



**Australian
Human Rights
Commission**

Euthanasia, human rights and the law

ISSUES PAPER

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ABN 47 996 232 602
Level 3, 175 Pitt Street, Sydney NSW 2000
GPO Box 5218, Sydney NSW 2001
General enquiries 1300 369 711
Complaints info line 1300 656 419
TTY 1800 620 241

Australian Human Rights Commission
www.humanrights.gov.au

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1 Introduction

This issues paper explores voluntary euthanasia. It is not intended to be exhaustive, however it aims to add to considerations of this very complex and sensitive topic through analysis of the domestic regulatory environment relating to both passive and active forms of voluntary euthanasia, and of relevant international laws by way of comparison with domestic regulation. It concludes with a human rights-based analysis of voluntary euthanasia and some commentary on the practice informed by human rights principles.

The word ‘euthanasia’ is derived from the Greek word *euthanatos* meaning ‘easy death’.¹ Generally it is used to describe the process of intentionally terminating a person’s life to reduce their pain and suffering.² Euthanasia is sought not only by those suffering excruciating pain, but for other reasons such as changes in quality of life resulting from catastrophic physical injury and psychological factors associated with incurable diseases.³

The current debate on euthanasia sits within a social context that is in a state of flux. Modern medical technology has led to increasing developments in, and greater availability of, artificial measures to prolong life.⁴ Concurrently there has been a significant increase in the ageing of the population internationally⁵ and a decline in the influence of organised religion in much of the developed world.⁶

The debate sees those who support an individual’s right to a ‘good death’ at a time of their own choosing at odds with those who believe strongly in the sanctity of human life.⁷ Additional is the fear that any form of state-sanctioned ‘killing’ will leave society’s most vulnerable groups at particular risk.⁸ Euthanasia raises some of the most fundamental philosophical questions of all – what is life, and are there forms of it that are so unbearable that they render living worthless?⁹

1.1 Terminology

‘Euthanasia’ is often incorrectly characterised as representing one particular kind of practice. However, it is more accurately understood as an umbrella term which covers a vast array of practices that can be described as different forms of euthanasia. These include:

- *Passive voluntary euthanasia* – when medical treatment is withdrawn or withheld from a patient, at the patient’s request, in order to end the patient’s life;
- *Active voluntary euthanasia* – when medical intervention takes place, at the patient’s request, in order to end the patient’s life;
- *Passive involuntary euthanasia* – when medical treatment is withdrawn or withheld from a patient, not at the request of the patient, in order to end the patient’s life;
- *Active involuntary euthanasia* – when medical intervention takes place, not at the patient’s request, in order to end the patient’s life.¹⁰

Notwithstanding some inevitable overlap between these terms, the parameters of this paper is consideration of the terms ‘passive’ and ‘active’ *voluntary* euthanasia. Involuntary euthanasia is not considered in this paper.

2 Passive voluntary euthanasia

Passive voluntary euthanasia involves the withdrawal or withholding of medical treatment from a patient, at the patient's request, in order to end the patient's life. Examples include not resuscitating a person in cardiac arrest, turning off a life support machine or withholding or withdrawing other medical care that would prolong life.¹¹

2.1 Current practice

(a) Good medical practice

Withholding or withdrawing medical treatment currently occurs in Australia under various circumstances and regulations.

First, the Medical Board of Australia and the Australian and New Zealand Society of Palliative Medicine (ANZSPM) states good medical practice involves medical practitioners:

...Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.¹²

...Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.¹³

The Australian Medical Association (AMA) similarly states that medical treatment may not be warranted where such treatment 'will not offer a reasonable hope of benefit or will impose an unacceptable burden on the patient'.¹⁴

There is debate, however, as to whether such measures fall within the meaning of euthanasia. The AMA states that not initiating or withdrawing life-prolonging treatment 'does not constitute euthanasia or physician assisted suicide' where a medical practitioner is acting in accordance with good medical practice.¹⁵

The ANZSPM explains that 'euthanasia and physician assisted suicide involve the primary, deliberate intention of causing the patient's death'.¹⁶

The Royal Australian College of General Practitioners (RACGP) similarly states:

Whilst doctors have an ethical duty to preserve life there is also a responsibility to relieve suffering...Death should be allowed to occur with dignity and comfort when death is inevitable...the law classifies the cause of death as the patient's underlying condition and not the actions of others. Any legislation therefore needs to recognize that a number of existing forms of end of life care, which may hasten death, are recognized as good medical practice and do not constitute euthanasia or assisted suicide.¹⁷

However, the statements by medical professionals to explain their position that existing end of life practices do not constitute euthanasia appear to reflect an understanding of euthanasia more in line with active, rather than passive,

euthanasia. What is clear is that regulations do currently exist to permit the withdrawing or withholding of medical treatment in certain circumstances, regardless of whether such practices are described as passive euthanasia or fall within the meaning of established medical practice.

(b) Legislation

Each state and territory has enacted laws to regulate the act of withholding or withdrawing medical treatment with the effect of hastening death. These laws provide for instruments that allow, in a formal and binding manner, the previously expressed wishes of competent adults to continue to have influence over the kind of treatment they receive (or do not receive) when they lose competence.

No piece of legislation characterises such practices as euthanasia. Indeed, as with members of the medical profession, certain government departments have explicitly stated that such instruments do not permit euthanasia.¹⁸ However, again, such statements seem to be focused on active, rather than passive euthanasia. The Western Australian Department of Health, for example, answers the question ‘Does an Advanced Health Directive permit euthanasia?’ with the statement ‘an Advanced Health Directive cannot require or authorise a doctor or other health professional to take active steps to unnaturally end life.’¹⁹ Despite not using the term, such practices may nonetheless fall within the practices characterised as passive voluntary euthanasia as described above.

There are two forms of instruments that exist to regulate the withholding or withdrawing of medical treatment: 1) advance directives and 2) enduring powers of attorney or guardianship. All states and territories apart from Tasmania and New South Wales have legislation recognising types of ‘advance directive’ (variously described across jurisdictions). All states and territories have legislation recognising enduring powers of attorney or guardianship. The table below sets out which instruments are available in each jurisdiction and the relevant Act.

Table: Legislation relating to passive voluntary euthanasia practices in Australia

Jurisdiction	Does legislation provide for advance directives?	Does legislation provide for enduring powers of attorney/guardianship?
South Australia	Yes – ‘Advance care directives’ (<i>Advance Care Directives Act 2013</i>)	Yes – ‘Substitute decision makers’ (<i>Advance Care Directives Act 2013</i>)
Northern Territory	Yes – ‘Advance consent decisions’ (<i>Advance Personal Planning Act 2013</i>)	Yes – ‘Decision makers’ (<i>Advance Personal Planning Act 2013</i>)
Victoria	Yes – ‘Refusal of treatment certificates’ (<i>Medical Treatment Act 1988</i>)	Yes – ‘Enduring powers of attorney’ (<i>Powers of Attorney Act 2014</i>)
ACT	Yes – ‘Health directions’ (<i>Medical Treatment (Health Directions) Act 2006</i>)	Yes – ‘Enduring powers of attorney’ (<i>Powers of Attorney Act 2006</i>)
Western Australia	Yes – ‘Advance health directives’ (<i>Guardianship and Administration Act 1990</i>)	Yes – ‘Enduring powers of guardianship’

		<i>(Guardianship and Administration Act 1990)</i>
Queensland	Yes – ‘Advance health directives’ <i>(Power of Attorney Act 1998)</i>	Yes – ‘Enduring powers of attorney’ <i>(Power of Attorney Act 1998)</i>
Tasmania	No (but an advance care plan can be registered as part of an enduring guardianship)	Yes – ‘Enduring guardianship’ <i>(Guardianship and Administration Act 1995)</i>
New South Wales	No	Yes – ‘Enduring guardian’ <i>(Guardianship Act 1987)</i>

The common key features and differences between these instruments are summarised below:

(i) Advance directives

Advance directives allow competent adults to execute formal directives in writing (except for the ACT where they may be oral),²⁰ specifying their wishes concerning medical treatment, including the refusal of treatment.²¹

Directives will generally apply in situations where the person has impaired decision-making capacity, meaning they are unable to consent to or refuse medical treatment.²² For example, in Queensland a directive specifying the withdrawal or withholding of treatment will only operate in certain circumstances (i.e. if the patient has a terminal illness, is in a persistent vegetative state, or is permanently unconscious).²³ In Victoria, a directive to withhold or withdraw treatment can only be made with regard to a current condition.²⁴

Directives in relation to refusal of treatment are generally legally binding on health professionals,²⁵ although there are circumstances in which a health provider will be protected for non-compliance (for example, if there are reasonable grounds to believe that the directive does not reflect the current wishes of the person, or where a directive is uncertain or inconsistent with good medical practice).²⁶

Health practitioners who act in good faith and/or reasonably refuse to provide or continue medical treatment in reliance on an advance directive are generally taken to be acting with the consent of the patient.²⁷ In Western Australia and the Northern Territory, legislation states that a health practitioner is deemed to be acting with valid consent when relying on an advance directive, even where this may hasten death.²⁸

With regard to liability, the Victorian, South Australian and Australian Capital Territory Acts specify that practitioners, acting reasonably and/or in good faith, that act in accordance with an advance directive are generally protected from criminal liability.²⁹ In Queensland, a person acting in accordance with an advance health directive is ‘not liable for an act or omission to any greater extent than if the act of omission had happened with the principal’s consent.’³⁰ However, the Queensland Act also specifies that reliance on an advance directive does not prevent criminal liability under section 296 of the Queensland *Criminal Code* which criminalises the acceleration of death.³¹

New South Wales has not legislated to provide for advance directives. However, it has developed ‘Using Advance Care Directives’ guidelines on the management of end-of-life decisions, and advance care directives that comply with the requirements

of these guidelines are legally binding in NSW, functioning as an 'extension of the common law right to determine one's own medical treatment' (discussed below).³²

(ii) Enduring powers of attorney or guardianship.

Enduring powers of attorney or guardianship allow a person to appoint one or more agents to make decisions about the provision or refusal of medical treatment if and when that person has impaired decision-making capacity.³³

The attorney or guardian is generally required to make treatment decisions that are consistent with directions given by the person when competent, including those specified within the enduring power of attorney/guardianship itself, or in an advance directive.³⁴

In some jurisdictions, there are limitations on the ability of attorneys and guardians to refuse treatment in certain situations. In Victoria, an agent or guardian may only refuse medical treatment on behalf of a patient if the medical treatment would cause unreasonable distress to the patient, or there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.³⁵ In Queensland, an enduring power of attorney cannot consent to the withholding or withdrawal of a life-sustaining measure unless this would be consistent with good medical practice.³⁶

As mentioned above with regards to advance directives, health practitioners who reasonably/in good faith rely on the decision of an attorney or guardian are generally protected from criminal and civil liability (in the Northern Territory, Western Australia, Tasmania, New South Wales and Queensland because they are deemed to have acted with the patient's consent) if the agent makes refusal of treatment decisions in compliance with a valid instrument.³⁷

(c) *Common law*

Common law rules govern the doctor-patient relationship and the provision of medical treatment more generally.³⁸ Advance directives legislation in every Australian jurisdiction except for South Australia explicitly states that common law rights are not displaced by the legislation.³⁹

With regard to passive voluntary euthanasia, the common law allows a competent adult to refuse medical treatment, even where that refusal will lead to death.⁴⁰ Where a patient's refusal is both voluntary and informed, the decision must be respected and practitioners acting in accordance with such decisions are shielded from liability.⁴¹

Two cases considering the common law position concerning the right to refuse medical treatment help to clarify this position.

(i) Case law

Hunter and the New England Area Health Authority v A:⁴²

In this case the Supreme Court of New South Wales considered the validity of a common law advance directive (there being no legislative provisions for such directives in NSW) given by Mr A, refusing kidney dialysis. One year after making the directive Mr A was admitted to a hospital emergency department in a critical state with a decreased level of consciousness. His condition deteriorated to the point that he was being kept alive by mechanical ventilation and kidney dialysis. The hospital sought a judicial declaration to determine the validity of his advance directive.

McDougall J confirmed that the directive was valid and held that the hospital must respect this decision. His Honour stated and applied the common law principle that:

A person may make an 'advance care directive': a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and it is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive.⁴³

Brightwater Care Group v Rossiter:⁴⁴

This case, also dubbed the 'right to starve' case, concerned a contemporaneous rather than anticipatory refusal of treatment by Mr Rossiter, a man with quadriplegia who was 'unable to undertake any basic human functions', including taking nutrition or hydration orally. Mr Rossiter was not terminally ill, dying or in a vegetative state and had full mental capacity. He had 'clearly and unequivocally' indicated that he did not wish to continue to receive medical treatment which, if discontinued, would inevitably lead to his death.

Martin CJ considered the position at common law and concluded:

[A]t common law, the answers to the questions posed by this case are clear and straightforward. They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment [namely the administration of nutrition and hydration via a tube inserted into his stomach] contrary to Mr Rossiter's wishes.⁴⁵

These cases concern the common law position regarding the doctor-patient relationship and provision of medical treatment in general, rather than the issue of passive voluntary euthanasia specifically. Further research is needed to confirm the current common law position in relation to passive voluntary euthanasia practices.

2.2 Comparative international legislative schemes

As the above section demonstrates, the regulation of passive voluntary euthanasia practices in Australia is complex and, in some aspects, inconsistent. Generally, however, the Australian context reflects trends in comparable international

jurisdictions, as shown by the following overview of comparative regulation and jurisprudence.

(a) *United States of America*

Legislation providing for advance directives (often referred to as ‘living wills’) and/or enduring power of attorney exists in all states in the United States. These instruments allow competent adults to state, in advance, that they do not wish to be kept alive by medical treatment in the latter stages of terminal illness.⁴⁶ Legislation in some states gives a patient’s family members the power to make decisions about life-sustaining medical treatment in situations where the patient has become incompetent and has not made an advance directive.⁴⁷

(b) *United Kingdom*

Under the *Mental Capacity Act UK (2005)*,⁴⁸ ‘advance decisions’ give a person the right to make a decision to refuse healthcare treatment in advance, including in situations where this would result in their death.⁴⁹ Advance decisions are legally binding and any person who withholds or withdraws treatment in accordance with a valid and applicable advance decision will not incur liability.⁵⁰

The UK Act also allows a person to appoint an agent to act on their behalf in the event that they lose capacity in the future, in the form of a ‘lasting power of attorney’.⁵¹ The attorney can be expressly authorised to give or refuse consent to medical treatment, including life-sustaining treatment.⁵²

(c) *Canada*

Many of the provinces in Canada (e.g. British Columbia, Saskatchewan, Manitoba and Nova Scotia)⁵³ have enacted legislation that permits people to make advance directives (variously termed). These instruments record a person’s wishes or instructions regarding their future health care, and permit a person to appoint a substitute decision-maker to make health care decisions on their behalf if they become incompetent.

2.3 Summary

This section has outlined the circumstances in which individuals or their authorised agents can decide to withhold or withdraw medical treatment, including where this would result in death.

While the regulatory approach varies between Australian states and territories, all states and territories permit people, in one form or another, to formally communicate their wishes in end of life situations, an approach reflected by international practice.

Passive voluntary euthanasia thus appears to be largely accepted within current medical practice (and, in most jurisdictions, generally recognised and permitted by law), despite the refusal of medical practitioners and policy makers to describe these activities in such terms.

3 Active voluntary euthanasia

The acceptance of the practice of passive voluntary euthanasia, however defined, is in stark contrast to the practice of ‘active’ voluntary euthanasia.

Active voluntary euthanasia can be said to occur when medical intervention takes place, at the patient’s request, in order to end the patient’s life. In contrast to passive voluntary euthanasia, which involves an ‘omission’ of steps or treatment, active voluntary euthanasia concerns a person undertaking positive steps to end a life. This can include administering high doses of painkillers that hasten death or providing and/or injecting a lethal substance or dose to end life.

Thus, unlike passive euthanasia, in which the cause of death is the underlying disease or condition, with active voluntary euthanasia the death results from the action of a medical professional or other party.

The Senate Legal and Constitutional Affairs Legislation Committee’s Inquiry into the Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014 (Senate Inquiry) received hundreds of submissions in support of and against the Bill. As will be explored in section 4.2 below, that Bill sought to legalise and regulate active voluntary euthanasia.⁵⁴

Some of the major arguments for and against the legalisation of active voluntary euthanasia as raised at the Senate Inquiry are summarised below, followed by an overview of the current legal situation, in section 3.3.

3.1 Arguments against legalising active voluntary euthanasia

(a) Role of the doctor

Arguments against the legalisation of active voluntary euthanasia include the view that such practices undermine the ‘role of the doctor’ as a ‘healer’, as characterised by the Hippocratic Oath.⁵⁵ For example, the Family Council of Victoria stated in its submission to the Senate Inquiry that:

When the medical profession becomes involved in killing, the delicate trust relationship between a patient and doctor is undermined. People trust their lives to doctors and health care workers in the knowledge that they are dedicated to the preservation of life, to healing, to caring. This after all is the basis of the Hippocratic tradition. The Hippocratic Oath includes the commitment not to kill a patient, even if the patient requests such a course.⁵⁶

This is a contested view. An alternative argument is that the relationship between doctor and patient can be more suitably defined in the terms of a provider/consumer relationship, whereby the patient as a consumer ‘can ask for whatever he or she wants’, and the doctor ‘can choose whatever he or she wants to provide.’⁵⁷ Under such an interpretation, a doctor taking action which could fall within the meaning of active voluntary euthanasia may be justified.

(b) *Palliative care*

Linked to this argument is the role of palliative care. A number of people submitted to the Senate Inquiry that the introduction of voluntary euthanasia would undermine investment in, as well as the role and value placed on, palliative care.⁵⁸

In his evidence to the Senate Inquiry, Assistant Professor Andrew Cole, a palliative care specialist, outlined that providing effective palliative care and support could be an alternative to euthanasia. He explained:

[H]astening times is not necessarily the way forward. Rather, it is providing care and support, letting the natural processes take their course and choosing to withdraw therapies that are not reasonable or not helpful.⁵⁹

Others argued that the introduction of active voluntary euthanasia would not undermine palliative care but would instead provide an additional option within the palliative care process.⁶⁰ This argument is based on the premise that there will be circumstances 'where even the best palliative care will not relieve the suffering or distress of a terminally ill patient'.⁶¹ For example, the South Australian Voluntary Euthanasia Society explained:

It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients – between 5-10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.⁶²

(c) *Slippery slope*

The Senate Inquiry heard from a number of groups warning against the 'slippery slope' effect that would result from the enacting of active voluntary euthanasia legislation. Specifically, the concern is that the legalisation of voluntary euthanasia in terminal cases would then lead to the practice of other forms of euthanasia such as involuntary euthanasia or voluntary euthanasia in non-terminal cases.⁶³ For example, the Australian Christian Lobby (ACL) stated that:

[W]e have clearly seen the slippery slope well and truly in action in Holland and in Belgium, in particular, where we have seen people being euthanized without their specific consent. That is not voluntary euthanasia.⁶⁴

However, many submissions countered this view. For example, Professor Margaret Otowski argued that:

The most commonly cited objection to the legalisation of active voluntary euthanasia is the 'slippery slope' argument: that the legalisation of active voluntary euthanasia would lead to widespread involuntary euthanasia and the termination of lives no longer considered socially useful. This is, however, a completely unsubstantiated argument. The 'slippery slope' argument is typically made without regard to the risks of abuse or other problems involved in retaining the present law.¹³

Similarly, Christians Supporting Choice stated:

From my understanding, in Oregon they have had this legislation for 17 years and they have done studies which have shown that this slippery slope you are referring to does not exist. It is a scaremongering tool used by those who are ideologically opposed to the proposed legislation and who will do anything they can to stop the law. We in Christians Supporting Choice side with loving compassion and mercy and not with religious dogmatic adherence to a particular point of view... There is no slippery slope.¹⁶

Further, there were criticisms that the slippery slope argument, in being focused on the potential for active voluntary euthanasia to lead to other, more controversial forms of euthanasia, did not provide a strong argument against the practice of active voluntary euthanasia itself. Mr Peter Short, a man with terminal cancer who appeared before the Committee, argued:

Is it rational to take a position of denying the terminally ill and suffering the choice at the end of their life, because we are concerned we cannot put effective rules around a dying process? We manage road rules, alcohol rules and smoking rules. All are slippery slopes far more difficult and destructive, but all well-accepted in society and in law.⁶⁵

Finally, Dying with Dignity Victoria argued that a 'slippery slope' was more likely to occur 'in an environment where voluntary euthanasia is prohibited rather than [in] a society where a transparent, legislative framework regulates the occurrence.'⁶⁶

3.2 Arguments in support of legalising active voluntary euthanasia

(a) Legitimacy and transparency

This leads to a broader, related argument in support of a legislative approach which would introduce 'appropriate scrutiny, support and regulation' so that this practice that is 'already occurring' is undertaken in a safe as possible manner.⁶⁷ The law would also provide much-needed certainty as well as necessary safeguards for patients and for doctors who provide assistance.⁶⁸

(b) Personal autonomy – the right to choose

A number of submitters to the Senate Inquiry saw the decision to end one's life as a 'personal one',⁶⁹ underpinned by 'the basic principle of respecting an individual's right to choose'.⁷⁰ In a 1994 US Federal District Court decision on assisted suicide, the judge relied on the claim by three Supreme Court Justices in an abortion case that:

Matters involving the most intimate and personal choices a person may make in a life-time are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, or meaning, of the universe, and of the mystery of human life.⁷¹

In the Australian context, Professor George Williams argues that the judge's decision in the Rossiter case was one 'based upon the autonomy of the individual'⁷² – specifically a person's right to refuse food in order to bring about their own death.⁷³ However in his view 'the law places major limits on autonomy' where 'the right to

choose does not extend to the more dignified and humane option of voluntary assisted dying'.⁷⁴

A number of these moral and ethical concerns are summarised in an excerpt of an article published by Father Frank Brennan:

Many Australians still believe that physician assisted suicide is wrong. While prepared to see a machine turned off, they are opposed to the administration of a lethal injection. They would never seek it for themselves. As health professionals they would never provide such assistance. Others are worried by the possible abuses, fearing that a lethal injection could be administered during a down period in a person's life, which need not necessarily be the end. But should there be a law against the administration of the injection given that many other Australians believe individuals should have a right to choose?⁷⁵

3.3 Current legal framework

This section will consider the current state of the law within Australia in respect of the regulation of active voluntary euthanasia. As the regulation varies depending on the practice in question, three different types of active voluntary euthanasia practice will be considered:

1. Where the patient (in excruciating pain) requests the doctor to relieve pain and the doctor administers increased doses of pain-killing drugs that hastens the patient's death;
2. Where the patient wants to die and asks the doctor for assistance (prescribing drugs, setting up a mechanism, providing advice) but the lethal act is performed by the patient rather than the doctor;
3. Where the patient wants to die and asks the doctor for assistance where the lethal act is performed by the doctor.⁷⁶

Each of these scenarios is considered in turn below.

- (a) *Where the patient (in excruciating pain) requests the doctor to relieve pain and the doctor administers increased doses of pain-killing drugs that hasten the patient's death*

The administering of painkillers in this context is considered an 'active voluntary euthanasia' practice for the purposes of this paper because the administering of painkillers is an 'active act' (as opposed to an omission) which can 'hasten death'. A somewhat open question at common law and in legislation regulating this practice is the meaning of 'hastens death'. One interpretation is that the administering of a significantly increased level of painkiller *causes* (and therefore 'hastens') death. Another interpretation is that when treatment is withheld, resulting in an increase of pain, painkillers are used to abate the pain for long enough so that the illness takes over and 'hastens' death in a relatively painless manner.

A number of legislative provisions that regulate the use of painkillers in this context refer for guidance to 'reasonable treatment', 'good medical practice' and 'proper professional standards of palliative care' (see the section below entitled 'Legislation').

The Australian Medical Association (AMA) characterises ‘the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death’ as part of ‘good medical practice’.⁷⁷ Presumably this would include the administering of painkillers. However, the acceptable level of painkillers in the circumstances, and whether it is incidental to or *causative* of a ‘hastened’ death, remains a grey area in the absence of express determination by the courts. Further research would need to be undertaken to confirm whether this has been determined. Arguably, a massive dose of painkillers that ‘cause’ death could be described as a lethal injection ‘by proxy’. In policy terms, it seems unlikely that current legislative provisions extend to cover this scenario, though in the absence of judicial clarification on what is considered ‘reasonable’ this remains unclear. For this reason the regulation of this practice is considered within the active voluntary euthanasia section with this caveat.

(i) Common law

As of the mid-nineties, there had been no criminal prosecutions of doctors in Australia in relation to their administration of pain relieving drugs that have hastened death.⁷⁸ Further research needs to be undertaken to confirm this is still the case.

In the UK (as at the mid-nineties) an exception existed at common law if the doctor’s intention could be described as an intention to relieve pain in terminal situations rather than as an intention to end the patient’s life.⁷⁹ In the absence of the required judicial clarification in Australia, it cannot be assumed that the legal ‘exception’ that exists in English law would necessarily form part of Australian criminal law.⁸⁰ It has been suggested that under a strict interpretation of the relevant Australian homicide laws a doctor may not be immune from liability for murder in this situation.⁸¹ Even though the doctor may not have ‘intended’ to cause death, administering drugs in the ‘knowledge’ that the patient may die as a result may give rise to liability for murder.⁸² In the absence of a determinative case the issue remains untested. The relevant legislative provisions are detailed below.

(ii) Legislation

Legislation in South Australia, Western Australia and Queensland provides some clarification regarding whether and in what circumstances a doctor providing pain relief which hastens death will be criminally liable. The common law position appears to be unaffected by legislation in Victoria, Tasmania, New South Wales and the ACT (in the case of the latter, however, within the context of a statutory right to pain relief). The situation in the Northern Territory is less clear.

Consent to Medical Treatment and Palliative Care Act 1995 (SA):

Section 17(1) applies to the situation where a doctor administers medical treatment to a patient in the terminal phase of an illness ‘with the intention of relieving pain or distress’, where ‘an incidental effect of the treatment is to hasten the death of the patient’.⁸³ This section provides that the doctor will not be found liable under criminal or civil law if the treatment was undertaken with consent; in good faith and without negligence and in accordance with proper professional standards of palliative care.⁸⁴ This provision accords with the UK exception.

Guardianship and Administration Act 1990 (WA):

In Western Australia the Act provides that if a health care professional commences or continues palliative care in accordance with an advance health directive or a decision by an enduring guardian, the health professional is taken to have done so in accordance with a valid treatment decision, even if an effect of doing so is to hasten the death of the patient.⁸⁵

Also, in 2008 the Western Australian Criminal Code was amended to provide that:

a person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care)...to another person for that other person's benefit...if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.⁸⁶

Criminal Code Act 1899 (Qld):

Section 282A of the Act absolves a doctor (or a person acting under a doctor's orders) of criminal responsibility for providing palliative care where such provision is provided 'in good faith and with reasonable care and skill' and 'is reasonable, having regard to the other person's state at the time and all the circumstances of the case'.⁸⁷ The Act makes clear that no liability will arise 'even if an incidental effect of providing the palliative care is to hasten the other person's death'.⁸⁸ The pain relief will only be judged as 'reasonable' if it is 'reasonable in the context of good medical practice'.⁸⁹

Palliative care for the purposes of that section is defined as 'care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering'.⁹⁰ Section 282A makes clear that the protection from liability depends on the intention behind the administration of the medication; it provides that 'nothing in this section authorises, justifies or excuses (a) an act done or omission made with intent to kill another person; or (b) aiding another person to kill himself or herself'.⁹¹

Medical Treatment Act 1988 (Vic):

The Act provides that its operation 'does not affect any right, power or duty which a medical practitioner or any other person has in relation to palliative care'.⁹² The definition of palliative care includes the provision of 'reasonable medical procedures for the relief of pain, suffering and discomfort'.⁹³ Accordingly the Victorian legislation leaves the common law position intact in terms of possible criminal liability for this type of active voluntary euthanasia.⁹⁴

Medical Treatment (Health Directions) Act 2006 (ACT):

Similar to the Victorian legislation, the Act provides that it 'does not affect any right, power or duty that a medical practitioner or any other person has in relation to palliative care'.⁹⁵ It has a similar palliative care definition as including 'the provision of reasonable medical and nursing procedures for the relief of pain, suffering and discomfort'.⁹⁶

However s 17 of the ACT Act gives statutory recognition to the right of the patient to pain relief. That section provides that a person who has given a health direction that medical treatment be withheld or withdrawn has ‘a right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances’.⁹⁷ The Act does not indicate what would be ‘reasonable’ for these purposes, merely stating that a health professional must ‘give adequate consideration to the person’s account of the person’s level of pain and suffering’ when administering pain relief to a patient.⁹⁸

Criminal Code Act 1924 (Tas):

Section 154 of the *Criminal Code Act 1924 (Tas)* provides that:

A person is deemed to have killed another in the following cases where his act or omission is not the immediate, or not the sole, cause of death... (d) where by any act or omission he hastens the death of another who is suffering under any disease or injury which would itself have caused death.

There does not appear to be any statutory exception to this provision for medical professionals providing pain relief.

Crimes Act 1900 (NSW):

There is no provision in the *Crimes Act 1900 (NSW)* dealing with the administering of pain relief which hastens death.

Advance Personal Planning Act 2013 (NT):

The situation in the Northern Territory is less clear. The *Advance Personal Planning Act 2013 (NT)* refers to ‘health care’ to which a person can consent under that Act. There is no express reference to palliative care (or therapeutic measures) within the definition of ‘health care’. The Act refers to ‘unlawful health care action’, and provides that ‘this Act does not permit the form of intentional killing of another called euthanasia or the assisting of a person to terminate his or her life’.⁹⁹

The NT Criminal Code does not appear to make any exceptions or provide any defences in relation to the provision of pain relief which hastens death. Section 26(3) of the Code provides that ‘a person cannot authorise or permit another to kill him or, except in the case of medical treatment, to cause him serious harm’. Read together these provisions seem to suggest that while consent to pain relief is permitted, pain relief that ‘hastens death’ may not be covered.

Quite apart from the question of whether the ‘hastening of death’ is caused by or incidental to the administering of painkillers, regulation of this issue is complex and, in many respects, inconsistent across jurisdictions. In contrast the laws that regulate what is clearly described as a ‘lethal act’ (as covered in the following two scenarios) are largely consistent across jurisdictions. However the use of various mechanisms within the criminal justice system to mitigate outcomes in these two situations makes the issue less clear.

(b) *Where the patient wants to die and asks the doctor for assistance (prescribing drugs, setting up a mechanism, providing advice) but the lethal act is performed by the patient rather than the doctor*

(i) Criminal law

Although the law in Australia no longer criminalises suicide or attempted suicide, assisting suicide is a crime in all Australian states and territories:

- In New South Wales, the ACT and Victoria, it is an offence for a person to (1) 'aid or abet' a person to commit or attempt suicide, or (2) to 'incite' or 'counsel' a person to commit suicide if the person does in fact do so (or attempts to do so) as a consequence.¹⁰⁰
- In Queensland and Western Australia, it is an offence to 'procure', 'counsel' or 'aid' another person to commit suicide.¹⁰¹
- In South Australia 'a person who aids, abets or counsels the suicide of another, or an attempt by another to commit suicide, shall be guilty of an indictable offence.'¹⁰²
- In Tasmania it is an offence to 'instigate or aid another to kill himself'.¹⁰³
- In the Northern Territory it is an offence to intentionally 'assist' or 'encourage' a person to kill (or attempt to kill) themselves, but only if the person does commit or attempt suicide and the perpetrator's conduct was in fact a contributing factor.¹⁰⁴

(ii) How is the law enforced?

As of the mid-nineties, prosecutions for assisting suicide were rare and where they occurred involved provision of assistance from family members or friends with 'compassionate motives'.¹⁰⁵ This is sometimes described as 'mercy-assisted suicide'.¹⁰⁶ The law is clear that liability for assisting suicide cannot be avoided by compassionate motives or other extenuating circumstances.¹⁰⁷ Nevertheless, Australian judges have imposed very lenient sentences on people convicted of assisting suicide in these circumstances.¹⁰⁸ Further research would be required to confirm that this remains the general approach.

Note that when the Northern Territory first enacted active voluntary euthanasia legislation in 1996 (described in detail in the next section) physician-assisted suicide was legal in some circumstances.¹⁰⁹ Shortly thereafter the Act was overridden by the Commonwealth, rendering it defunct.

While the criminal law comprehensively and largely consistently regulates this issue, the use of mitigation mechanisms reveal different policy considerations being employed in this context. Attempts at balancing 'intention' and 'outcome' against an appropriate punitive response seem to underpin this approach. A similar situation can be noted in the third 'active voluntary euthanasia' scenario below.

(c) *Where the patient wants to die and asks the doctor for assistance where the lethal act is performed by the doctor*

(i) Criminal law

If a doctor complies with a patient's request and performs an act that ends the patient's life, the doctor will be exposed to criminal liability, namely the offence of murder.¹¹⁰ In all Australian states and territories, a person who commits an act which causes the death of another, with the intention to cause death, is liable for murder.¹¹¹ Life imprisonment is the mandatory sentence for a conviction of murder in the Northern Territory, Queensland, and South Australia.¹¹² In Western Australia, there are some exceptions to the otherwise mandatory imposition of a sentence of life imprisonment for murder.¹¹³ The sentence for murder is discretionary (with life imprisonment as the maximum sentence) in New South Wales, Victoria, Tasmania and the ACT.¹¹⁴

(ii) How is the law enforced?

As of 1996-97, no doctor had been prosecuted for murder in Australia for performing active voluntary euthanasia.¹¹⁵ Further research is needed to confirm that this is currently the case. There have been a number of cases involving family members and friends, referred to as 'mercy killing cases'.¹¹⁶ Similar to assisted suicide provisions, compassionate motives or other extenuating circumstances are not relevant as a defence to liability for murder, but the Australian criminal justice system has treated this situation with leniency:¹¹⁷

... a number of mechanisms within the criminal justice system have been invoked to temper the rigours of the criminal law in true instances of mercy killing... These include the exercise of prosecutorial discretion, acquittals (either by the judge or the jury) or findings of guilt on a lesser charge, lenient sentencing by the courts, favourable parole determinations, and the exercise of executive leniency.¹¹⁸

As with the second scenario above, criminal law comprehensively regulates this practice, yet available mechanisms have been used to temper the application of these laws and to mitigate outcomes. Against the backdrop of the criminal justice system grappling to find a satisfactory response to these situations, legislation has been proposed in Australia to clarify the regulation of, and make consistent, active voluntary euthanasia practices. These legislative schemes are summarised below.

4 Legislative attempts to regulate active voluntary euthanasia

A number of states and territories have made attempts to legalise active voluntary euthanasia. In November 2013 the Voluntary Assisted Dying Bill 2013 was defeated by only two votes in the Tasmanian Parliament. To date only the Northern Territory has been successful in enacting legislation (the Act having been subsequently constitutionally overridden by the Commonwealth). Even today the Northern Territory's statutory scheme is of continuing relevance as it has formed the benchmark for subsequent reform proposals, including the proposed scheme currently before the Commonwealth Parliament.

The key features of the Northern Territory Act are summarised below. Also summarised is the proposed Commonwealth scheme which attempts to introduce a federal regime to regulate active voluntary euthanasia. Being a federal scheme, issues are raised relating to the constitutional power the Commonwealth possesses to enact such legislation, which are also discussed.

4.1 *Rights of the Terminally Ill Act 1995 (NT)*

The *Rights of the Terminally Ill Act 1995 (NT)* (NT Act) Act set out a statutory regime under which physician-assisted suicide and active voluntary suicide were permitted without violating the criminal or any other applicable law.¹¹⁹

The NT Act provided for neither an unqualified ability to end life nor an unqualified affirmation of a competent adult's right to assistance in dying.¹²⁰ Instead the Act allowed a doctor to comply with a request from a terminally ill, competent adult patient for assistance in ending the patient's life where specified conditions were satisfied.¹²¹ Such conditions included:

- The terminal illness is causing the patient 'severe pain and suffering' and there are no palliative care options that alleviate this to a level acceptable to the patient.¹²²
- Having been given information on prognosis and treatment options by a palliative care specialist, the patient informs the doctor of a desire to end their life.¹²³
- The doctor is satisfied as to the terminal nature of the prognosis and that the only medical treatment available is palliative care (a specialist doctor must confirm the doctor's prognosis and a psychiatrist must confirm the patient is not suffering from a treatable clinical depression).¹²⁴
- A patient (or where physically unable, an agent of the patient) must sign a witnessed certificate of request (no witness must knowingly stand to gain a financial or other advantage as a result of the death), and the patient must have access to a qualified interpreter where required.¹²⁵
- The imposition of two 'cooling off' periods.¹²⁶

Even where all these conditions had been met, the patient was entitled 'at any time and in any manner' to rescind the request for assistance in dying.¹²⁷ Also a doctor who received a request to assist with euthanasia could 'for any reason and at any time, refuse to give that assistance'.¹²⁸ Where the doctor assisted the patient, the doctor could do so by prescribing and/or preparing and/or administering the most appropriate lethal substance.¹²⁹ The doctor was required to provide information to friends and family, answer questions afterwards and keep detailed written records (including reporting the death to the Coroner who in turn reports to the Attorney-General).¹³⁰

A doctor who complied with the legislative regime and assisted in euthanasia was immune from legal and professional disciplinary action provided the assistance was undertaken in good faith and without negligence.¹³¹ This immunity extended to other relevant health professionals.¹³² Strict penalties were imposed for threats to a doctor or other person to assist; deception/improper influence to procure the signing and/or

witnessing of a certificate of request and failure to comply with record-keeping and reporting requirements.¹³³

(a) *Constitutional issues*

The Commonwealth Parliament has the power under section 122 of the *Australian Constitution* to enact its own legislation to override the NT Act.¹³⁴ The power under section 122 of the Constitution is a plenary power and enables the Commonwealth Parliament to pass legislation to override any Northern Territory law.¹³⁵

Mr Kevin Andrews MP introduced a Private Member's Bill into the Commonwealth Parliament for the express purpose of overriding the NT Act.¹³⁶ The Commonwealth *Euthanasia Laws Act 1997* was passed two years later which had the effect of overriding the NT Act and rendering it invalid.¹³⁷

In March 2016 Senator Richard Di Natale introduced a Private Member's Bill into the Commonwealth Parliament entitled the Restoring Territory Rights (Dying with Dignity) Bill 2016. The purpose of the Bill is to repeal the *Euthanasia Laws Act 1997* (Cth). The Bill is not intended to restore the operation of the *Rights of the Terminally Ill Act 1995* (NT), but only to restore the powers of the Legislative Assemblies in the ACT and Northern Territory to make laws in relation to voluntary euthanasia.¹³⁸

4.2 *Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (Cth)*

The Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (Cth) (Draft Bill)¹³⁹ was prepared by Senator Richard Di Natale of the Australian Greens. The key features largely mirror the regime proposed under the NT Act (the detail of which will not be repeated here).

In summary, the objectives of the Draft Bill were to recognise the right of a mentally competent adult who is suffering intolerably from a terminal illness to request a medical practitioner to provide medical services to the person to end their life.¹⁴⁰ It also granted to a medical practitioner who provided such services immunity from liability in civil, criminal and disciplinary proceedings.¹⁴¹

Key provisions set out the ability to make a request and the pre-conditions to be met in accessing dying with dignity medical services.¹⁴² This included the ability to rescind a request as well as the provision of safeguards (information provision, three doctor sign off, Certificate of Request).¹⁴³ There were record-keeping obligations and offence provisions (including failure to keep records and undue influence) as well as exclusion of liability provisions.¹⁴⁴

(a) *Senate Inquiry/Constitutional issues*

On 24 June 2014 the Senate referred the Draft Bill to the Legal and Constitutional Affairs and Legislation Committee for inquiry and report by 27 October 2014.¹⁴⁵ The Senate Committee made two recommendations: the first that technical and other issues raised in evidence to the Committee be addressed and further advice sought of relevant experts before the Bill is taken further.¹⁴⁶ Secondly that if a Bill dealing

with this broad policy issue is introduced in the Senate, that Party Leaders allow Senators a conscience vote.¹⁴⁷

The Senate Inquiry also considered possible issues in relation to the constitutionality of the Draft Bill, specifically the power of the Commonwealth Parliament to legislate for euthanasia.¹⁴⁸ This issue will be considered in some detail. Four constitutional heads of power have been referred to in the Draft Bill and will be considered in turn.

(i) The medical services power¹⁴⁹

Contrasting views were submitted to the Senate Inquiry on whether euthanasia would be covered under this head of power. Views against the proposition included ‘if you have reached, by definition, an end of what medical treatment can do, then that which you are doing is not medical treatment’.¹⁵⁰ Arguments for the proposition included ‘some words or concepts expressed in the Constitution...are given ambulatory meaning so as to necessarily encompass later developments in a particular field’.¹⁵¹ The Public Law and Policy Research Unit at the University of Adelaide concluded that a ‘dying with dignity medical service’ is a medical service within the meaning of subsection 51(xxiiiA) of the Constitution.¹⁵² The basis for this is that the meaning of ‘medical services’ ‘must be informed by the dynamic nature of the medical practice’ and that, ‘from a purely constitutional standpoint, there is no obvious inference to be drawn that the meaning of “medical service” is solely limited to the “preservation of life”’.¹⁵³

(ii) The corporations power¹⁵⁴

The corporations power has been interpreted broadly by the High Court to extend to any law that ‘imposes a duty or liability, or confers a right or privilege, only on a constitutional corporation’.¹⁵⁵ This includes regulating the conduct of ‘those through whom it acts’ including employees.¹⁵⁶ The High Court has emphasised that to fall within the corporations power, the law needs to regulate or permit acts done by or on behalf of corporations.¹⁵⁷

A number of arguments were mounted against the use of this head of power to support the Draft Bill. This included that there was no requirement in the Bill that the medical practitioner provide the service on behalf of a constitutional corporation.¹⁵⁸ Even where that was the case, doubts exist as to whether this amounts to a ‘sufficient’ enough connection to bring it within the coverage of the corporations power.¹⁵⁹ The Public Law and Policy Research Unit at the University of Adelaide suggested that validity under this head of power would be strengthened if the Bill was ‘confined to a medical practitioner employed by a constitutional corporation acting in the course of their employment by that corporation’.¹⁶⁰ If that is accepted then arguably the intended coverage of the Bill would be far more limited than that potentially offered under the ‘medical services’ head of power.

(iii) The territories power¹⁶¹

It was generally accepted by submitters to the Senate Inquiry that insofar as conduct occurring in a territory was concerned, the head of power was unlimited and unqualified’ in subject matter covered and could easily be relied on.¹⁶² The obvious

limitation with this head of power is that it only applies to the territories and precludes national coverage.

(iv) Implied powers

The Bill also refers to and relies on the ‘implied legislative powers of the Commonwealth’.¹⁶³ In the absence of an Explanatory Memorandum or similar document no submissions considered whether there was an applicable implied power upon which the Bill could rely.¹⁶⁴

(b) *Consequences of constitutional invalidity*

It should be noted that the Draft Bill would provide medical practitioners with immunity from ‘civil, criminal and disciplinary action’. This requires the Bill ‘to create an inconsistency with the relevant State legislation under s 109 of the Constitution, thus rendering the State laws inoperative’. Accordingly, if the Bill is enacted but later found to be unconstitutional, medical practitioners may face the prospect of homicide charges despite fully complying with the provisions of the Bill.

It seems on balance that a relevant constitutional head of power (most likely the medical services power) may be relied on should Parliament decide to proceed with enacting a federal active voluntary euthanasia regime. If such legislation was enacted it would most likely be subject to constitutional challenge in the High Court where the question of whether a ‘medical service’ includes a service that ‘terminates’ life would be determined.

While currently a comprehensive statutory scheme regulating active voluntary euthanasia practices does not exist in Australia, this is not the case elsewhere. Active voluntary practices have been legislated for, to varying extents, in other comparable countries which are considered below.

4.3 International legislative schemes

A number of countries have legalised certain forms of active voluntary euthanasia and/or assisted suicide (the latter, for the purposes of this paper, is considered a form of active voluntary euthanasia). Some of these schemes and/or provisions have been summarised below.

(a) *The Netherlands*

With the passing of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)* (Neth),¹⁶⁵ the Netherlands became the first country in the world to legalise euthanasia.¹⁶⁶ News reports state that strict conditions must be satisfied including that patients have an incurable condition and face unbearable suffering.¹⁶⁷ Key criteria include the patient has to be in full possession of mental faculties; a second medical opinion must be sought; and after the event it is referred to a regional review committee (which includes a doctor, a legal expert and a medical ethicist).¹⁶⁸ The Act allows for both doctor administered and self-administered assisted (assisted suicide) dying.¹⁶⁹ Additionally, a patient can request doctor-administered assisted dying through an advance directive.¹⁷⁰

(b) *Belgium*

Belgium became the second EU country to legalise euthanasia with the enactment of the *Belgium Act on Euthanasia* (28 May 2002).¹⁷¹ News reports describe the Act as allowing adults who are in a ‘futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated’ to request voluntary euthanasia.¹⁷² Doctors who practise euthanasia commit no offence if prescribed conditions and procedures have been followed (the patient has legal capacity; the request is made voluntarily and repeatedly with no external pressure and the patient’s medical state is hopeless with constant, unbearable pain or mental suffering which cannot be relieved).¹⁷³ The Act does not cover assisted suicide¹⁷⁴ (only doctor-administered assisted dying) although the Belgian federal oversight body, *Commission Federale de Controle et Evaluation* acknowledges that some cases of self-administered assisted dying are covered by the law.¹⁷⁵ Similar to the Netherlands, a patient can request doctor-administered assisted dying through an advance directive.¹⁷⁶ In May 2014, Belgium became the first country in the world to allow children access to euthanasia.¹⁷⁷

(c) *Luxembourg*

Luxembourg became the third European country to legalise euthanasia¹⁷⁸ with the passing of *The Law of 16 March 2009 on Euthanasia and Assisted Suicide* (Lux).¹⁷⁹ News reports state that the law permits euthanasia and assisted suicide in relation to those with incurable conditions (requirements include repeated requests and the consent of two doctors and an expert panel).¹⁸⁰ Doctors who provide euthanasia and assisted suicides do not face ‘penal sanctions’ or civil suits for damages and interest.¹⁸¹

(d) *Switzerland*

Article 115 of the Swiss *Criminal Code* (1994) states that inciting or assisting suicide is a punishable offence, however it is only a crime if it is undertaken out of self-interested motivations.¹⁸² This has the effect of ‘legalising’ assisted suicide in Switzerland without having a specific euthanasia law in place.¹⁸³ In Switzerland, assistance is provided almost exclusively by a range of not-for-profit right to die organisations¹⁸⁴ (which can involve non-physicians).¹⁸⁵ However it is the patient who must self-administer the ‘lethal dose’.¹⁸⁶ All forms of active euthanasia (i.e. doctor-administered assisted dying) remain prohibited in Switzerland.¹⁸⁷

(e) *The United States of America (states of Oregon, Washington, Vermont, Montana)*¹⁸⁸

Active euthanasia remains illegal in most of the United States.¹⁸⁹ The United States does not provide for federal provisions or a federal regime for active voluntary euthanasia practices.

Assisted suicide is legal in the states of Oregon, Washington, Vermont and Montana,¹⁹⁰ with legislation passed in both Oregon and Washington.¹⁹¹ In both Oregon and Washington only self-assisted dying is permitted.¹⁹² Doctor-administered

assisted dying and any form of assistance to help a person commit suicide outside the provisions of these Acts remains a criminal offence.¹⁹³

(f) *Canada*

On 6 February 2015 the Supreme Court of Canada found that the prohibition on physician-assisted death in place in Canada (in ss 14 and 241(b) of the Canadian *Criminal Code*) unjustifiably infringed the right to life, liberty and security of the person in article 7 of the *Charter of Rights and Freedoms* in the Canadian Constitution.¹⁹⁴ The Supreme Court declared the infringing sections of the *Criminal Code* void:

insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.¹⁹⁵

The Supreme Court suspended the declaration of invalidity of the provisions in the *Criminal Code* for 12 months, to give the Canadian legislatures time to revise their laws. On 15 January 2016 the Supreme Court granted the Canadian governments a further 4 months to make any law reform.¹⁹⁶ This means that the Supreme Court's decision will take effect, and the prohibition on physician-assisted suicide in Canada will therefore end, on 6 June 2016.

The Supreme Court made clear that:

nothing in the declaration of invalidity...would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures.¹⁹⁷

Since the Supreme Court's decision, the Canadian governments have been exploring options for legalising and regulating physician-assisted dying. A Special Joint Committee on Physician-Assisted Dying was appointed by the Canadian Parliament to 'make recommendations on the framework of a federal response on physician-assisted dying respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians'.¹⁹⁸ The Special Joint Committee released its report in February 2016, recommending a legislative framework which would regulate 'medical assistance in dying' by imposing both substantive and procedural safeguards, namely:

Substantive Safeguards:

- A grievous and irremediable medical condition (including an illness, disease or disability) is required;
- Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
- Informed consent is required;
- Capacity to make the decision is required at the time of either the advance or contemporaneous request; and

- Eligible individuals must be insured persons eligible for publicly funded health care services in Canada.

Procedural Safeguards:

- Two independent doctors must conclude that a person is eligible;
- A request must be in writing and witnessed by two independent witnesses;
- A waiting period is required based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician;
- Annual reports analyzing medical assistance in dying cases are to be tabled in Parliament; and
- Support and services, including culturally and spiritually appropriate end-of-life care services for Indigenous patients, should be improved to ensure that requests are based on free choice, particularly for vulnerable people.¹⁹⁹

It should be noted that physician-assisted has already been legalised in the province of Québec. Québec passed *An Act respecting end-of-life care* (the Québec Act) in June 2014, with most of the Act coming into force on 10 December 2015. The Québec Act provides a 'framework for end-of-life care' which includes 'continuous palliative sedation' and 'medical aid in dying', defined as 'administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death.'²⁰⁰ In order to be able to access medical aid in dying under the Québec Act a patient must:

- (1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
- (2) be of full age and capable of giving consent to care;
- (3) be at the end of life;
- (4) suffer from a serious and incurable illness;
- (5) be in an advanced state of irreversible decline in capability; and
- (6) experience constant and unbearable physical or psychological suffering
- (7) which cannot be relieved in a manner the patient deems tolerable.²⁰¹

The request for medical aid in dying must be signed off by two physicians.²⁰² The Québec Act also established a Commission on end-of-life care to provide oversight and advice to the Minister of Health and Social Services on the implementation of the legislation regarding end-of-life care.²⁰³

4.4 Summary

Unlike passive voluntary euthanasia, active voluntary euthanasia does not, in a regulatory sense, enjoy the same widespread acceptance. This is despite the apparent widespread public support for these practices as revealed in general polls on the issue. Arguments for and against these practices range from the role of the doctor, support of palliative care and the 'slippery slope' to arguments about legitimacy and transparency in our laws and the importance of autonomy in the right to choose.

Currently legislative provisions on the administering of painkillers that hasten death are inconsistently regulated across states and territories. In contrast the performance

of a 'lethal act' (or assistance of) is consistently regulated in criminal law but reveal a criminal justice system seeking out mechanisms for mitigation of outcomes. From this situation have emerged various legislative attempts that seek to directly regulate active voluntary euthanasia practices. While such laws are not yet in existence in Australia, elsewhere such legislative schemes have been enacted and are in operation today.

Another relevant source of guidance is to be found in a human rights-based analysis, which is contained in the following section.

5 International human rights issues and considerations

Australia is a party to seven key human rights treaties. The most relevant obligations when discussing voluntary euthanasia are contained in the *International Covenant on Civil and Political Rights* (ICCPR).²⁰⁴ The following rights in the ICCPR may be engaged by the practice of voluntary euthanasia:

- right to life (article 6)
- freedom from cruel, inhuman or degrading treatment (article 7)
- right to respect for private life (article 17)
- freedom of thought, conscience and religion (article 18).

The *Convention on the Rights of Persons with Disabilities* contains specific obligations in relation to people with disability that are also relevant to a discussion of voluntary euthanasia, and therefore will also be considered below.²⁰⁵

5.1 Right to life

Article 6(1) of the ICCPR provides:

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

The right to life has been characterised as the 'supreme human right', as 'without effective guarantee of this right, all other rights of the human being would be devoid of meaning'.²⁰⁶ It is the only right in the ICCPR that is expressly described as 'inherent'.²⁰⁷

The second sentence of article 6(1) imposes a positive obligation on States to provide legal protection of the right to life. However, the subsequent reference to life not being 'arbitrarily deprived' operates to limit the scope of the right (and therefore States' duty to ensure the right).²⁰⁸

Comments from the UN Human Rights Committee suggest that laws allowing for voluntary euthanasia are not necessarily incompatible with States' obligation to protect the right to life.²⁰⁹ As one leading commentator on the ICCPR has concluded:

If a national legislature limits criminal responsibility here after carefully weighing all the affected rights and takes adequate precautions against potential abuse, this is within the scope of the legislature's discretion in carrying out its duty to ensure the

right...the State's obligation to ensure does not go so far as to require that life and health be protected against the express wishes of those affected.²¹⁰

The UN Human Rights Committee has emphasised that laws allowing for euthanasia must provide effective procedural safeguards against abuse if they are to be compatible with the State's obligation to protect the right to life. In 2002 the UN Committee considered the euthanasia law introduced in The Netherlands. The Committee stated that:

where a State party seeks to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believes that the Covenant obliges it to apply the most rigorous scrutiny to determine whether the State party's obligations to ensure the right to life are being complied with (articles 2 and 6 of the Covenant).²¹¹

The UN Human Rights Committee expressed concern about whether the wording of the conditions under the Dutch law for legally terminating a life provided adequate safeguards.²¹² The Committee commented that the large numbers of cases referred to the Dutch review committee in 2000 (and the very low proportion of negative assessments by that committee) 'raise doubts whether the present system is only being used in extreme cases in which all the substantive conditions are scrupulously maintained.'²¹³

The UN Committee recommended to the Netherlands that it:

re-examine its law on euthanasia and assisted suicide in the light of these observations. It must ensure that the procedures employed offer adequate safeguards against abuse or misuse, including undue influence by third parties.²¹⁴

When the Netherlands came up for review again by the Human Rights Committee in 2009, the Committee again expressed concern about its euthanasia law, noting:

Under the law on the Termination of Life on Request and Assisted Suicide, although a second physician must give an opinion, a physician can terminate a patient's life without any independent review by a judge or magistrate to guarantee that this decision was not the subject of undue influence or misapprehension (art. 6).²¹⁵

The Committee 'reiterate[d] its previous recommendations in this regard and urge[d] that this legislation be reviewed in light of the Covenant's recognition of the right to life'.²¹⁶

The European Court of Human Rights (ECtHR) has adopted a similar position to the UN Human Rights Committee when considering euthanasia laws and the right to life in article 2 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (European Convention).²¹⁷ According to the ECtHR, the right to life in article 2 cannot be interpreted as conferring a right to die, or a right to self-determination in terms of choosing death rather than life.²¹⁸

However, the ECtHR has held that a State's obligation to protect life under that article does not preclude it from legalising voluntary euthanasia, provided adequate safeguards are put in place and adhered to. In *Hass v Switzerland* the ECtHR explained that the article 2:

creates for the authorities a duty to protect vulnerable persons, even against actions by which they endanger their own lives... this latter Article obliges the national authorities 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*.²¹⁹

Accordingly, the ECtHR concluded that:

the right to life guaranteed by Article 2 of the Convention obliges States to establish a procedure capable of ensuring that a decision to end one's life does indeed correspond to the free will of the individual concerned.²²⁰

In its most recent decision regarding end of life issues, *Lambert and Others v France*,²²¹ the ECtHR considered whether the decision to withdraw artificial nutrition and hydration of Vincent Lambert violated the right to life in article 2.

Vincent Lambert was involved in a serious road-traffic accident, which left him tetraplegic, and with permanent brain damage. He was assessed in expert medical reports as being in a chronic vegetative state, and required artificial nutrition and hydration administered via a gastric tube.

Mr Lambert's medical team initiated the collective procedure provided for under the relevant French law in relation to patient's rights and end-of-life issues. This process ultimately resulted in the Judicial Assembly of the *Conseil d'Etat* authorizing the withdrawal of the artificial nutrition and hydration of Mr Lambert.

Mr Lambert's parents applied to the ECtHR alleging that the decision to withdraw his artificial nutrition and hydration breached, inter alia, the State's obligations under article 2 of the European Convention.

The ECtHR highlighted that article 2 imposes on States both a negative obligation (to refrain from the 'intentional' taking of life) and a positive obligation (to 'take appropriate steps to safeguard the lives of those within its jurisdiction').²²² The Court held that the decision of a doctor to discontinue life-sustaining treatment (or 'therapeutic abstention') did not involve the State's negative obligation under article 2, and therefore the only question for the Court under article 2 was whether it was consistent with the State's positive obligation.²²³

The ECtHR emphasized that 'the Convention has to be read as a whole', and therefore:

in a case such as the present one reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses.²²⁴

The Court noted that there was a consensus among European member States 'as to the paramount importance of the patient's wishes in the decision-making process, however those wishes are expressed'.²²⁵ It identified that in dealing with end of life situations, States have some discretion in terms of striking a balance 'between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy'.²²⁶

The Court considered that the provisions of the Act of 22 April 2005, as interpreted by the *Conseil d'Etat*, constituted a legal framework which was sufficiently clear to

regulate with precision the decisions taken by doctors in situations such as in Mr Lambert's case. The Court found the legislative framework laid down by domestic law, as interpreted by the *Conseil d'État*, and the decision-making process, which had been conducted in meticulous fashion, to be compatible with the requirements of the State's positive obligation under article 2.

5.2 Right to freedom from cruel, inhuman or degrading treatment

The purpose behind the prohibition on torture or cruel, inhuman or degrading treatment or punishment in article 7 of the ICCPR is 'to protect both the dignity and the physical and mental integrity of the individual.'²²⁷ This article imposes a duty on State Parties:

to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited by article 7, whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity.²²⁸

Article 7 therefore imposes a positive obligation on States to protect persons in its jurisdiction from ill-treatment reaching the requisite threshold. There are two ways in which it may be argued that a State denying a person the option of voluntary euthanasia may have the result of forcing them to endure cruel, inhuman or degrading treatment.

The first is that a prohibition on voluntary euthanasia may force people to live with extreme and chronic pain, against their express wishes. It is debatable however whether the State's positive obligation under article 7 of the ICCPR requires it to allow active voluntary euthanasia where the only options for a person are to endure what they consider to be unbearable suffering, or to choose to end their life.

In the ECtHR case of *Pretty v the United Kingdom*, the applicant suffered from Motor Neurone Disease. She was paralysed from the neck down, had 'virtually no decipherable speech' and was being fed through a tube. Her life expectancy was a matter of only months or even weeks. However, she had full mental capacity. The ECtHR noted that:

The final stages of the disease are exceedingly distressing and undignified. As she is frightened and distressed at the suffering and indignity that she will endure if the disease runs its course, she very strongly wishes to be able to control how and when she dies and thereby be spared that suffering and indignity.²²⁹

Because of her disease, the applicant was unable to end her own life. She sought an undertaking from the Director of Public Prosecutions not to prosecute her husband if he assisted her to commit suicide, as the latter was a criminal offence under English law. The Director refused. The applicant alleged, among other things, a violation of article 3 of the European Convention.

The ECtHR recognised that article 3 (combined with article 1) of the European Convention imposes a positive obligation, in that it 'requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman and degrading treatment or punishment, including such treatment administered by private individuals'.²³⁰ However, the ECtHR concluded that this

positive obligation did not extend to require that the State ‘sanction actions intended to terminate life’ by legalising (or at least decriminalising) assisting suicide.²³¹

A State prohibition on *passive* voluntary euthanasia (i.e. consensual withdrawal of life-sustaining treatment) may potentially raise issues under article 7 of the ICCPR if it requires doctors to administer treatment against the wishes of the patient. The physical integrity of a person (which article 7 is designed to protect) may be compromised if they are subjected to medical treatment without their consent.

However, article 7 does not protect against all interferences with physical integrity, and therefore ‘medical treatment, even if given without consent, will have to reach a certain level of severity before violating article 7’.²³²

Interferences with personal (including physical) integrity which are not so severe as to fall within article 7 may however violate the right to privacy in article 17, as will be discussed immediately below.²³³

5.3 Right to privacy

Article 17 of the ICCPR provides:

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
2. Everyone has the right to the protection of the law against such interference or attacks.

A leading commentator on the ICCPR has explained that ‘the right to privacy protects that particular area of individual existence and autonomy that does not touch upon the sphere of liberty and privacy of others’.²³⁴

In terms of protecting individual existence, this includes a person’s physical (and mental) integrity.²³⁵ Accordingly ‘medical treatment without consent or against the will of the patient is to be deemed interference with privacy, as this term also covers the inviolability of one’s own body’.²³⁶ Such interference with personal integrity is therefore permissible only when it is both lawful and non-arbitrary, i.e. ‘when it serves a legitimate purpose and observes the principle of proportionality’.²³⁷

Article 17 also encompasses protection of ‘that area of individual autonomy in which human beings strive to achieve self-realisation by way of actions that do not interfere with the liberty of others’.²³⁸ The right to privacy ‘gives rise to a right to one’s own body’, and therefore protection of individual autonomy includes actions which may be injurious to a person’s own health.²³⁹ Refusals to allow passive euthanasia or assisted suicide despite the express wishes of the patient therefore represent interferences with the right to privacy.²⁴⁰

Under article 17 any interference with privacy, even if lawful ‘should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances.’²⁴¹

The question is whether legislation which prohibits voluntary euthanasia meets these requirements for a justifiable interference with the right to privacy.

The ECtHR has considered the relevance of the right to privacy in article 8 of the European Convention in the context of requests for access to voluntary euthanasia. While the wording of that article is not identical to article 17 of the ICCPR, the substance and scope of the right protected by both articles is sufficiently similar that comments made by the ECtHR about article 8 can offer useful guidance on the possible application of article 17 of the ICCPR.²⁴²

In *Pretty v the United Kingdom*, the ECtHR stated that '[t]he very essence of the Convention is respect for human dignity and human freedom'.²⁴³ The Court held that 'it is under Article 8 that notions of the quality of life take on significance'.²⁴⁴

The ECtHR recognised that the concept of 'private life' in article 8 of the European Convention 'covers the physical and psychological integrity of a person'.²⁴⁵ It also held that 'the notion of personal autonomy is an important principle underlying the interpretation of [Article 8's] guarantees'.²⁴⁶

In relation to personal autonomy, the Court noted that:

the ability to conduct one's life in a manner of one's own choosing may...include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned...even where the conduct poses a danger to health or, arguably, where it is of a life-threatening nature, the case-law of the Convention institutions has regarded the State's imposition of compulsory or criminal measures as impinging on the private life of the applicant within the meaning of Article 8 § 1 and requiring justification in terms of the second paragraph'.²⁴⁷

In relation to a person's choice to refuse medical treatment, the ECtHR stated that:

the refusal to accept a 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...a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life'.²⁴⁸

The ECtHR held in *Pretty* that the fact that the applicant was 'prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life' constituted an interference with her right to respect for private life in article 8.²⁴⁹ However, the Court concluded in that case that the blanket ban on assisted suicide was justified as 'necessary in a democratic society' for the protection of the rights of others, and therefore was a permissible limitation of the right.²⁵⁰

In subsequent cases the ECtHR has confirmed that the right to respect for private life includes:

- 'an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence',²⁵¹ and

- ‘the right of each individual to decline to consent to treatment which might have the effect of prolonging his or her life’.²⁵²

5.4 Rights of people with disability

As is evident from the facts in the cases of *Lambert* and *Pretty* (discussed above), an analysis of the issues raised by voluntary euthanasia includes consideration of the rights of people with disability. Australia is a party to the *Convention on the Rights of Persons with Disabilities* (the Disability Convention), and therefore is under an obligation to ensure that people with disability enjoy all their human rights without discrimination of any kind on the basis of disability.²⁵³

The Disability Convention does not provide a comprehensive definition of disability, but provides that ‘persons with disabilities’ include those who have long-term mental impairments and intellectual impairments. When a person’s impairment interacts with various barriers that restrict a person’s effective participation in society on an equal basis to others, they are considered to have disability.²⁵⁴

Key principles which underpin the Disability Convention include non-discrimination and ‘[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons’.²⁵⁵

The Disability Convention makes clear that all people with disability have an inherent right to life, and places an obligation on States to take all necessary measures to ensure that people with disability enjoy this right on an equal basis with others.²⁵⁶ The Convention requires States parties to provide people with disability equal protection under the law as those without disability.²⁵⁷

These obligations would, for example, prohibit States from passing laws which allow for involuntary euthanasia of people with disability because of their disability. Article 25 of the Disability Convention specifically prohibits the ‘discriminatory denial of health care or health services or food and fluids on the basis of disability’.²⁵⁸

However, in the case of voluntary euthanasia, the same balancing of the right to life with the right to personal autonomy that occurs for people without disability applies under the Disability Convention for those with disability. The Convention makes clear that people with disability, like those without disability, have a right to respect for their physical and mental integrity, and privacy.²⁵⁹ People with disability are entitled to make choices as to their own welfare, and to be supported to do so where necessary. They enjoy legal capacity on an equal basis with those without disability, and are entitled to support in exercising that capacity.²⁶⁰ Any safeguards which are put in place in relation to people with disability exercising their legal capacity, to protect against undue influence and/or abuse, must respect the rights, will and preferences of the person.²⁶¹

Respect for the right of people with disability to make decisions includes deciding whether to agree to medical treatment. Article 25 of the Disability Convention places an obligation on States Parties to require health professionals to ‘provide care of the same quality to persons with disabilities as to others, including on the basis of free

and informed consent'.²⁶² The UN Committee on the Rights of Persons with Disabilities has made clear that:

The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment.²⁶³

The UN Committee on the Rights of Persons with Disabilities has further stated that treating people with disability without their consent may violate a number of rights in the Disability Convention, as:

forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options...and must provide access to independent support...The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.²⁶⁴

5.5 Freedom of thought, conscience and religion

Article 18 of the ICCPR requires protection of freedom of thought, conscience and religion, and provides that:

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others...

Article 18 of the ICCPR distinguishes between the freedom to hold or adopt a particular belief, and the freedom to manifest that belief in conduct. It is clear from the different focuses of paragraphs (2) and (3) of article 18 that the freedom to hold a belief is broader than the freedom to act upon it.

The right to hold a belief is absolute - the State is not permitted to interfere with a person's right to autonomously develop thoughts and a conscience.²⁶⁵ However, once a belief is manifested (that is, implemented) in action, it leaves the sphere of absolute protection and may be the subject of legitimate limitations, because the manifestation of a religious belief may have an impact on others. The right to freedom of belief

therefore ‘does not always guarantee the right to behave in public in a manner governed by that belief’.²⁶⁶

Discussions about the legalisation of voluntary euthanasia will often touch on matters of personal belief, whether it is belief in the ‘sanctity of life’ or belief in ‘personal autonomy’ and an individual’s right to choose a ‘good death’. The extent to which article 18 would require the State to permit actions based on these beliefs will depend on all the circumstances.

A law legalising voluntary euthanasia may need to make allowances for those whose beliefs in the sanctity of life would preclude them from being able to participate in end-of-life processes, in order to be compatible with article 18. This could take the form, for example, of a ‘conscientious objection’ provision for doctors whose beliefs are incompatible with involvement in euthanasia.

In the case of the belief in personal autonomy and a person’s right to choose a ‘good death’, the extent to which this might found an argument that the State is required to decriminalise voluntary euthanasia was considered by the ECtHR in *Pretty v the United Kingdom*. In that case the Court considered the right to freedom of thought, conscience and religion in article 9 of the European Convention. The ECtHR held that:

The Court does not doubt the firmness of the applicant's views concerning assisted suicide but would observe that not all opinions or convictions constitute beliefs in the sense protected by Article 9 § 1 of the Convention. Her claims do not involve a form of manifestation of a religion or belief, through worship, teaching, practice or observance as described in the second sentence of the first paragraph. As found by the Commission, the term “practice” as employed in Article 9 § 1 does not cover each act which is motivated or influenced by a religion or belief... To the extent that the applicant's views reflect her commitment to the principle of personal autonomy, her claim is a restatement of the complaint raised under Article 8 of the Convention.²⁶⁷

The ECtHR accordingly concluded that the fact that assisted suicide was criminal in the applicant’s case did not result in a violation of her right to freedom of thought, conscience and religion under article 9.²⁶⁸

6 Analysis

An analysis of international human rights law relevant to the practice of voluntary euthanasia does not lead to ‘the’ answer. Rather it reveals a balancing of rights, the appropriate balance of which may be subject to competing views.

The right to life does not (as a corollary) include a right to choose to die. But nor does it require a State to ensure that a person’s life is protected when this is against the express wishes of that person. In the case of a request for voluntary euthanasia, the State’s obligation to protect life must be balanced against the right to personal autonomy which is contained within the right to privacy.

Laws prohibiting access to voluntary euthanasia may interfere with the right to respect for private life as guaranteed under article 17 of the ICCPR, and as such need to be able to be justified as a legitimate limitation of that right.

In relation to access to passive euthanasia, it is important to note that to subject a person to medical treatment against their will or without their consent may violate their physical integrity and breach their rights under article 17 (and possibly article 7) of the ICCPR.

Further, the Disability Convention makes clear that people with disability are entitled to the same respect for their rights to life, health, physical integrity and personal autonomy as people without disability.

If a State does choose to legalise voluntary euthanasia, article 6 of the ICCPR requires that the legislation includes strict and effective safeguards against abuse. In order to be compatible with the right to freedom of thought, conscience and belief, such laws may need to include an appropriately worded ‘conscientious objection’ provision.

The analysis suggests that there is no one identifiable right that necessarily requires the legalisation of voluntary euthanasia, nor is there one identifiable right that prevents its legalisation, provided stringent safeguards are instituted. It would seem from a human rights perspective, the option exists to support legalisation of voluntary euthanasia practices provided that sufficient safeguards are put in place to prevent ‘arbitrary’ (including discriminatory) deprivations of life.

7 Commentary

Individual support for the issue of euthanasia is, at its core, a matter of personal belief. Values based on ‘sanctity of life’ and ‘personal autonomy’ are usually grounded in deeply held moral and/or religious beliefs. Further, supporting euthanasia may not be an absolute position. People may support some forms of euthanasia, such as passive voluntary euthanasia, while rejecting other, more active, forms of euthanasia.

The functions of the Australian Human Rights Commission include examining legislation and proposed legislation for compliance with human rights standards,²⁶⁹ and promoting understanding, acceptance and public discussion of human rights in Australia.²⁷⁰

Any definitive position taken by the Commission on voluntary euthanasia will depend on the way in which it is framed in legislation. In the absence of a specific proposal to legislate for any form of euthanasia, the commentary below should be taken as indicative of a general position based on consideration of the relevant human rights laws and principles presented in this paper.

(a) Passive voluntary euthanasia

The most striking aspect of passive voluntary euthanasia, defined as the withdrawal or withholding of treatment by omission, is that it is already occurring, although is not referred to as such. Whether it is called palliative care or ‘good medical practice’ it forms part of our current medical landscape when considering ‘end of life choices’ and is subject to regulation. As these practices already exist, are generally accepted within the Australian community and are broadly consistent with human rights

standards, there seems little to be gained in arguing for or against these practices. Instead the form of regulation in place can usefully be subject to scrutiny.

Currently the regulation of passive voluntary euthanasia practices rests with the states and territories, where, in the absence of legislation or other regulation, the common law applies. Mostly state-level regulation focuses on setting up systems that allow people to formalise or ‘expressly state’ their wishes through instruments such as advanced care directives and enduring powers of attorney or guardianship. These systems also include an array of safeguards to ensure that decisions are voluntary and informed.

From a human rights perspective, any potential breach of the right to life is arguably alleviated by the inclusion of strict safeguards in advance directives and enduring powers of attorney. Other rights – the rights to privacy and freedom of belief - are similarly served by these instruments that place at the forefront the control of the individual over their bodies, beliefs and end of life choices.

What can be subject to criticism is the inconsistent nature of this regulation. Common regulatory features exist between states and territories, however the level of regulation varies significantly as do the consistency in safeguards and liability provisions. For example, while advance directives legislation exists in some states/territories, in New South Wales these practices are wholly regulated by guidelines. If reliance is given to the existence of adequate safeguards in ensuring the ‘non-arbitrary’ deprivation of life then, at minimum, such safeguards should be consistent and represent best human rights practice across the country. There may be a role for the Federal Government in leading development of a nationally consistent approach on this issue.

(b) *Active voluntary euthanasia*

Currently active voluntary euthanasia practices involving a ‘lethal act’ are illegal in Australia and are regulated by assisted suicide and murder provisions in criminal law. The practice of administering pain relief with the *incidental* effect of ‘hastening death’ is legal in a number of states/territories although, in the absence of judicial determination, it is unclear whether practices amounting to ‘a lethal act’ would be covered by these provisions. Again, there may be a leadership role for the Federal Government towards ensuring that ‘hastening death’ provisions are consistent across states and territories and accord with best practice human rights standards.

It is noteworthy that where a ‘lethal act’ is clearly identified in so-called ‘mercy-killings’, courts have typically imposed more lenient sentences, which perhaps indicates a shift in how these practices are viewed. The recent Senate Inquiry referenced Australian polls that show strong public support for active voluntary euthanasia. Yet unlike passive voluntary euthanasia, supporting active voluntary euthanasia would require law reform, where the form of regulation would be a matter of debate, rather than improving on an existing system.

Notwithstanding this, the precedent has been set in Australia with the now invalid *Rights of the Terminally Ill Act 1995* (NT) which has, subsequently, been used as the model for the exposure draft of the Medical Services (Dying with Dignity) Exposure

Draft Bill presented to Federal Parliament in 2014 and subjected to a subsequent inquiry by the Senate Legal and Constitutional Affairs Legislation Committee.

Apart from arguments about ‘sanctity of life’ and personal autonomy, the major objections to regulating active voluntary euthanasia as summarised by the Senate Inquiry are largely practical. The ‘role of the doctor’ and end of life choices within a palliative care process can co-exist with an active voluntary euthanasia regime. People who would not wish to choose active voluntary euthanasia options could remain within the palliative care process and access the options it offers. All doctors would not be required to provide euthanasia services, only those who wished to do so.

Further, non-doctors could possibly be involved in the provision of euthanasia services, which currently occurs in Switzerland. ‘Slippery slope’ arguments are primarily concerned with the risk that unsanctioned deaths would occur without specific consent and/or in non-terminal cases. The practical solution to this would be to improve the safeguards contained within any regulatory regime in order to prevent this from occurring, to the greatest extent possible.

Well drafted ‘proactive’ legislation permitting and regulating active voluntary euthanasia can deliver certainty, transparency and above all, protection to all who may be involved in these practices. This would not be the case if such practices were simply decriminalised. If jurisdictions in Australia were simply to decriminalize participation in voluntary euthanasia processes without regulating such processes, this may not be consistent with the State’s positive obligation to protect against arbitrary deprivations of life in article 6 of the ICCPR.

It is arguable whether practices amounting to active voluntary euthanasia are best regulated by criminal law provisions. The use of a number of ‘mitigating’ mechanisms in so-called ‘mercy killings’ seems to indicate a criminal justice system grappling to find the right balance between intention and outcome. However, it must be acknowledged that for some the best possible safeguard is a total ban on these practices that the criminal law currently provides.

If it is accepted that a ‘proactive’ legislative approach was able to deal with the practical objections to active voluntary euthanasia, then it would be incumbent on the Commission to advocate for a model with best practice safeguards which meet human rights standards. Other international comparative jurisdictions may provide better safeguards or approaches to improve upon the model presented to Federal Parliament in 2014. The safeguards contained within that model would allow people to ‘expressly state’ their wishes through a ‘Certificate of Request’. Such an instrument is intended to provide certainty to all participants in the process, including health professionals and law enforcement, and would be accompanied by a range of safeguards to ensure that the decision made is both voluntary and informed. Such safeguards aim to minimise the risk of any arbitrary deprivation of life, and confer to people the right to control over their end of life choices in a manner that is consistent with their beliefs.

The alternative is to allow the prohibition of such practices to remain within the realm of criminal law. However, the groundswell of public support and history of legislative attempts within Australia, as well as the general trend toward legislating active

voluntary euthanasia in a number of comparable countries, may signal a social shift on this issue which may in time compel a definitive legal response.

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- ¹ Castan Centre for Human Rights, *Euthanasia*, Have you got that right? At <http://www.haveyougotthatright.com/seasons/season-1/#euthanasia> (viewed 8 April 2016).
- ² Castan Centre for Human Rights, *Euthanasia*, Have you got that right? At <http://www.haveyougotthatright.com/seasons/season-1/#euthanasia> (viewed 8 April 2016).
- ³ Castan Centre for Human Rights, *Euthanasia*, Have you got that right? At <http://www.haveyougotthatright.com/seasons/season-1/#euthanasia> (viewed 8 April 2016).
- ⁴ George Zdenkowski, *Human Rights and Euthanasia*, Occasional Paper of the Human Rights and Equal Opportunity Commission (1996), 2. At <https://www.humanrights.gov.au/our-work/rights-and-freedoms/projects/human-rights-and-euthanasia> (viewed 8 April 2016).
- ⁵ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), pi.
- ⁶ George Zdenkowski, *Human Rights and Euthanasia*, Occasional Paper of the Human Rights and Equal Opportunity Commission (1996), p 2.
- ⁷ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), pi.
- ⁸ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), pi.
- ⁹ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), pi.
- ¹⁰ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), piii.
- ¹¹ See, e.g. Queensland Government: Queensland Health, *Implementation Guidelines: End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients, part 2*. At: <https://www.health.qld.gov.au/ghpolicy/docs/gdl/gh-gdl-005-1-2.pdf>
- ¹² Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 28.
- ¹³ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 28.
- ¹⁴ Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (Amended 2014)*. At: <https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007-amended-2014> (viewed 8 April 2016).
- ¹⁵ Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (Amended 2014)*. At: <https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007-amended-2014> (viewed 8 April 2016).
- ¹⁶ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 28.
- ¹⁷ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 28-9.
- ¹⁸ See, for example, NSW Government, Department of Health, *What is Advance Care Planning?* (11 February 2016). At: <http://www.health.nsw.gov.au/patients/acp/Pages/advance-care-planning.aspx> (viewed 8 April 2016); Government of Western Australia, Department of Health, *Frequently Asked Questions*, Advance Health Directives. At <http://www.health.wa.gov.au/advancecareplanning/home/faqs.cfm#25> (viewed 8 April 2016).
- ¹⁹ Government of Western Australia, Department of Health, *Frequently Asked Questions*, Advance Health Directives. At <http://www.health.wa.gov.au/advancecareplanning/home/faqs.cfm#25> (viewed 8 April 2016).
- ²⁰ *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7 and 9.
- ²¹ *Advance Care Directives Act 2013* (SA) s 11 (requires use of particular form); *Advance Personal Planning Act 2013* (NT) ss 8(1)(a), 9, 10, and 38; *Medical Treatment Act 1988* (Vic) s 5; *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7-9; *Guardianship and Administration Act 1990* (WA) ss 3 and 110P; *Powers of Attorney Act 1998* (Qld) s 35. Note though, for example, in Victoria and the ACT palliative care is expressly excluded from the definition of medical treatment which a person can refuse (see ss 3 and 4 of the *Medical Treatment Act 1988* (Vic) and s 6 of the *Medical Treatment (Health Directions) Act 2006* (ACT)).
- ²² *Advance Care Directives Act 2013* (SA) s 34(2); *Advance Personal Planning Act 2013* (NT) s 40; *Medical Treatment (Health Directions) Act 2006* (ACT) s 11; *Guardianship and Administration Act*

1990 (WA) s 110S ('at any time the maker of the directive is unable to make reasonable judgments in respect of that treatment').

²³ *Powers of Attorney Act 1998* (Qld) s 36. Also, s 66A of the *Guardianship and Administration Act 2000* (Qld) provides that whether contained in an advance directive or given by an enduring power of attorney, 'consent to the withholding or withdrawal of a life-sustaining measure for the adult cannot operate unless the adult's health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.'

²⁴ *Medical Treatment Act 1988* (Vic) s 5.

²⁵ *Advance Care Directives Act 2013* (SA) ss 19 and 36 and *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(2)(b); *Advance Personal Planning Act 2013* (NT) ss 41, 45, 52 and 53(1) and (4); *Medical Treatment Act 1988* (Vic) s 6; *Guardianship and Administration Act 1990* (WA) s 110ZJ (note however that there is an exception in this Act for urgent treatment following an attempted suicide, in which case a directive may be overridden – see s 110ZIA); *Powers of Attorney Act 1998* (Qld) s 36 (1)(b) (but see s 103, which protects health providers for non-compliance with an advance health directive in certain circumstances, including if the health provider believes that the directive is 'inconsistent with good medical practice').

²⁶ See, e.g. *Powers of Attorney Act 1998* (Qld) s 103; *Advance Care Directives Act 2013* (SA) s 36(2).

²⁷ See, for e.g., *Advance Care Directives Act 2013* (SA) s 38; *Advance Personal Planning Act 2013* (NT) s 45; *Guardianship and Administration Act 1990* (WA) s 110ZK.

²⁸ See *Advance Personal Planning Act 2013* (NT) ss 45 and 46 and *Guardianship and Administration Act 1990* (WA) s 110ZL.

²⁹ *Medical Treatment Act 1988* (Vic) s 9; *Advance Care Directives Act 2013* (SA), s 41; *Medical Treatment (Health Directions) Act 2006* (ACT) s 16.

³⁰ *Powers of Attorney Act 1998* (Qld) s 101.

³¹ *Powers of Attorney Act 1998* (Qld) s 37. Section 296 of the *Criminal Code 1899* (Qld) provides that 'A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.'

³² NSW Government, NSW Health, *Guideline: Advance Care Directives (NSW) – Using* (2005) 5. At http://www0.health.nsw.gov.au/policies/gl/2005/GL2005_056.html (viewed 8 April 2016).

³³ *Advance Care Directives Act 2013* (SA) ss 21, 23(1) and 34(1); *Advance Personal Planning Act 2013* (NT), ss 15, 16, 17, 20; *Powers of Attorney Act 2014* (Vic) ss 22, 23; *Powers of Attorney Act 2006* (ACT) ss 8, 13(2), 32; *Guardianship and Administration Act 1990* (WA) ss 3, 110B 110F and 110G(1); *Powers of Attorney Act 1998* (Qld) ss 32 and 33(4); *Guardianship and Administration Act 1995* (Tas) ss 25(2)(e) and 32; *Guardianship Act 1987* (NSW) ss 3, 6 and 6A.

³⁴ *Advance Care Directives Act 2013* (SA) s 35; *Advance Personal Planning Act 2013* (NT) ss 18 and 21; *Medical Treatment (Health Directions) Act 2006* (ACT) ss 44, 46 and sch 1, cl 1.11(2); *Guardianship and Administration Act 1990* (WA) ss 110G(1) and 110ZJ(2); *Guardianship and Administration Act 1995* (Tas) s 32(6); *Guardianship Act 1987* (NSW) s 6E (1)(d), (2) and (3); *Powers of Attorney Act 2014* (Vic) ss 21 and 24.

³⁵ *Medical Treatment Act 1988* (Vic) s 5B(2).

³⁶ *Guardianship and Administration Act 2000* (Qld) s 66A and *Powers of Attorney Act 1998* (Qld) sch 2 cl 5(2).

³⁷ *Advance Care Directives Act 2013* (SA) s 41; *Advance Personal Planning Act 2013* (NT) s 46; *Medical Treatment Act 1988* (Vic) s 9 (and see sch 3); *Guardianship and Administration Act 1990* (WA) s 110ZK; *Guardianship and Administration Act 1995* (Tas) ss 47 and 48; *Guardianship Act 1987* (NSW) s 6G.

³⁸ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 1.

³⁹ *Advance Personal Planning Act 2013* (NT) s 55; *Medical Treatment Act 1988* (Vic) s 4; *Medical Treatment (Health Directions) Act 2006* (ACT) s 6; *Guardianship and Administration Act 1990* (WA) s 110ZB; *Powers of Attorney Act 1998* (Qld) s 39.

⁴⁰ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 1.

⁴¹ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), i-ii.

⁴² (2009) 74 NSWLR 88.

⁴³ *Hunter and the New England Area Health Authority v A* (2009) 74 NSWLR 88, [40].

⁴⁴ (2009) WASC 229.

⁴⁵ *Brightwater Care Group v Rossiter* (2009) WASC 229, [32].

- ⁴⁶ See U.S. Living Will Registry, *Frequently Asked Questions (FAQ) About the U.S Living Wills Registry*, <http://www.uslivingwillregistry.com/faq.shtm> (viewed 8 April 2016).
- ⁴⁷ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 1: Passive Voluntary Euthanasia*, Parliamentary Library Research Paper No 3 (1996-7), 19.
- ⁴⁸ Applying to England and Wales.
- ⁴⁹ *Mental Capacity Act UK* (2005) ss 24, 25(5) &(6).
- ⁵⁰ *Mental Capacity Act UK* (2005) ss 25-6.
- ⁵¹ *Mental Capacity Act UK* (2005) s 11.
- ⁵² *Mental Capacity Act UK* (2005) s 11.
- ⁵³ For more information see Canadian Virtual Hospice, *Advance Care Planning Across Canada* (15 July 2015). At http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Decisions/Advance+Care+Planning+Across+Canada.aspx (viewed 8 April 2016).
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- ⁵⁶ Family Council of Victoria, Submission No 85 to Senate Legal and Constitutional Affairs Legislation Committee, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014*, August 2014, 2-3. At: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Dying_with_Dignity/Submissions (viewed 8 April 2016).
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- ⁵⁸ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 10.
- ⁵⁹ Quoted in Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 12.
- ⁶⁰ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 11.
- ⁶¹ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 11.
- ⁶² Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 11.
- ⁶³ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 7.
- ⁶⁴ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 8.
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- ⁶⁶ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 10.
- ⁶⁷ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 6.
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- ⁶⁹ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 38.
- ⁷⁰ Senate Legal and Constitutional Affairs Legislation Committee, Parliament of Australia, *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* (2014) 38.
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- ⁸⁶ *Criminal Code Act Compilation Act 1913* (WA) s 259(1).
- ⁸⁷ *Criminal Code Act 1899* (Qld) s 282A(1).
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- ⁹² *Medical Treatment Act 1988* (Vic) s 4(2).
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- ⁹⁴ See *Medical Treatment Act 1988* (Vic) s 4(3) and Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 2: Active Voluntary Euthanasia*, Parliamentary Library Research Paper No 4 (1996-7) 6.
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- ⁹⁸ *Medical Treatment (Health Directions) Act 2006* (ACT) s 17(3).
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- ¹⁰⁰ *Crimes Act 1900* (ACT) s 17; *Crimes Act 1900* (NSW) s 31C; *Crimes Act 1958* (Vic) s 6B(2).
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- ¹²⁴ Natasha Cica, *Euthanasia – the Australian Law in an International Context Part 2: Active Voluntary Euthanasia*, Parliamentary Library Research Paper No 4 (1996-7) 12.
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- ²²² *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [117].
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²⁶⁰ *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008), art 12(2) and (3).

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²⁶⁷ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [82].

²⁶⁸ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [83].

²⁶⁹ *Australian Human Rights Commission Act 1986* (Cth) s 11(e).

²⁷⁰ *Australian Human Rights Commission Act 1986* (Cth) s 11(g).