention to commit suicide, and who required assistance of another person to do so, was a complete and utter fool, careful observation of the readily available English guidelines, or those identified in *Carter v Canada*, it would be likely that the DPP would spend considerably more time than heretofore exercising her discretion not to prosecute cases of assisted suicide, and would do so in the knowledge that she had the endorsement of no less an institution than that of the High Court.

While it may be a matter of some consolation to those who believe that the function of the courts is to uphold the law, and not to instigate jurisprudential rebellion, that the Director of Public Prosecutions is unlikely, of her own volition, to heed the enjoinment of the High Court in this matter, it would have been of even greater comfort had the Supreme Court, in exercising its appellate authority, discouraged those who, as a result of an unprecedented display of judicial hubris, believe that assisted suicide may, in the future, be carried out with impunity. Unfortunately, and for whatever reason, the Supreme Court decided to ignore the observations of the High Court.

However, this is a matter that will undoubtedly appear on the jurisprudential horizon in the not too distant future.

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[92] *[2013] IEHC 2, at para 171.* Author's emphasis.

[93] See Chapter IX on Ireland supra.

[94] The Court cited a list of factors – in support of public interest considerations which would tend towards non-prosecution in the case of an assisted suicide – which had been identified in *Carter v Canada [2012] BCSC 886.* It alluded to these factors *"to the extent that they add value to the exercise of the Director's discretion, and may also be taken into account by her in this jurisdiction." Fleming v Ireland [2013] IEHC 2, at para 172.*

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