

What Can Oregon Teach Australia about Dying?

Lyn Carson¹ & Brette Blakely²

¹ Business Programs Unit, The University of Sydney Business School, Sydney, Australia

² School of Humanities and Communication Arts, University of Western Sydney, Sydney, Australia

Correspondence: Lyn Carson, Business Programs Unit, The University of Sydney Business School, Sydney, Australia. E-mail: lyn.carson@sydney.edu.au

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Abstract

Australia has an unusual history with regards to the legalisation of voluntary euthanasia and assisted suicide. The first people to die through legalised physician aid in dying did so in the Northern Territory under the *Rights of the Terminally Ill Act* which was passed in 1995. However, after intervention by the federal government, no territories in Australia are allowed to pass legislation legalising voluntary euthanasia or assisted suicide. No states have since succeeded in passing any acts either, despite a high level of public support for these end of life options. This paper looks at the process by which other jurisdictions have legalised either voluntary euthanasia or assisted suicide, to help understand the current Australian situation.

Keywords: assisted suicide, euthanasia, end of life, Australia, Oregon

1. Prologue

At the 2011 Sydney Film Festival one of the authors (Carson), was riveted by a film, *How to Die in Oregon* (Note 1). It told the story of Oregon's legislation which countenances physician assisted dying. The author noted the parallels between Oregon, and the Northern Territory where legislation existed for less than a year before it was quashed by the Australian parliament. Oregon had to withstand many challenges including federal intervention before its Act was recognised and came into effect. But it was the personal stories in this award-winning documentary which captured the author's attention. One cancer sufferer takes his own life while reassuring viewers, "It was easy folks, it was easy." The main focus is on a woman in her 50s dying from liver cancer; her story and physical deterioration is harrowing. She eventually takes her own life with considerable dignity. Today, as we write, a mass murder is reported in the US—a dozen dead and more than 50 wounded in a cinema in Colorado. Many Americans remain convinced that personal gun ownership is a right that is too important to give away. There are some influential advocates for the right to bear arms (Note 2), and, in 2012, this right extends to high-powered assault weaponry. The US is, therefore, a curiosity to those of us who hear of mass murders in the same breath as its citizens' insistence on armed self-defence while simultaneously expressing outrage when someone wants to die in peace, on their own terms.

The authors can recall the Karen Ann Quinlan case. In 1976 the New Jersey Supreme Court permitted her parents to turn off the artificial respirator—an important landmark for advocates of assisted dying. In 1983 author Arthur Koestler made quite an impact when he committed suicide (alongside his wife); Koestler was terminally ill, his wife was not. In 2005 American media was dominated by the fight between those wanting to keep forty-one year old Terry Schiavo alive—even though she had been in a vegetative state for a decade—and those who wanted life-support to be denied.

Opponents of assisted dying are often, but not always, motivated by religious beliefs and rulings such as that in 1980 when Pope John Paul II issued a declaration opposing voluntary euthanasia (whilst permitting painkillers to ease pain as well as the right to refuse extraordinary means for sustaining life (Note 3)). The argument is not this simple, but could be expressed as: "God has given life to us; only God has the right to take it away". However,

[a] great many people instinctively feel that suicide and assisted suicide are such individual acts of freedom and free will that they assume there are no legal prohibitions. This fallacy has brought many people into trouble with the law. While suicide is no longer a crime – and where it is because of a failure to update the law it is not enforced – assistance remains a crime almost everywhere by some statute or other (Humphry, 2005).

This leaves us in a quandary. Advances in medical science and improved quality of life means that people are now living longer (Australian Bureau of Statistics, 2011) and also taking longer to die from terminal illnesses. How we die is an extremely personal issue, and, mostly, no-one has the choice about how to die. Death chooses us, via a sudden heart attack or stroke, for example. However, for some, life goes on for too long and these people want to end the extreme suffering which can precede their inevitable death. Sometimes they want only the *means* to end their life—giving them a much-needed level of control. Approximately 100,000 people can expect to die this year in Australia due to old age or diagnosed terminal illness which has no suitable treatment (a number which is likely to grow as the population ages). The experience in Oregon suggests that people wish to shorten their lives because of a loss of autonomy and dignity—pain and fear are distant factors (Lewis, 2012). Baby boomers will surely demand their right to die.

Societies are confronted by many intractable problems (e.g. climate change, asylum seeking, water management) that cross departmental boundaries and transcend state/national borders. Physician assisted dying is one of these issues which affects everyone, and where, in Australia, public opinion is not reflected in the legislation. Surveys regularly show overwhelming support by Australians for assisted dying legislation (typically more than 80%). How, then, might Australians be brought into a public deliberation about these matters? How might they become part of the political discussion? This became a quest in 2012: for one of the authors to convene public conversations (Note 4) on the topic “Who decides how we die?” Four were convened by the time this paper was written. More are scheduled. What follows are the facts that were collected along the way.

2. Background

Ohio was the first state to introduce a bill for assisted dying—in 1906—and it was unsuccessful. Many American states have continued to try, and a few have succeeded (more about these later). Various places have tackled the needs of the terminally ill either by enacting legislation or demonstrating tolerance for assisted suicide, often in quite different ways, having followed disparate policy-making trajectories. For example, Oregon began with a ballot initiative, so too did Washington. Montana did not.

Concern over the suffering of those with life-limiting illness has contributed to an increased debate about end-of-life choices; including refusal of life sustaining treatments, cessation of treatment, unintended hastening of death using pain relief, and intentional physician assisted dying. This last category includes assisted suicide and voluntary euthanasia. For the purposes of this paper, assisted suicide means where a person who requests assistance to end her/his own life is assisted by another person to *self-administer* life-ending treatment. Assistance may include the writing and issuing of a prescription, by a doctor and a pharmacist, for a lethal dose to bring about a peaceful death. In contrast voluntary euthanasia is the *administration* of life-ending treatment by someone other than the person requesting to die, usually by the person’s attending doctor. These two forms of physician aid in dying (Note 5) have been legalised through a variety of mechanisms in several places around the world.

The reader might wonder about Scandinavian countries. Why do none have legislation? One might expect this group of countries to adopt a liberal view in relation to assisted suicide but this is not necessarily so. There have been court cases in Sweden and Norway involving people who have assisted others to die. Finland seems not to act against those who do so and Denmark has no specific law. In other words, some countries, including Scandinavian countries, have mechanisms within their criminal code which enable prosecution of those who assist another to die, defining this as manslaughter or murder. Others do not. There are countries that ban books which give advice about assisted suicide or voluntary euthanasia (France is one, Australia is another).

Some countries (not Scandinavian ones) have legislation approving assisted euthanasia, but most do not (Humphry, 2005). This paper focuses on those places (countries and states) that openly and legally enable physician aid in dying: three US states—Oregon, Montana, Washington, and four European countries—Switzerland, The Netherlands, Luxembourg and Belgium. The first section outlines the history leading to legalisation. In the section which follows, the current situation is explained. Finally, Australia is analysed, by state, including where legalisation was achieved and then reversed by federal ruling. The overall situation is discussed in the concluding section.

3. History of Legislation in Seven Jurisdictions

3.1 Switzerland

Switzerland’s situation in regards to assisted suicide is very different from that of other countries. The Swiss penal code, established in 1937 and came into effect in 1942, does not prohibit suicide, nor does it prohibit assistance with suicide if free from personal motivation (*Homicide. Inciting and assisting suicide*, 1937).

However, there is still much debate over both assisted suicide by physician, and voluntary euthanasia. First, this approach means that legally, someone does not need to be terminally ill to be assisted in suicide (see **Current situation** later). Importantly, physicians are not given any special standing; meaning that anyone can assist someone to die, as long as they are not selfishly motivated (Hurst & Mauron, 2003). Organisations such as Exit Deutsche Schweiz and Dignitas have been helping both local and overseas people commit suicide for decades (Fischer et al., 2008). This may give the impression that the Swiss are extremely liberal in these issues; however, this is far from the case, and there is much debate in Switzerland around the role of physicians and the sanctity of life.

One of the first major events in the modern debate on assisted dying was the submission of a new Article 115 presented by National Councillor Victor Ruffy in 1994 (Swiss National Advisory Commission on Biomedical Ethics, 2005). Due to the ensuing debate the Federal Department of Justice and Police (EJDP) set up a Working Group in 1997 which recommended alteration to penal code allowing voluntary euthanasia (again not exclusively for physicians (Hurst & Mauron, 2003)) in very particular cases (Swiss National Advisory Commission on Biomedical Ethics, 2005). These recommendations were rejected by the National Council in 2000. However, in 2003 the Council of States approved a motion for voluntary euthanasia from the Committee for Legal Affairs of the Council of States (Swiss National Advisory Commission on Biomedical Ethics, 2005). With the debate back in parliament, the Swiss National Advisory Commission on Biomedical Ethics (NEK) was asked to examine the issue. As the motion was passed by the National Council, it then sat before the Federal Council, increasing the need for further investigation and debate (Swiss National Advisory Commission on Biomedical Ethics, 2005).

Meanwhile, the Swiss Academy of Medical Sciences (SAMS) issued an opinion in 2004, outlining criteria for physician-assisted suicide which: focused on only those who were near death, advised that it was a personal decision for the physician, ensured the request met particular criteria, and declared that the acting physician could not issue the death certificate and must report the event as an unnatural death. In the same document, they also expressly forbade euthanasia in any form as a crime falling under Article 114 of the penal code (Swiss Academy of Medical Sciences, 2004). Following this, the advice of the NEK in 2005 was similar, and advocated no change in the legislation (Swiss National Advisory Commission on Biomedical Ethics, 2005). The following year, NEK issued a second statement outlining minimum duty of care criteria for assisted suicide including absence of external factors, mental illness or depression, the exhaustion of alternatives, and the need for a second opinion (Swiss National Advisory Commission on Biomedical Ethics, 2006).

3.2 Oregon

Oregon was the first state in the US to legalise physician assisted suicide, and therefore was subject to some of the most fervent opposition. Oregonians first passed the Oregon Death with Dignity Act (Measure 16) in November 1994, by a slim margin of 51% to 49% (Chin, Hedberg, Higginson, & Fleming, 1999). However, it took three years before it could be implemented due to a legal injunction imposed by a ruling at the U.S. District Court level by Chief Judge Hogan. He supported claims by the plaintiffs, Gary Lee *et al.*, that Measure 16 violated the Equal Protection Clause of the Fourteenth Amendment of the US Constitution by singling out terminally ill patients and no longer protecting them from suicide ("Lee v. State of Oregon," 1995). This injunction was removed by the Ninth Court of Appeals on October 27, 1997 which argued against the likelihood of the measure to cause unwanted deaths and also found that, as the plaintiffs were arguing "hypothetical" fears, that the federal court did not have jurisdiction ("Lee v. State of Oregon," 1997). Soon after, in November of the same year, measure 51 repealing the Death with Dignity Act was also placed on the general ballot and rejected by 60% of Oregonians (Chin, et al., 1999).

The twice affirmed *Oregon Death with Dignity Act* has since held, but not without significant opposition. On November 6, 2001 US Attorney General John Ashcroft interpreted the Controlled Substances Act to prevent physicians from writing prescriptions for the barbiturates typically used (Oregon Health Authority, n.d.). This became known as the "Ashcroft directive" ("Oregon v. Ashcroft," 2002). This was only a temporary impediment to physicians, though, as Oregon filed a lawsuit and on November 20, 2001 a restraining order was placed on Ashcroft's interpretation by a district court until a trial could be held (Oregon Health Authority, n.d.). At the following trial, District Court Judge Robert Jones upheld the Death with Dignity Act with a ruling on April 17, 2002, finding that Ashcroft exceeded his powers in issuing the directive (and questioned his processes which did not include issuing any notifications or asking for comments) ("Oregon v. Ashcroft," 2002). During his opinion, Judge Robert Jones also referenced the Supreme Court decision in *Washington v. Glucksberg*, 521 U.S. 702, 735, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997) where the court considered states as able to resolve these issues

themselves through the democratic process, making specific reference to Oregonians voting in favour of the Death with Dignity Act ("Oregon v. Ashcroft," 2002; Washington v. Glucksberg," 1997).

Undeterred, Attorney General Ashcroft continued his campaign to defeat this measure, appealing unsuccessfully to the 9th Circuit of Appeals ("Oregon v Ashcroft," 2004). Ashcroft's term having ended, then U.S. Attorney General Alberto Gonzalez appealed finally to the Supreme Court, where the Oregon Death with Dignity Act was again upheld and the Ashcroft directive considered beyond the powers granted to the Attorney General in the Controlled Substances Act ("Gonzales v. Oregon," 2006).

Since 1997, minor refinements have been made to the Act, for example to clarify the documentary requirements that establish proof of residency in Oregon.

3.3 *The Netherlands*

The delay between public approval and legislative action on physician aid in dying is perhaps most clear in the case of the Netherlands. Assisted suicide and voluntary euthanasia are specifically prohibited in the Dutch penal code (Section 294 and 293 respectively) (Leenen, 1987). Despite this, both the criminal courts and the public have a history of condoning voluntary euthanasia. This tolerance can be traced back, formally, to 1973 when a doctor was convicted of killing her dying mother by request with an overdose of morphine. Her sentence, however, was only symbolic and the Leeuwarden court, in its decision, laid out the circumstances under which voluntary euthanasia would go unpunished (Leenen, 1987). Thus, criteria for 'legal' euthanasia were first established:

- the patient is incurably ill,
- the patient suffers unbearably,
- the patient has requested the termination of his life,
- the termination of the patient's life is performed by the doctor who treats the patient or in concert with him (Leenen, 1987).

Through another case, a Rotterdam court in 1981, similarly described the conditions under which assisted suicide would go unpunished (Leenen, 1987). Through these, and a series of other cases which were appealed through various courts culminating in the decision of the Supreme Court in 1984 that 'force majeure' (an unavoidable circumstance necessitating the committing of a crime) could exempt from criminal liability a doctor needing to decide between ending suffering and prolonging life, euthanasia and assisted suicide were thus essentially legalised under certain circumstances (Gevers, 1987; Gevers, 1996; Leenen, 1987). These rulings were also supported by a statement from the Royal Dutch Medical Association, aiming to give clarity and guidance, which also made euthanasia under certain circumstances professionally allowable (Gevers, 1987; Gevers, 1996).

These rulings were in line with general public opinion and, in part, prompted the government to establish the State Commission on Euthanasia in 1982. In a majority opinion, the commission stated that it was in favour of legalising euthanasia under the condition "...that the patient should be in a untenable situation with no prospect of improvement" ("Final Report of the Netherlands State Commission on Euthanasia: an English Summary," 1987). It further highlighted the importance of definitive legislation, rather than the continued difficulties of interpreting court actions (which depended on each case and so varied as to the culpability of the doctors in ways which were unclear to the public) stating that "[T]he State Commission deems it essential for Parliament to make plain its position on euthanasia" ("Final Report of the Netherlands State Commission on Euthanasia: an English Summary," 1987). A draft bill was presented to the Dutch Parliament, which seemed predominantly to support the legislation. However, the Christian Democrats, in office at the time and unsupportive of the bill, delayed voting through the presentation of a more stringent version, resulting in both bills being referred to the Council of State (Gevers, 1987; Leenen, 1987). In the meantime, an election was held in which the Christian Democrats were reinstated. Based partially on the statement from the Council of the State in July 1986, the government declared on January 16, 1987 that it would not enact legislation on euthanasia, but wait for more court rulings (Gevers, 1987; Leenen, 1987).

This left the issues of reporting, death certificates, autopsy and burial unclear. Therefore, in 1990, the Royal Dutch Medical Association and the Minister of Justice agreed on new procedures for physicians: they would fill out a detailed questionnaire, which went to the medical examiner who passes the information onto the district attorney, who then satisfies him/herself whether the criteria set out by the court rulings have been met and decides if prosecution is warranted (Gevers, 1996). As a result, *reported* cases of euthanasia rose dramatically (Gevers, 1996). During this time, a government inquiry was also conducted, gathering information about the end of life decisions routinely made by doctors. As a result, the number of deaths involving physician assistance of all types was established, including 0.8% which involved euthanasia without persistent request (Gevers, 1996).

The government reacted to the results of the inquiry by refusing to legalise voluntary euthanasia, but suggesting the new reporting processes be incorporated into the *Burial Act* (Gevers, 1996). Finally, in November, 2000 the Dutch *Termination of Life on Request and Assisted Suicide Act* was passed (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, 2000).

3.4 Belgium

Belgium was the second country to legalise voluntary euthanasia. Although the resulting legislation bears some resemblance to the Dutch law, the history of legalization is very different. While in the Netherlands there was a history of leniency towards voluntary euthanasia which was reflected in court ruling, ultimately establishing legal guidelines for acceptability, Belgium did not have any of this court sanctioning.

A very detailed report by Maurice Adams (2001) describes a fairly long history of debate in Belgian politics. Historically, neither voluntary euthanasia nor assisted suicide were specifically addressed in the penal code, but they could be prosecuted under various related criminal codes (Adams, 2001). The Belgian Medical Association Rules of Conduct also specifically prohibited both voluntary euthanasia and assisted suicide (Adams, 2001). Debate around the issue increased through the 1980's although, with the more conservative Christian Democrats leading the country, there was little chance of any change in legislation (Adams, 2001). Through the 1980's and 1990's debate raged over the issue and commissions were established to help advise on issues relating to end of life (Adams, 2001). Weighing heavily into the debate in 1997 was the advice of the Advisory Committee for Bio-ethics, a committee established for the investigation of such issues. The Advisory Committee for Bio-ethics discussed the desirability of legislation specifically on voluntary euthanasia; however, as it was formed to represent all segments of society, it offered four varying proposals which covered the spectrum from legalising, to formally making illegal (Adams, 2001).

The political debate continued to rage. However, in 1999 something unexpected happened: the conservative Christian Democrats lost power in the June elections, leaving the way clear for a coalition of the Liberals, Socialists and Greens (Adams, 2001). Old and new bills on voluntary euthanasia were presented to the new government. The political parties fought over specific aspects and in 2000 a Senate Committee held hearings on the most recent bill being considered; this was followed by more back and forth over details. Then, information regarding voluntary euthanasia rates in Belgium was published, which put into perspective many of the issues, and importantly demonstrated the small amount of cases being considered (Note 6) (Adams, 2001; Deliens et al., 2000).

After significantly more debate and hundreds of revisions, the Belgian Act on Euthanasia was passed on November 5, 2001, along with a sibling Act which doubled funding for palliative care. Due to the lack of slow reform seen in the Netherlands, it was considered by some a sudden change (Deliens & van der Wal, 2003).

3.5 Montana

Mr. Robert Baxter along with Compassion and Choices and four physicians brought suit against the state of Montana claiming that not allowing physician assisted suicide was unconstitutional. They did so on three grounds. First, within Montana's constitution, Article II Section 4, is a guarantee of equal protection (*The Constitution of the State of Montana*, 1974). This was interpreted by Baxter et al as meaning that while terminally ill patients could ask for physician assistance in dying through the withdrawal of treatment (and be protected from the charge of homicide by Section 50-9-205 MCA), terminally ill patients without that option were being denied the same right of physician assistance in dying ("Baxter v Montana," 2008). This logic had already been refuted by the U.S Supreme Court which drew a distinction between refusing treatment as an act which protects a body from invasive processes and the active process of ending a life ("Vacco v Quill," 1997).

Secondly, they argued that Article II Section 4 also states that "[T]he dignity of the human being is inviolate" ("Baxter v Montana," 2008). Previously, this dignity had been interpreted by several courts, including the U.S. Supreme Court, to include the concept of self-determination and basic choices about the meaning of life. These ideas were reflected in the ruling in *Planned Parenthood of Southeastern Pennsylvania v Casey* 505 US 833 (1991) which was also quoted in the case of *Compassion in Dying v State of Washington* 850 F. Supp 1454 (1994) to apply to end of life choices ("Baxter v Montana," 2008; *Compassion in Dying v State of Washington*, 1994). Hence Judge McCarter supported this interpretation of the Montana constitution as protecting end-of-life choices ("Baxter v Montana," 2008).

The third basis for the plaintiffs' argument was Article II, Section 10, which guarantees privacy ("Baxter v Montana," 2008; *The Constitution of the State of Montana*, 1974). Judge McCarter asserted that the right to privacy, within Montana, was considered more stringently protective of the individual against intrusion by the

government than interpretations at the federal level for the corresponding U.S. Constitutional right to privacy ("Baxter v Montana," 2008). Together, the more stringent interpretation of privacy, with the concept of dignity reflected in *Casey* ("Planned Parenthood of Southeastern Pennsylvania v Casey," 1992), Judge Dorothy McCarter ruled that the right of the terminally ill to choose the manner of their death was protected by the state constitution ("Baxter v Montana," 2008). As the right to an abortion necessitates freeing physicians from the charge of homicide, likewise, Judge McCarter ruled that his interpretation of the Montana Constitution meant that physicians who prescribed lethal drugs to terminally ill patients could not be prosecuted under that state's homicide laws ("Baxter v Montana," 2008).

On appeal to the Montana Supreme Court, Judge McCarter's interpretation of the constitution was not upheld as it was decided that the case could be reviewed without making a constitutional decision ("Baxter v Montana," 2009). Historically, Montana has no specific legislature on physician assisted suicide or euthanasia. Suicide is not illegal in Montana; rather section § 45-5-105 (Mont. Code Ann. *Aiding or soliciting suicide*) of the criminal code allowed prosecution only for failed assisted suicide, with the assumption that all successful cases would constitute homicide. However, consent is a legal defence in Montana (Mont. Code Ann. §45-2-211 (2)(d) *Consent as a defense*) where the person wishing to hasten death is able to give consent and where it is not against "public policy" to allow the action. The Montana Supreme court assumed that the ability of the individual to give proper consent (i.e. make an informed request), was case specific and focused on the public policy issue. It found that there was nothing within Montana law to suggest that the prescribing of lethal medication for the terminally ill was against public policy; in fact they found it was in line with the reasoning of the Mont. Code Ann. § 50-9-103 (*Montana Rights of the Terminally Ill Act*). Thus, as the act itself was up to the patient (hence technically suicide) and suicide itself is not illegal, they ruled that physician aid in dying (by means of supplying a lethal drug for self-administration) was legal in the State of Montana ("Baxter v Montana," 2008).

3.6 Washington

Bradley K. Robinson of Seattle filed a measure to allow physician assisted suicide and voluntary euthanasia on March 14, 1990 to the Washington State legislature with 218,327 signatures, resulting in its addition to the legislature on February 8, 1991 (Washington Secretary of State, Elections Division, n.d.). Having collected sufficient signatures, the initiative *could* have been passed directly into law by the Washington legislature without placing on the general ballot (Washington Secretary of State, n.d.). However, with no action taken by the legislature to enact the initiative, it was duly passed on to the ballot (Washington Secretary of State, Elections Division, n.d.).

As the first state to seriously be considering such legislation, in the lead up to this ballot the whole of the U.S. was watching. In a New York Times article, the intensity of the campaigning from both sides was portrayed. The main proponent, the Hemlock Society, had already failed to get a similar measure on the ballot in California and Oregon, and so threw all its efforts into this attempt in Washington (Egan, 1991). The article points out that in Washington, the politicians were unusually about on their views compared to the fervour of debate in the community:

The campaign has been high on emotionalism and personal stories and low on sound bites from politicians, most of whom have not taken a position on the initiative (Egan, 1991).

On November 5, 1991, Washington State voters were asked in Initiative 119 "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?". Although early polls were said to show a majority in favour (Egan, 1991), the initiative failed with a narrow margin of 53.6% No to 46.4% Yes (Washington Secretary of State, Elections Division, n.d.). Over the next several years, three Senate Bills for assisted suicide in Washington failed: Terminally Ill Patient Act of 1995 SB 5596 (1995), End-of-life Care Act. SB 6576 (1998), and The Washington "Death with Dignity" Act SB 6843 (2006) (*Attempts to Legalize*; "Senate Bill 5596," 1995; "Senate Bill 6576," 1998; "Senate Bill 6843," 2006).

During this time, judicial avenues were also being explored. In 1994 the organisation Compassion in Dying along with three terminally ill patients and five physicians took Washington State to court, claiming that the state law Wash Rev. Code § 9A.36.060 (*Promoting a suicide attempt*), prohibiting assisted suicide, was against the Fourteenth Amendment of the U.S. Constitution as far as it applies to physicians ("Compassion in Dying v State of Washington," 1994). Chief Judge Rothstein ruled the Washington law unconstitutional in line with the rationale of the U.S. Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v Casey* 505 US 833 (1991) that:

... [A]t 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... ("Planned Parenthood of Southeastern Pennsylvania v Casey," 1992) ("Compassion in Dying v State of Washington," 1994).

This decision was reversed by the Ninth Court of Appeals (*Compassion in Dying v. Washington*, 49 F. 3d 586, 591 (1995)), but then reaffirmed upon second hearing (*Compassion in Dying v. Washington*, 79 F. 3d 790, 798 (1996)) ("Washington v. Glucksberg," 1997). Finally, in June 1997, just before Oregonians reaffirmed the *Oregon Death with Dignity Act*, the U.S. Supreme Court found that the Washington law prohibiting assisted suicide did not contravene the Fourteenth Amendment ("Washington v. Glucksberg," 1997). However, in doing so, they also reiterated that it was up to the democratic process in each state to determine the legality of assisted suicide of voluntary euthanasia, quoting a string of rulings (*Cruzan v Director, Mo. Dept. of Health*, 497 U. S. 261, 292 (1990) citing *New State Ice Co. v Liebmann*, 285 U. S. 262, 311 (1932)) which referred to the states as "laboratories" for such decisions ("Washington v. Glucksberg," 1997).

Following the adoption of the *Oregon Death with Dignity Act* in 1997, the Netherlands's *Termination of Life on Request and Assisted Suicide Act* in 2000, *Belgian Act on Euthanasia* in 2002, and the many reports from these places, Washingtonians passed the *Washington Death with Dignity Act*, Initiative 1000 (Wash. Rev. Code § 70.245), on the 4th of November, 2008 (*Washington State Death with Dignity Act*).

3.7 Luxembourg

The debate about voluntary euthanasia at the parliamentary level in Luxembourg began in 1996, after two years of campaigning by the Luxembourg Greens Party to place it on the agenda (*Depenalizing euthanasia in Luxembourg*, 2008). A commission on ethics was created and a special report in 1999, on palliative care and end of life decisions and medical practices, added to the debate; despite this, the emotional deliberations in parliament remained unresolved (Association pour le droit de mourir dans la dignité-Lëtzebuerg a.s.b.l., 2008; Minister of Health & Minister of Social Security, 2010).

Another attempt to legalise voluntary euthanasia was made in 2004, including a well endorsed petition to the government. However, the Christian-Socialist party (CSV), in power at the time, focused on palliative care instead (Association pour le droit de mourir dans la dignité-Lëtzebuerg a.s.b.l., 2008). Finally, in 2008 the CSV lost power and the new leader suggested parliamentarians vote according to their conscience on two new bills which were before them (Association pour le droit de mourir dans la dignité-Lëtzebuerg a.s.b.l., 2008). One, a bill on voluntary euthanasia, had been brought to parliament by a Socialist MP Lydie Err and a Greens' Party deputy Jean Huss, and was thus called the Err-Huss Bill (Watson, 2009). Although it met with a favourable first reading and was passed by parliament, Luxembourg's Archduke Henri, as a Catholic, refused to sign the voluntary euthanasia bill, leading to constitutional change which makes royal approval unnecessary for the enactment of laws (Frieden, 2009; Israely, 2008). Therefore the voluntary euthanasia debate in Luxembourg was so powerful as to result in fundamental changes to the legislature and the role of the monarch (Note 7) (Frieden, 2009; Israely, 2008).

The two laws before parliament were enacted at the same time, the *Law Relating to Palliative Care* and the *Law on Euthanasia and Assisted Suicide*, in an effort to highlight the government's commitment, first to doing all that was possible for people at the end-of-life, but also providing the option of death with dignity for exceptional cases where people were suffering intolerably (Minister of Health & Minister of Social Security, 2010).

4. Current Situation in Seven Jurisdictions

4.1 Switzerland

In Switzerland the debate continues. In 2011 voters in the canton Vaud chose not to restrict assisted suicide to residents, a reasoning put forward by the NEK failing to differentiate between residents and non residents in the logic behind the law (National Advisory Commission on Biomedical Ethics, 2005; Exit International, n.d.). On June 17, 2012, the Swiss in Vaud were asked to decide if people in nursing homes should be guaranteed the right to assisted suicide ("Swiss canton to vote on assisted suicide on June 17," 2012; Patients' Rights Council, n.d.). Currently nursing homes may choose not to allow staff or others to assist in suicide, thereby limiting the options of residents who may have restricted mobility. The result was 62% of voters in favour of obliging nursing homes to allow the practice where the patient is incurable and "of sound mind" ("Vaud to get first Swiss assisted suicide law," 2012), making this the first explicit law on assisted suicide in Switzerland.

People do not have to be terminally ill to be assisted under Swiss law. However, in practice, organisations that help, such as Dignitas (Digitas, n.d.), do require medical records showing an advanced incurable condition. They apply organisational regulations even if the law does not.

4.2 Oregon

The *Oregon Death with Dignity Act* (Or. Rev. Stat. § 127.800-127.897 (1994)) stipulates the conditions under which the request for a prescription for life terminating drugs must be made. The Act includes forms to be used for the written request and ensures that the request is reiterated more than fifteen days after the initial request (*Oregon Death with Dignity Act*, 1994). Doctors are also unable to prescribe the necessary medications within certain waiting periods (15 days after first oral request or 48 hours after written request) (*Oregon Death with Dignity Act*, 1994). Physicians must also ensure that the person making the request is terminally ill, a resident, aware of other end of life options and their prognosis, provide counselling where appropriate and ensure the conditions under which the person is making the decision comply with the act (*Oregon Death with Dignity Act*, 1994). Reporting criteria are also to be followed and the Oregon Health Authority has produced annual reports, the first was released in February 1999 (*Annual Reports*, 2012; *Oregon Death with Dignity Act*, 1994).

4.3 The Netherlands

The Dutch act stipulates that doctors must satisfy themselves of the criteria set out in the act (reflecting the court rulings) concerning the status of the patient and their request as well as evidence of having consulted another physician. They then report the death to the regional pathologist as a non-natural death. The physician's report and that of the pathologist (which is also sent to the Public Prosecutor) go to a regional review committee consisting of at least one of each of the following: a legal specialist, a physician, and an expert in ethics, such as a philosopher (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, 2000). They can then determine whether the matter is appropriate for prosecution and if the body can be approved for burial by the Public Prosecutor (Netherlands Ministry of Foreign Affairs, 2010; *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, 2000)

Although the Netherlands took the bold step of being the first country to legalise voluntary euthanasia, the final step of enacting complete legislation certainly lagged behind general opinion and accepted medical practice. Since the enacting of the Dutch *Termination of Life on Request and Assisted Suicide Act* rates of voluntary euthanasia and assisted suicide have not, as many feared, increased; rather going from 2.6% (euthanasia) and 0.2% (assisted suicide) in 2001, to 1.7% and 0.1% respectively (van der Heide et al., 2007).

4.4 Belgium

Interestingly, the Belgian act does not, like the Dutch law, include assisted suicide, nor does it change the penal code (*Act on Euthanasia*, 2001; Deliens & van der Wal, 2003). It also differs from the Dutch act in its reporting processes (Smets et al., 2009). In Belgium, a physician has four days to report anonymously to the review committee which is composed of 16 people, equally representing the two language groups of Belgium (§ 5 *Act on Euthanasia*, 2001; Smets, et al., 2009). It varies again from other laws in that it specifically addresses the situation of those who are not likely to die in the near future, requiring the consultation of a third physician (§ 3(3) *Act on Euthanasia*, 2001). The Belgian law also mentions physical and psychiatric suffering (§ 3(1) *Act on Euthanasia*, 2001). Reporting is done biannually (§ 9 *Act on Euthanasia*, 2001).

4.5 Montana

Since the *Baxter v Montana* case in 2008, efforts have been made to enact legislation around assisted suicide (LC2180, 2009; LC2189, 2009; SB 167), as well as to implement prohibitive legislation (LC 1981, 2009; LC2181, 2009, SB 116). However, all have failed thus far (Montana Legislature, n.d.). Interestingly, the dual presentation of Senate Bills 116 and 167, for the prohibition and legalisation, respectively, of assisted suicide, both failing to gain sufficient support, demonstrates the stalemate within the legislature around this issue, leaving physician assisted suicide legal by rule of the courts, but otherwise unregulated.

4.6 Washington

The *Washington Death with Dignity Act* is modelled on that of Oregon and applies only to those terminally ill, defined as adults with six months or less to live (*The Washington Death with Dignity Act*, 2008). Thus far 103 people requested assistance in 2011 with 70 confirmed as having using the prescribed drug (Washington State Department of Health, 2011). Overwhelmingly, most patients who requested the lethal prescription suffered from cancer (Washington State Department of Health, 2011).

4.7 Luxembourg

The new voluntary euthanasia and assisted suicide law does not decriminalise either, but sets out criteria exempting doctors from prosecution, given they demonstrate (within eight days) adherence to the new legislation to the Commission for Control and Assessment (on supplied forms) ("Loi du 16 mars 2009 sur l'euthanasie et

l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide,]). The Commission can refer matters to the Public Prosecutor and the Medical Council if the criteria in the *Law on Euthanasia and Assisted Suicide* are not met by the patient's physician (Minister of Health & Minister of Social Security, 2010).

The legislation recognises requests from patients in writing where the patient:

- is an adult; and,
 - is not under pressure or undue influence; and
 - is under constant and unbearable physical or mental suffering without prospects of improvement; and
 - makes a request in writing
- (Minister of Health & Minister of Social Security; Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide,]).

Patients can also make end-of-life provisions for when they are no longer able to express their wish for voluntary euthanasia (e.g. due to unconsciousness) (Minister of Health & Minister of Social Security, 2010). End-of-life provisions are all registered with the Commission for Control and Assessment with the possibility of alteration and amendment at any time and include nomination of a "person of trust" to speak for the patient should they lose their ability to do so for themselves (Minister of Health & Minister of Social Security, 2010). Should someone change their mind or waiver at any point a request for euthanasia in a registered end-of-life provision is made void (Minister of Health & Minister of Social Security, 2010).

Unusually, the legislation does not refer to residency or nationality. However, it applies to doctors acting in Luxembourg and they must have a close relationship with the patient (being a main practitioner for them over time). This makes the use of the law difficult for people residing elsewhere but having a Luxembourg doctor (Minister of Health & Minister of Social Security, 2010).

5. Australian Experience

5.1 Background

Australia was the first country to have one of its jurisdictions legalise physician aid in dying, and it has had public approval for many years. Surveys show that support for assisted suicide and voluntary euthanasia rose between the 1960 and 1990's, and has stayed 70%-80% in agreement since (Sikora & Lewins, 2007). Research prior to legalisation in the Northern Territory had also revealed that about 30% of doctors had taken steps to end life. In contrast, only 6% believed laws should be changed to accommodate physician assistance in dying for the terminally ill (Ryan, 1996). Despite public support and the frequency of doctors hastening death, the Australian Medical Association has consistently opposed voluntary euthanasia (Ryan, 1996), although peak body Palliative Care Australia remains neutral (Palliative Care Australia, 2006; Palliative Care Australia, n.d.).

Considering the level of public support, it should not be surprising that a number of bills have been put forward throughout Australia aiming to legalise some form of physician aid in dying (See Table 1). Many States or Territories appointed committees of inquiry in response to proposed bills, all except the Northern Territory recommending against legalisation. A summary for each is below.

5.2 South Australia

In 1991 the House of Assembly of the South Australian Parliament set up the Select Committee on the Law and Practice Relating to Death and Dying. In the second interim report the Select Committee totally rejected the idea of any medical assistance in dying (Fleming, 2000). Thus the *Consent to Medical Treatment and Palliative Care Act*, passed in 1995, was carefully worded to ensure voluntary euthanasia was clearly not sanctioned (although it did protect doctors who hastened death with pain relief) (Fleming, 2000). Later, the Voluntary Euthanasia Bill 1997 introduced by J.A.W. Levy, MLC was also referred to the Social Development Committee of the parliament for inquiry. In 1999 the inquiry recommended the law remain unchanged. There have been a number of unsuccessful attempts since that time (see Table 1).

5.3 Victoria

The Social Development Committee of Parliament of the State of Victoria looked into law relating to end-of-life decisions in 1985/6. The result was the *Medical Treatment Act 1988* which allows for refusal of treatment, but the committee had argued against recognition of a 'right to die' (Fleming, 2000; Research Service, Parliamentary Library, Department of Parliamentary Services, 2008). Common law supports advance directives, however, the *Medical Treatment Act 1988* neither contradicts common law, nor does it allow advance directives as such, only recognising a Refusal of Treatment Certificate (RTC) for current conditions (Leo, 2004; Research Service, Parliamentary Library, Department of Parliamentary Services, 2008). Victorian law no longer criminalises

suicide, but does prohibit assistance or encouragement to commit suicide (Research Service, Parliamentary Library, Department of Parliamentary Services, 2008).

5.4 Tasmania

The Community Development Committee of the Tasmanian Parliament conducted an inquiry into the voluntary euthanasia issue in 1997 (after the NT legislation). It recommended against legalising, based on protecting vulnerable members of society (Fleming, 2000).

More recently the *Dying with Dignity 2009* bill put forward by Mr. Nick McKim was referred to the Joint Standing Committee on Community Development. The committee summarised arguments for and against physician aid in dying without making any conclusions, however consensus was that the *Dying with Dignity 2009* bill in its current form did not ‘...provide an adequate or concise legislative framework to permit voluntary euthanasia/physician assisted suicide’ (Joint Standing Committee on Community Development, Parliament of Tasmania, 2009). The current Premier (2012) has announced she intends to introduce a dying with dignity bill during her term of office.

5.5 New South Wales

When the first person died under the NT legislation on September 22, 1996, New South Wales Premier Bob Carr set aside the day for Parliamentary debate. Through the course of the debate, it was clear that the majority opposed voluntary euthanasia, leaving the issue moot (Fleming, 2000).

Currently, Green’s member Cate Faehrmann has committed to introduction of a Rights of the Terminally Ill bill to the NSW parliament (*Dying with Dignity NSW*, n.d.).

5.6 Western Australia

In Western Australia, Mr. Norm Kelly MLC put forward the Voluntary Euthanasia Bill 1998 (in October of 1997). The following year, an inquiry by the Constitutional Affairs Committee of the Western Australian Parliament, called Petitions Regarding Voluntary Euthanasia, stated that it would not make a recommendation, but that with better palliative care, the issues would be reduced (Fleming, 2000). In 1999 Mr. Norm Kelly MLC suggested the Bill be reintroduced, in line with public support. However no action was taken (Fleming, 2000).

Most recently the *Voluntary Euthanasia Bill 2010* introduced by Robin Chapple was not agreed to at its second reading (Western Australia Parliament, n.d.).

5.7 Queensland

Comparatively little debate has taken place in Queensland on the issue. However, a Power of Attorney Bill in 1997 was passed which included refusal of treatment.

5.8 Australian Capital Territory

Several attempts have been made to legalise voluntary euthanasia in the ACT. The Legislative Assembly’s Select Committee on Euthanasia rejected the idea in 1994 and a Medical Treatment (Amendment) Bill failed in 1995 by three votes. This bill was reintroduced in 1996; however the enactment of the Andrews Bill made the issue moot (Andrews Bill explained and discussed in detail below in *Northern Territory*). In an attempt to work around the federal prohibition, Independent MLA Michael Moore suggested keeping voluntary euthanasia illegal, but enacting only an on the spot \$50 fine. This was not widely supported and failed (Fleming, 2000).

5.9 Northern Territory

By comparison, the Northern Territory moved quickly legalising voluntary euthanasia, needing to amend their legislation the following year due to issues not identified before its passing (Fleming, 2000). After a report by the Select Committee on Euthanasia in May 1995 the *Rights of the Terminally Ill Act 1995* was passed (Legislative Assembly of the Northern Territory, 1995; *Rights of the Terminally Ill Act*, 1995). The Northern Territory Act was unique in that the parliament is said to have ‘... specifically rejected a definition of terminal illness that included the expectation of death within a specified period’ (Ryan, 1996). It also allowed any Australian to use the laws, not just NT residents (Senate Legal and Constitutional Legislation Committee, 1997). However, the need for competent adult decision making prevented use by patients with dementia type illnesses and use on others (such as people in vegetative states), nor did it include advance directives (Ryan, 1996).

Although radical, in that it was the second jurisdiction to legalise physician aid in dying (after Oregon (Note 8)), it was the first to take effect. The law was described well at the time:

Those who oppose voluntary euthanasia on religious or ethical grounds will find nothing to praise in the legislation. Some who favor euthanasia will complain that the act is still too conservative or that its rigorous safeguards place an unreasonable burden on those it is intended to assist (Ryan, 1996).

The planned start date was July 1, 1996, however the validity of the legislation was challenged in the Supreme Court, where an injunction was sought (Fleming, 2000). However, the plaintiff's case failed and so another attempt to stop the bill was made by the opposition, putting forward a bill to repeal it in August 1996 which was also defeated (Fleming, 2000). In 1995 a request was made to the Prime Minister, Paul Keating, to have the Governor-General withhold assent to the NT Act using powers the Commonwealth has over Territories; Keating rejected the approach as it was 'up to the people of the Northern Territory... not the Commonwealth' (letter from the Office of Prime Minister, 9 February 1996, to the NT Voluntary Euthanasia Society).

Federal Member Kevin Andrews joined forces with the organisation *Euthanasia No!*, led by Tony Burke. This was significant because opposition came from members of both major parties. *Euthanasia No!* was created for the purpose of preventing euthanasia in Australia and its inception was described as:

... the story of a network—all the principals are Catholics—its influential connections, its single-mindedness and the tactics it employed ... The clear consensus was that the group was about one thing only: stopping euthanasia in NSW [it was suggested NSW would follow the NT]. It was to have no profile, no newsletter, and no members. Only a result (Gordon, 1997).

Together, Andrews and those behind *Euthanasia No!* campaigned for the Euthanasia Laws Bill (a.k.a. Andrews Bill) aimed at stopping the NT law by limiting the self-governance of the territories (Northern Territory, ACT and Norfolk Island). The help of Rev. Dr. John Fleming and Jonathan Wells QC was used in the drafting of the Andrews Bill, which sought to define voluntary euthanasia as intentional killing, and also prevented efforts to circumvent the law (like the ACT proposing a \$50 fine) by prohibiting any laws that "...have the effect of permitting [voluntary euthanasia or assisted suicide]..." (*Euthanasia Laws Act*, 1997; Fleming, 2000).

As a result of this very active but also somewhat covert campaign, in which Catholics from both major parties joined forces (Gordon, 1997), the Euthanasia Laws Bill was passed by the House of Representatives on December 6, 1996 (Fleming, 2000). During this time, the bill was referred to the Senate Legal and Constitutional Legislation Committee which reported in March 1997, but gave no recommendation stating it was a conscience vote issue (although several opinions were given by various members) (Senate Legal and Constitutional Legislation Committee, 1997). This report was closely followed by passing by the Senate and royal assent (Fleming, 2000).

5.10 Current Situation

The Northern Territory did consider trying to circumvent the law by using the ACT idea of trivialising the punishment to a \$50 fine, but this did not gain much support (Fleming, 2000). Since, there have been several attempts, mainly by Federal Parliament members of the Australian Greens Party, to reinstate territory rights to make self-determining legislation in this area. In 2010 Senator Bob Brown put forward a Private Member's Bill which requires both houses of Federal parliament to disallow a territory law. This bill was passed, affecting both the ACT and the Northern Territory (*Territories Self-Government Legislation Amendment (Disallowance and Amendment of Laws) Act*, 2011). His second *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010* remains before Parliament which would specifically repeal the *Euthanasia Laws Act 1997*.

Lobby groups such as Dying with Dignity are still campaigning for legislation. Other groups, for example, Exit International, are advising people (not necessarily terminally-ill) of their options. However, the enactment of the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* prohibits using electronic means (phone, fax, internet) to disseminate how-to-suicide information; also prohibited is the dissemination of information encouraging or explaining how to suicide (*Criminal Code Amendment (Suicide Related Material Offences) Act*, 2005). Table 1 summarises the various attempts to legislate at federal, state and territory levels of Australian government.

Table 1. Relevant bills and acts by state/territory

	Bills/Acts	Relevant Information
Commonwealth	<i>Euthanasia Laws Act 1997</i> (Cth)	aka Andrews Bill
	Euthanasia Laws (Repeal) Bill 2004	presented by Mr Kevin Andrews MP

	<i>Criminal Code Amendment (Suicide Related Material Offences) Act 2005 (Cth)</i>	limits ability to disseminate information about suicide or euthanasia, inhibiting lobby groups
	Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 (Cth)	
	Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010 (Cth)	
Northern Territory	<i>Natural Death Act 1988 (NT)</i>	
	<i>The Rights of the Terminally Ill Act 1995 (NT)</i>	
	<i>The Rights of the Terminally Ill Amendment Act 1996 (NT)</i>	
	Adult Decision Making Bill 2012 (NT)	allows for appointment of a representative and advance directives for when an adult loses capacity
South Australia	<i>Consent to Medical Treatment and Palliative Care Act 1995 (SA)</i>	
	Voluntary Euthanasia Bill 1997 (SA)	defeated
	Dignity in Dying Bill 2003 (SA)	lapsed August 12, 2004
	Dignity in Dying Bill 2005 (SA)	lapsed December 8, 2005
	Voluntary Euthanasia Bill 2006 (SA)	lapsed April 5, 2007
	Voluntary Euthanasia Bill 2007 (SA)	lapsed
	<i>Consent to Medical Treatment and Palliative Care Act 2008 Amendment Bill (SA)</i>	
	Voluntary Euthanasia Bill 2008 (SA)	lapsed
	Voluntary Euthanasia Bill 2010 (SA)	lapsed
	Voluntary Euthanasia Bill 2012 (SA)	negative
A.C.T	Voluntary and Natural Death Bill 1993	
	Medical Treatment (Amendment) Bill 1995 (ACT)	
	Crimes (Assisted Suicide) Bill 1997 (ACT)	
	Medical Treatment (Amendment) Bill 1997 (ACT)	
	Euthanasia Referendum Bill 1997	
	Medical Treatment (Health Directions) Act 2006 (ACT)	
New South Wales	Rights of the Terminally Ill Bill 2001 (NSW)	Private Member's Bill, defeated March 21, 2002
	Voluntary Euthanasia Trial (Referendum) Bill 2003 (NSW)	Private Member's Bill, a trial for 18 months, defeated November 13, 2003
Western Australia	Voluntary Euthanasia Bill 1998 (WA)	
	Voluntary Euthanasia Bill 2000 (WA)	lapsed July 1, 2000
	Voluntary Euthanasia Bill 2000 (WA)	lapsed January 10, 2002
	Voluntary Euthanasia Bill 2002 (WA)	lapsed January 23, 2005
	Voluntary Euthanasia Bill 2010 (WA)	
Tasmania	Dying with Dignity Bill 2009 (Tas)	defeated
Victoria	Medical Treatment Act 1988 (Vic)	
	Medical Treatment (Physician Assisted Dying) Bill 2008 (Vic)	

Description: Listed by state or territory those bills and acts relevant to assisted suicide and euthanasia legislation in Australia (Australasian Legal Information Institute, n.d.; ACT Government, n.d.; Research Service, Parliamentary Library, Department of Parliamentary Services, 2008; Parliament of South Australia, n. d.).

6. Concluding Discussion

The road to enactment of legislation in order to protect citizens and their personal/medical carers from prosecution is a rather bumpy one. Table 2 shows the various contributing factors that have led to satisfactory legal arrangements in seven jurisdictions.

Table 2. Summary table

	Assisted Suicide or Voluntary Euthanasia Legalised	Parliamentary Debate	Political Party Campaigning	Ethics /Commission Report	Petitions by interested individuals or groups	Change of government	Public Vote/Referendum	Court ruling	Statute or Constitutional Interpretation	Constitutional change
Switzerland	AS	✓		✓			✓		✓	
Oregon	AS				✓		✓			
Northern Territory	AS/VE	✓		✓						
The Netherlands	AS/VE	✓		✓		✓		✓		
Belgium	VE	✓		✓		✓				
Montana	AS							✓	✓	
Washington	AS				✓		✓			
Luxembourg	AS/VE	✓	✓			✓				✓

Description: Table showing some of the major contributing factors associated with the enactment of legislation on assisted suicide and/or voluntary euthanasia in the places listed.

The distinction between assisted suicide and voluntary euthanasia has been critical in some jurisdictions. In Switzerland it has meant that assisted suicide is an extension of an existing attitude towards suicide in general. An extension of the reasoning against making suicide illegal draws on the idea that respect for individual human dignity encompasses a right to determine the manner of one's own death. This reasoning was also part of the foundation for the ruling in Montana where rights to dignity and privacy, contained within the Montana State Constitution as inviolable, were the basis for determining that assisted suicide is legal. The autonomy of the individual also appears to be favoured in the United States where voices of citizens, rather than lawyers, politicians or lobbyists were loudest, through plebiscites, at least in Oregon and Washington (with Massachusetts most recently voting No to Initiative 2 on the November 6, 2012 ballot (Elections Division, Secretary of the Commonwealth, 2012)).

Those places which have made voluntary euthanasia possible (The Netherlands, Luxembourg and Belgium) have a culture of parliamentary debate that leads to progressive social change through legislation. However, the first country to adopt such legislation, The Netherlands, did so long after there was tacit approval both publicly and by the courts. Therefore, in general, there appears to be a reluctance by governments to enact legislation allowing assisted suicide or voluntary euthanasia, even when it is clear that a majority of the public believe the practices should be legal.

In the US, a citizens' ballot has been a crucial catalyst, allowing circumvention of politicians. A change of government can offer a window of opportunity for a new ruling party to demonstrate a fresh direction through passing previously stymied bills (the case for Belgium, the Netherlands and Luxembourg). In Luxembourg the (unchangeable) monarch even altered the constitution to avoid standing in the way of the people and the new government, but also to avoid adding an endorsement which would have been contrary to his conscience. Interestingly, this apparent trepidation of governments to sanction physician aid in dying can also be seen in how much of the legislation has been enacted. For example, in the Netherlands the criminal prohibitions on assisted suicide and euthanasia are still in place, and parliament has only formalised the court's approach of exempting physicians from prosecution where they have satisfied rigorous procedures.

The Australian experience, however, may be one of the most pronounced examples of parliaments persistently opposing public opinion, first by federally quashing the Northern Territory legislation (and preventing all territories from passing Bills legalising voluntary euthanasia and assisted suicide), and at the state level repeatedly rejecting assisted suicide and voluntary euthanasia bills in the face of a considerable majority of public support.

There are reasons why politicians are resistant to translating the views of their constituents into legislation. They may fear a backlash (and therefore doing nothing becomes a safer option); they may be more conservative than their constituents. Meadowcroft notes other reasons for politicians' hesitancy: "(a) there are lots of other things to worry about; (b) uncertainties overwhelm action; and (c) change disturbs established interests" (Meadowcroft, 2011). All of these impediments are evident in the debate about physician aid in dying.

Given such resistance, it is clear that the Australian parliamentary arena, where elected representatives vote along party lines, is an ill-fit for this discussion. A conscience vote might help to break the deadlock but freeing elected representatives to attend to their own consciences does not translate into attending to their constituents' consciences. Therefore, even though parliaments are the end point where legislation must be ratified, the deliberation is best done elsewhere. Citizens have demonstrated their willingness to wrestle with policy complexity, and their competence in doing so (Carson, Gastil, Hartz-Karp, & Lubensky, in press; Gastil & Levine, 2005). Deliberation surely belongs to the people who are directly affected by this vexing issue.

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Notes

Note 1. Directed by *How to Die in Oregon*, Directed by Peter D. Richardson, Clearcut Productions, 2011—winner of Grand Jury Prize (Documentary) at Sundance Film Festival.

Note 2. For example, Charlton Heston (President of the National Rifle Association 1998-2003) is a former film star (and former Democrat, later Republican stalwart), and therefore a powerful spokesman for conservative Americans. Here is one rather sobering film clip: <http://www.youtube.com/watch?v=YImDfKOk97k>

Note 3. See <http://www.deathwithdignity.org/historyfacts/chronology>

Note 4. For details about the public conversations that were convened throughout Australia in 2012, contact the author.

Note 5. Switzerland is an exception to this, as there anyone without selfish motive may help another commit suicide.

Note 6. Euthanasia was linked to 1.1% of examined deaths whereas the use of pain relief with the effect of shortening death occurred in 18.5% of the examined deaths (Adams, 2001).

Note 7. Excerpt from article by Jeff Israely in *Time World* (2008) entitled 'Luxembourg's Monarch Steps Back on Euthanasia Bill': "Henri wants to avoid popular dissent around his reign, which may help explain his decision to cede political authority in order to hold on to the Duke's role as symbol of national unity. Michel Pauly, a professor of transnational Luxembourg history at the University of Luxembourg, says stripping the Duke of any legislative authority is the "natural democratic evolution" of the country, and predicts that Luxembourg will eventually go down the path of the purely ceremonial monarchy in place in countries such as Sweden and Denmark."

Note 8. Oregon's practice is assisted suicide, not voluntary euthanasia since Oregon doctors prescribe a lethal substance but the patient must be able to administer it herself/himself. A doctor is not permitted to administer it.

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