
“Voluntary Assisted Dying” in Australia: The Victorian Parliamentary Committee’s Tenuous Case for Legalization

John Keown, D.C.L.*

ABSTRACT: In 2016 a Parliamentary Committee in Victoria, Australia, recommended the legalization of physician-assisted suicide and voluntary euthanasia. Its report was deeply flawed. Its treatment of key objections to legalization, both principled and practical, was superficial and selective. The Voluntary Assisted Dying Act, passed by the Victorian Parliament in November 2017, is built on the report’s shaky foundations.

Introduction

Whether the criminal law should permit doctors intentionally to end the lives of patients on request, and/or intentionally assist them to end their own lives, is probably the most important debate in contemporary law, medicine and ethics. Unfortunately, in that debate emotion often trumps reason, generating more heat than light. Committees of inquiry can play an important role in informing the debate by identifying and clarifying the key issues; in canvassing opinion from experts in relevant disciplines including law, philosophy and medicine, and in assessing the experience of those few jurisdictions which have relaxed their laws.¹

* (Oxon.), Rose Kennedy Professor, Kennedy Institute of Ethics, Georgetown University. Editor of *EUTHANASIA EXAMINED* (1995) (“KEOWN1”); author of *EUTHANASIA, ETHICS AND PUBLIC POLICY* (2002; 2nd ed. forthcoming 2018) (“KEOWN2”) and *THE LAW AND ETHICS OF MEDICINE* (2012) (“KEOWN3”), and co-author (with Emily Jackson) of *DEBATING EUTHANASIA* (2012) (“KEOWN4”).

¹ See for example the impressive reports, containing much valuable evidence, of the *NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* (1994) and the *HOUSE OF LORDS SELECT COMMITTEE ON MEDICAL ETHICS, REPORT OF THE SELECT COMMITTEE ON MEDICAL ETHICS* (1994).

This article analyzes the report of a committee of politicians in the Australian State of Victoria published in June 2016. The report of the Parliamentary Committee into end of life choices (the “Parliamentary Report”) contained a majority recommendation that what it styled “voluntary assisted dying” should be legalized for competent adults over 18 at the “end of life” (in the “final weeks or months of life”) suffering from a “serious and incurable condition” causing “enduring and unbearable suffering” that could not be relieved in a manner they deemed “tolerable.”² Another committee, the Ministerial Advisory Panel on Voluntary Assisted Dying, was then appointed to explore how best to implement the Parliamentary Committee’s recommendation; it reported in July 2017.³ Though the members of both committees were doubtless well-intentioned, both reports were seriously flawed. This article, whose focus is the Parliamentary Report, identifies two key weaknesses:⁴

- It failed to articulate a clear and coherent ethical case in support of legalization.
- It failed to refute the case against legalization. That case is supported by the principled argument that legalization rejects human equality in favor of discriminatory and arbitrary judgments, which invite logical extension, about whose life is not worth living. It is supported also by the practical argument that effective control is not feasible. The force of both arguments has been confirmed by the experience of those few jurisdictions which have relaxed their laws. Rather than substantiating its reassuring assessment of the experience of those jurisdictions, the Report omitted to produce a formal review of the evidence; to mention several major sources, or to respond to the well-documented criticisms those sources contain.⁵

As will appear, the Parliamentary Report scarcely provided an adequate basis for a balanced and properly-informed debate, let alone for legalization.

First, a note on terminology. This article eschews neologisms such as “assisted dying” or “voluntary assisted dying” (VAD). Such phrases are vague: some use them to mean a patient taking lethal drugs intentionally prescribed for that purpose by a physician

² PARLIAMENT OF VICTORIA, LEGISLATIVE COUNCIL, LEGAL AND SOCIAL ISSUES COMMITTEE, INQUIRY INTO END OF LIFE CHOICES. FINAL REPORT (PP No174, Session 2014-16; hereafter “PR”) at 221-23; 237-38. This response to the Report is concerned solely with this recommendation and not with the other 48, which concerned palliative care and advance care planning.

³ STATE OF VICTORIA, DEPARTMENT OF HEALTH AND HUMAN SERVICES, MINISTERIAL ADVISORY PANEL ON VOLUNTARY ASSISTED DYING. FINAL REPORT (2017) (“Panel Report”) The Panel’s remit was not to consider whether but how the law should be relaxed. It was charged to advise the government “about how a compassionate and safe legislative framework for voluntary assisted dying could be implemented.” Panel Report, 5.

⁴ The Panel Report failed to appreciate how these weaknesses also undermined its recommendations. As we shall see, the framework it proposed was morally arbitrary and incapable of ensuring effective control.

⁵ Thumbnail sketches of the law in five jurisdictions (the Netherlands, Switzerland, Canada, Quebec and Oregon) were provided in an appendix to the Parliamentary Report (PR, Appendix 3) and a comparative table of the laws in eight jurisdictions in another (*id.* Appendix 4). The experience of the Netherlands over the previous 32 years merited a mere two and a half pages (*id.* Appendix 3 at 269-71).

(physician-assisted suicide or PAS), others to include the intentional administration of a lethal injection by a physician at the patient's request (voluntary euthanasia or VE). They are also euphemistic: the question is not whether the law should permit physicians to assist patients who are dying but whether it should permit them intentionally to kill patients or to assist patients to kill themselves.⁶

Superficial Treatment of Ethical Arguments

The Report failed to articulate a clear and coherent ethical case in favor of legalization or to engage at all adequately with the ethical arguments against. Indeed, the ethical arguments both for and against were simply summarized in an appendix.⁷ One is, moreover, struck by the inadequate formulation of some of the arguments, particularly the argument from the "sanctity" or "inviolability" of human life, and by the failure to distinguish the two, independent "slippery slope" arguments ("empirical" and "logical"). The poor formulation of the arguments may have owed something to some of the sources on which the committee relied.

The Report stated that the summaries of the arguments were informed by four recent "investigations" into "assisted dying."⁸ First, why only these four? Why did the committee ignore the reports of the New York State Task Force on Life and the Law⁹ (the finest yet published); the House of Lords Select Committee on Medical Ethics,¹⁰ and the

⁶ The Panel Report stated that whereas deaths from suicide were avoidable and every effort should be made to prevent them, the people who were the focus of its report were facing an "inevitable, imminent death" as a result of an incurable illness or condition. (*Id.* at 8) But why shouldn't every effort be made to prevent *their* suicide? Was it because they were facing an "inevitable, imminent" death from illness? If so, many people who kill themselves for all sorts of reasons – such as being old, lonely and neglected – have short life expectancies. And the Panel recommended that people with up to 12 months to live should be eligible for VE/PAS (*id.* at 13), even if they refused a treatment which could maintain their life beyond 12 months. (*Id.* at 67-68) In what sense is death 12 months or more away "imminent"?

The Panel adopted the phrase "voluntary assisted dying" because this emphasized that it was "a decision initiated by" a person who was suffering and took responsibility for the decision. (*Id.* at 8). The Panel objected (*id.*) to the word "euthanasia" in the case of patients who could not kill themselves even with assistance because the word suggested that they "require the merciful action of a medical practitioner." The Panel thought it important to emphasize that even in such a situation the patient was "in control of the decision and the process." (*Id.*) However, just as the phrase "voluntary assisted dying" obscures the important reality that the cause of death is unnatural not natural – killing not dying – so too conflating physician-assisted suicide with euthanasia obscures the reality that in the latter case the patient does indeed require the "action of a medical practitioner."

⁷ PR, Appendix 7. There was also imbalance. Why one counter-argument to the case for legalization but four the other way? *Id.* at 312-13.

⁸ *Id.* 303. One of the four was simply a background paper by two academics: Ben White and Lindy Willmott, *How should Australia regulate voluntary euthanasia and assisted suicide?* (2012). The paper was vulnerable to various criticisms, including its inadequate summary of the arguments against legalization and its omission of several important sources. For debates putting the arguments for and against see KEOWN1 (chapters 1-6, 8 and 10), and KEOWN4.

⁹ *Supra* note 1.

¹⁰ *Id.*

Scottish Health Committee?¹¹ Second, why did the Parliamentary Report not consider whether, and the extent to which, the authors of the four “investigations” were supporters of legalization? One of the four was the UK Commission on Death and Dying, which was cited several times.¹² The Parliamentary Report noted that this committee was chaired by Lord Falconer, funded by Sir Terry Pratchett and included a “broad range of experts.”¹³ The Report omitted to inform the reader that Lord Falconer is the leading activist in the UK Parliament for PAS; that Sir Terry was a patron of the pressure-group “Dignity in Dying”; that nine of the twelve appointees were known to favor legalization and that many bodies, including the British Medical Association, declined to give evidence to this self-styled “Commission.”¹⁴ Again, the Parliamentary Report noted that another of the four “investigations,” by the Panel of the Royal Society of Canada, was produced by a group of academics but the Report omitted to mention that four of the six academics were internationally prominent advocates of legalization.¹⁵ If one’s understanding of the ethical arguments is influenced by “investigations” dominated by those who are pro-legalization there is a risk that one will fail to appreciate the nature and force of the arguments against. The Report nowhere evinced an understanding of the key principled argument against legalization (and of the logical, and not only practical, implications of rejecting it), an argument to which we shall turn after we have criticized the Report’s failure to articulate a clear and coherent case for legalization.

In the appendix listing the moral arguments for and against legalization the Report stated: “In describing these arguments here, the Committee does not assign any particular value or make any critique of them....”¹⁶ But *describing* arguments is not *engaging* with them, let alone *answering* them. The Report’s chapter recommending a framework for legalization stated: “In explaining this framework, the Committee chose not to focus solely on arguments for and against legalising assisted dying.”¹⁷ It made this decision because “the various arguments put by supporters and opponents are well known and have been addressed many times in many different reports and research papers, both in Australia and internationally.”¹⁸ It added that concerns raised against legalization, such as the inability to implement and maintain effective safeguards, had not been borne out

¹¹ SCOTTISH HEALTH AND SPORT COMMITTEE, STAGE 1 REPORT ON ASSISTED SUICIDE (SCOTLAND) BILL (SP Paper 712, 6th Report, Session 4, 2015).

¹² PR at 15; 212; 215; 304.

¹³ *Id.* at 304.

¹⁴ “British Medical Association?” <http://bit.ly/2n8ilN4> (accessed 26 January 2018).

¹⁵ PR at 304. A key source for Professors White and Willmott’s “snapshot” of the experience of jurisdictions with relaxed laws was, moreover, one of these prominent advocates of legalization. BEN WHITE AND LINDY WILLMOTT, HOW SHOULD AUSTRALIA REGULATE VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE? (2012), 21-25.

¹⁶ *Id.* at 306. *See also* at 309; 312; 313.

¹⁷ *Id.* at 205.

¹⁸ *Id.*

in jurisdictions which had relaxed their laws.¹⁹ It observed: “The Committee did not find compelling evidence to support the negative consequences predicted by these claims.”²⁰

There are three problems with all of this. First, as we shall see, there was in fact a substantial body of evidence (not mentioned in the Report) bearing out those concerns. Second, the ethical arguments were not as well-known as the committee seemed to think, as its own defective summary (particularly of the two key arguments against that we mentioned above) demonstrated. Third, whether those arguments were well known or not it was surely incumbent on the committee *to make out a reasoned case for legalization and to respond to the arguments against*, not just relegate them to a list in an appendix. Legislative recommendations need to be supported by argument not assertion. Moreover, unless those recommendations flow from principled arguments they are arbitrary. Why should the law allow *this* conduct but not *that* conduct? Why in relation to *this* patient but not *that* patient?

The Report’s ethical argument for legalization appears (for it was nowhere clearly articulated) to have run along the following lines. Some people were committing suicide in dreadful ways, many dying alone and in pain.²¹ Fifty people a year were committing suicide in Victoria after experiencing “irreversible deterioration in physical health.”²² Others were being prosecuted for “acts of love and compassion towards their relatives and loved ones” that broke the law.²³ The criminal justice system displayed great leniency and, while this was desirable on a case-by-case basis, it threatened to bring the law into disrepute and undermine public confidence in the administration of justice.²⁴ Some doctors were providing criminal assistance and this was happening without regulation, sometimes without the patient’s consent.²⁵ The Report identified three options: maintain the status quo; enforce the law, or change the law.²⁶ The first was a “head in the sand” approach and the second option lacked support and might heighten the fears of some doctors about providing adequate pain relief, but the committee had heard extensive evidence in support of third option: relaxing the law.²⁷ The Report proceeded to recommend legalization to enable the “small percentage of eligible Victorians who want help to end their suffering” without fear of prosecution.²⁸ The Report’s line of argument invites six responses.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.* at 206.

²² *Id.* at 197.

²³ *Id.* at 207.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.* at 208.

²⁷ *Id.* at 208-09.

²⁸ *Id.* at 213.

Discouraging Suicide

The fact that some people commit suicide is not an argument against the law prohibiting assisting suicide. The policy of the public health and criminal justice systems has long been to discourage not encourage suicide. The crime of suicide has been widely abrogated precisely because of our greater understanding of suicide and of how people are frequently driven to it by depression and despair. How many of those people who have tragically ended their own lives in Victoria, or who have been assisted to end their own lives, have done so because of psychological disturbance, unrealistic fears of a painful death or the unavailability of good palliative care? How many could have been diverted from suicide by timely psychiatric, psychosocial or palliative support? Indeed, one of the cases cited by the Report was that of an elderly man “suffering with depression and a variety of physical ailments” who believed everyone had a right to end their own life instead of “suffering through debilitating physical decline.”²⁹ What if his depression had been successfully treated and his suffering palliated? Why was this not done? The Report, having listed a number of cases in which people with serious illnesses had killed themselves, stated: “While it is impossible to know whether people would have availed themselves of the option of assisted dying if it existed, the evidence suggests that decisions to suicide are desperate and occur in the absence of a less devastating alternative.”³⁰ How can we know that these desperate people would not have been deflected from killing themselves if they had been offered a less devastating alternative such as psychosocial or palliative care?³¹ And even if those alternatives had failed, how can we know they would have opted for PAS?

Suicidal Ideation’s Various Causes

If one thinks the law should take its cue from the incidence of suicide (and assisted suicide) then one needs to recognize that there are many reasons why people take their own lives including, as we have just noted, a desire not to suffer through debilitating physical decline. Or bereavement. Or loneliness. Or addiction. Or being “tired of life.” Or being bullied or stigmatized, perhaps for being gay or transgender. In Oregon, the two most common reasons for seeking PAS are “losing autonomy” (91%), and being “less able to engage in activities making life enjoyable” (90%). Feeling a burden on one’s family is a reason in 44% of cases, and inadequate pain control, or concern about it comes down the list at 26%.³² We recall that the Report recommended that VE/PAS

²⁹ *Id.* at 173.

³⁰ *Id.* at 200.

³¹ The Report usefully documented significant shortcomings in palliative care in Victoria: there were “gaps in quality and provision of palliative care in Victoria”; care services were “not easily accessible” by people in rural and regional areas; there was a “considerable variation” in the quality of care, and care was “fragmented” and at times “poorly integrated” with the rest of the health system. *Id.* at xxiii.

³² Oregon Health Authority, Public Health Division, *Oregon Death with Dignity Act. 2017 Data Summary*. Table 1. The figure of 26% raises questions about the availability of adequate palliative care in Oregon.

be available for those at “the end of life”³³ suffering from a serious and incurable condition causing enduring and unbearable suffering that cannot be relieved in a manner they deem tolerable.³⁴ But why limit VE/PAS to this subset of people who may want to end their lives? What of the person who is not at “the end of life” but who is suffering greatly and wants to die? Why should they be denied relief, particularly when someone who is at “the end of life” and who is suffering less would qualify? Indeed, it is far from clear that the elderly man cited above who killed himself would have qualified under the committee’s proposals, or several of the other sad cases cited by the Report, such as the patients with arthritis and back pain; early dementia; prostate cancer, or multiple sclerosis.³⁵

Illegal PAS

The Report noted that there was an incidence of illegal practice by medical practitioners.³⁶ It quoted a study in which patients died without having received assessment for depression and without adequate palliative care.³⁷ But why weren’t these patients assessed for depression or given adequate palliative care? This is bad medicine not bad law, for which the solution is not weakening the law but improving medical education and training. Another risk identified was the non-consensual ending of life, in some cases involving incompetent patients, and instances were cited of doctors feeling coerced into hastening the deaths of patients they hardly knew.³⁸ But how would legalizing VE/PAS reduce the practice of killing patients who are incapable of requesting it? And if some doctors, when the law has their back, succumb to pressure from relatives, why would those doctors not succumb if the law no longer had their back? As we shall see, the experience of those few jurisdictions that have relaxed their laws does little to support claims that legalization brings clandestine VE/PAS out “into the open” and subjects it to effective legal control.³⁹ In many cases doctors have simply ignored the requirements, such as the requirement to report cases, and continue to do so. Moreover, legalization does nothing to reduce the opportunity for abuse of the law. If some doctors are currently prepared to break the criminal law prohibiting VE/PAS, why should we expect them to respect guidelines permitting them?

³³ The Panel interpreted this to mean no longer than 12 months from death. Panel Report, 73-74. Whether someone a year away from death is in the “final weeks or months of life” (PR at 223) or “at the very end of life” (*id.* at 224) is debatable.

³⁴ See text at note 2. The Report claimed (PR at 194) that its proposal for legalization aimed to address those with “irremediable pain and suffering.” But its proposal mentioned suffering, not pain, and if the patient was to determine whether their suffering could not be relieved in a manner they deemed tolerable, what had happened to irremediability? Moreover, given the inherent subjectivity of suffering, could the requirement of suffering not be satisfied simply by the patient’s say-so?

³⁵ PR at 198-99.

³⁶ *Id.* at 181.

³⁷ *Id.* at 182.

³⁸ *Id.* at 183.

³⁹ See *infra* text at notes 84 to 95.

Problems of and Leniency in Enforcement

The Report claimed that the difficulty of prosecuting doctors for “assisted dying” and the lenient treatment of those charged with assisting suicide were serious flaws in the legal framework in Victoria.⁴⁰ This does not follow. First, many criminal laws, such as the law against rape, are difficult to enforce. Second, the fact that the criminal law treats cases of assisted suicide with leniency and compassion is not a matter for criticism but for compliment. That is how the criminal law is supposed to work: the discretion of prosecutors is an inherent feature of common law systems. In England and Wales, for example, the Director of Public Prosecutions has published guidance in relation to the exercise of prosecutorial discretion in cases of assisting suicide.⁴¹ That guidance has been commended by Members of Parliament but Parliament has, nevertheless, repeatedly voted down proposals to legalize PAS. UK legislators rightly appreciate the difference between compassion on the one hand and condonation on the other. The Report’s claim that such exercise of discretion threatens to bring the law into disrepute and undermine confidence in the legal system⁴² was, then, misconceived.⁴³ As Lord Bingham explained in the leading UK case rejecting a right to assisted suicide, the broad policy of the criminal law is to apply offence-creating provisions to all and to give weight to personal circumstances either when deciding whether to prosecute or upon sentencing.⁴⁴

Encouraging Suicide

What effect might legalizing VE/PAS have on the suicide rate? One paper (not cited in the Report’s bibliography) which considered the position in the United States, concluded: “Legalizing PAS has been associated with an increased rate of total suicides relative to other states and no decrease in nonassisted suicides.”⁴⁵ In relation to the Netherlands, Professor Theo Boer, a former euthanasia review committee member, has written that the assumption that euthanasia will lead to lower suicide rates lacks statistical support. In the Netherlands, the mortality rate from euthanasia tripled from 1.3% in 2002 to 4.08% in 2016 and during the same period the number of suicides increased from 1,567 to 1,894, a rise of 20.8%. Moreover, compared to neighboring countries, the Netherlands showed the largest increase in suicide.⁴⁶ It is puzzling that the

⁴⁰ PR at 185.

⁴¹ CROWN PROSECUTION SERVICE, “ASSISTED SUICIDE,” <http://bit.ly/2r1fb88> (accessed 26 January 2018).

⁴² *Id.* at 193.

⁴³ This is not to suggest that the criminal law in jurisdictions which prohibit VE and PAS could not benefit from certain reforms, such as (in England and Wales) the abolition of the mandatory life sentence for murder, a reform that would recognize that murderers vary in blameworthiness. There is also an argument in favor of the creation of a separate offence of “mercy killing,” though the problem of determining whether a killer’s motive was compassionate has, not unreasonably, led to the rejection of this proposal in England and Wales.

⁴⁴ R (Pretty) v. DPP UKHL 61, 2 AC 800, at [36] (2001).

⁴⁵ David Albert Jones and David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?* 108(10) SOUTHERN MEDICAL JOURNAL 599 (2015).

⁴⁶ Theo A. Boer, *Does Euthanasia have a Dampening Effect on Suicide Rates? Recent Experiences from the Netherlands*, 10(1) JOURNAL OF ETHICS IN MENTAL HEALTH 1, 6-7 (2017).

Parliamentary Report, which attached so much importance to the incidence of suicide, did not examine this issue.

A Further Option

The Report presented an incomplete set of alternatives: there are not three but at least four policy options. A fourth option is that of maintaining the current legal prohibition on VE/PAS but improving the quality and availability of palliative and social care and of making any legal changes which would enhance patient care at the end of life. There may, for example, be a case for legislation to make it clear that doctors need have no fear of criminal prosecution for administering palliative drugs in accordance with the well-established principle of “double effect.” It seems at the very least premature for the Report, which made so many recommendations about improving the provision of palliative care and the law relating to advance care planning, to have recommended the legalization of VE/PAS before waiting to see what improvements in end of life care those other recommendations might yield.

Having questioned the cogency of what appeared to be the Report’s implicit argument for legalization, we may now turn its failure to respond to two key objections.

Two Unanswered Objections

From Principled Prohibition to Arbitrary Permission

The bright-line prohibition in the criminal law and in professional medical ethics on intentionally ending the life of patients, and on intentionally assisting patients to end their own lives, reflects a foundational ethical and legal principle: the “sanctity” or “inviolability” of human life.⁴⁷ This philosophical principle is grounded in a recognition that we all share—regardless of illness, life-expectancy, age, disability, gender, race, religion or sexual orientation—an *intrinsic and equal worth* which makes it wrong for any physician intentionally to kill any patient or to help any patient end their own life. This principle does not require life to be preserved at all costs: it is not “vitalistic” and accepts that it is perfectly proper to withhold or withdraw life-prolonging treatment in a range of circumstances.⁴⁸

By contrast, laws which permit VE/PAS trade on the notion that there are two categories of patient: those with lives “worth living” and those who would be “better off dead.” Such laws invite fundamentally *discriminatory* judgments about the worth of patients’ lives. The superficially attractive argument that VE/PAS are justified by respect for patient choice fails. Laws and proposed laws to allow VE/PAS (like those in both Reports) do not allow them for *any* patient who autonomously wants them. They allow them only for *some* patients who want them, such as those at the “end of life” or those

⁴⁷ Or, as it is sometimes expressed, the “ethic of equality in right to life.”

⁴⁸ The chairman of the Parliamentary Committee wrote that the current law is inconsistent because it prohibits assisting suicide but allows the withdrawal of life-prolonging treatment at the patient’s request and the administration of palliative drugs which shorten life. PR at xvi. There is no inconsistency: respecting a refusal of treatment and administering palliative drugs need involve no intent to hasten death.

“suffering unbearably.” So, VE/PAS are not fundamentally about patient choice at all but about the judgment that the choices of *some* patients should be accommodated because it is thought *by others* in society that death would benefit them, that they would be “better off dead.” (It is small wonder that many disability groups, who see this more clearly than many others, are strongly opposed to legalization.)

The Panel Report stated that its first guiding principle was that “Every human life has equal value.”⁴⁹ But to allow physicians intentionally to help patients kill themselves, and to kill them if they are physically unable to do so, is obviously inconsistent with the principle of fundamental human equality. As we have just noted, the key underlying moral argument for VE/PAS is that death would benefit certain patients because their lives are no longer worth living. Unlike either the Parliamentary or Panel Reports, the report of the House of Lords Select Committee on Medical Ethics clearly identified the basis and importance of the criminal law’s complete prohibition on the intentional killing of patients or helping patients to kill themselves. The Select Committee aptly described that prohibition as the “cornerstone of law and of social relationships” that “*protects each one of us impartially, embodying the belief that all are equal.*”⁵⁰ Contrast the Select Committee’s assured grasp of this core philosophical argument with the vaguer and feebler formulation in the appendix to the Parliamentary Report, which read: “Legalising assisted dying devalues life generally, and can lead to the situations described in the arguments above concerning vulnerable people, and the slippery slope.”⁵¹ It added, distractingly: “This argument is sometimes framed from a religious perspective, with a deity being the only agent with the authority to give or remove life.”⁵² Although the principle can be formulated in theological terms it can also be formulated in purely philosophical terms, as the House of Lords Select Committee recognized when it conceptualized and expressed the prohibition’s basis in terms of fundamental human equality.

Not only are laws allowing VE/PAS discriminatory, they are *arbitrary*. Why PAS/VE for those who are expected to die within a year? Why not for those with conditions like multiple sclerosis or motor neurone disease (ALS) or arthritis who may face years of suffering? And why not for suffering caused by mental illness or intractable grief, or for existential suffering resulting from being old, lonely and “tired of life”? The Report stated that the committee received “compelling evidence” that under the current law

⁴⁹ Panel Report at 11. The Parliamentary Report stated that the committee had “defined” a set of “core values” for end of life care which underpinned its approach. PR at 15. The first was “Every individual person has inherent value.” *Id.* at 16.

⁵⁰ *Supra* note 1 at para. 237 (emphasis added).

⁵¹ PR at 310.

⁵² *Id.* Perhaps the Report’s poor understanding of the argument was influenced by one of the four “investigations” it cited (*id.* at 303) whose authors wrote that the principle (which they did not accurately explain in their fleeting 15-line account) tended to be grounded “in religious ideology”; proceeded to reinforce this distraction by quoting a statement by the Catholic church, and then cited a legal case in which the judges misunderstood the principle. BEN WHITE & LINDY WILLMOTT, HOW SHOULD AUSTRALIA REGULATE VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE? (2012) at 17-18. There is no shortage of books on which the Report could have drawn for an accurate account of the principle, including KEOWN3.

the nature of dying for people with terminal illnesses and chronic and degenerative diseases could sometimes be harrowing.⁵³ Why, then, deny relief to those with chronic and degenerative diseases who are not at the “end of life”? Again, the Panel Report read that VE/PAS allowed individuals to make choices about the end of their life. It went on: “The focus is on individual choice because there is no right or wrong answer, and an individual is best placed to decide what is most appropriate for them.”⁵⁴ It added: “How a person defines ‘a good death’ will depend on their preferences, needs and values.”⁵⁵ Why, then, deny the choices of those who are not at the “end of life” but who want to die in accordance with their “preferences, needs and values”?

Why, moreover, lethal injections only for those who are thought unable to kill themselves even with assistance?⁵⁶ Why should other patients be denied their preference for a reliable and quick dispatch? Is it because doctors cannot be trusted with administering lethal injections? If so, why should they be trusted with issuing lethal prescriptions? If they can be trusted with lethal injections in the case of the patient who is so incapacitated as to be thought unable to end their own life even with assistance, why not in the case of the less vulnerable patient who is able to die with assistance but would much prefer a lethal injection, perhaps to avoid any possibility of bungling the attempt and/or of a slow, lingering end?

Why, further, should the law allow a hastened death only for those who can request it? Why not for those who are suffering, perhaps even more gravely, but who are (like those with advanced dementia) unable to formulate a request? Why discriminate against them by denying them relief? Indeed, once one accepts lethal injections for the competent one is *logically committed* to lethal injections for the incompetent (“non-voluntary” euthanasia or NVE.) The moral case for VE rests on two arguments: respect for autonomy and the duty of beneficence. VE is thought to be justified because we should (1) respect patients’ choices for a hastened death (2) when to do so would benefit them. Why, then, deny patients this benefit merely because they cannot request it? True, such patients are not autonomous, but their lack of autonomy does not negate our duty to help them. *The absence of autonomy does not cancel the duty of beneficence.* In what other situation do doctors withhold beneficial interventions from patients merely because the patient cannot request them? This “logical slippery slope” argument is unanswerable, which may well be why those who campaign for VE/PAS regularly evade it.

The Report described the “slippery slope” argument sketchily in terms of the erosion of safeguards, such that an extension to those who lack capacity will be “difficult to resist.”⁵⁷ This is an incomplete and inadequate account of slippery slope concerns,

⁵³ PR at 193.

⁵⁴ Panel Report at 7.

⁵⁵ *Id.* at 9.

⁵⁶ One means available to everyone to end life, with or without assistance, is stopping eating and drinking. The Dutch medical and nursing associations have published guidance on how to help patients do precisely that. THE KNMG AND THE DUTCH NURSES’ ASSOCIATION, CARING FOR PEOPLE WHO CONSCIOUSLY CHOOSE NOT TO EAT AND DRINK SO AS TO HASTEN DEATH (2014).

⁵⁷ PR at 309-10.

which are in reality twofold. They are not only (as we shall see below) empirical concerns about ineffective control (largely as a result of problems of drafting and enforcement), valid those they are. They are also, as we have just seen, logical. The Report failed even to describe the logical slippery slope argument let alone answer it. This is odd because the Report affected familiarity with the Dutch experience. In 1996 the Dutch courts, twelve years after they had declared VE lawful to relieve suffering, held NVE lawful for the same reason.⁵⁸ That the Report failed to mention this disturbing legal and logical slide is noteworthy.⁵⁹ Perhaps the delegation from the committee which visited the Netherlands did not have it drawn to their attention by their Dutch hosts? But then why was this obviously important and well-documented development not disclosed by the committee's "extensive evaluation of material from other jurisdictions"?⁶⁰ Or, if it was, why was it not mentioned in the Report?

The Report's own "core values" for end of life care provided little justification for limiting access to VE/PAS in the way it proposed. They included the values that the right to self-determination is a fundamental principle that should be respected; that end of life care should be patient-centered not paternalistic; that the goal of end of life care should be to minimize a patient's pain and suffering; that all forms of discrimination in end of life care should be ended as far as possible, including those based on physical condition, and that the law should be coherent.⁶¹ How, applying these values, could the Report coherently justify limiting access to VE/PAS in the way it did? What of the self-determination of those who face years of suffering? What of those who are suffering and lack self-determination but who (a) requested a hastened death by advance directive or (b) would request a hastened death if competent or (c) would benefit from a hastened death? The Panel Report opposed euthanasia by advance directive (which is permitted in the Netherlands), but its reasoning was weak. The Panel thought there was a fundamental difference between advance refusals of life-prolonging treatment and advance requests for euthanasia because in the former case people were not asking to die, and because it was not possible accurately to identify in advance a point at which they would want to die.⁶² However, sometimes people do refuse treatment in advance because they would rather be dead and, whether or not that is a person's intention in refusing treatment, if it is possible for them to identify a point at which they would not want treatment why it is not possible for them to identify a point at which they would want euthanasia?

A Bill limiting VE/PAS to competent adults with a stipulated prognosis would, then, be merely a first step. Sooner or later, whether as a result of a legislative or a judicial

⁵⁸ See KEOWN2 at 119-20.

⁵⁹ The Panel Report asserted: "No jurisdiction anywhere in the world permits involuntary assisted dying." Panel Report at 87. If by "involuntary assisted dying" the Report meant NVE, as it appeared to, it was wrong.

⁶⁰ PR at 13.

⁶¹ *Id.* at xxi.

⁶² Panel Report at 61.

decision recognizing that such limitations are arbitrary and discriminatory restrictions on the newly-established “right to die,” the law would be extended to allow VE/PAS more generally for competent patients, and also NVE. The Dutch and the Belgians realized years ago when they first relaxed their laws that it made no moral sense to permit PAS but not VE, or to limit them to those at the “end of life.” And, as we have just noted, the Dutch have, entirely logically, extended their law to permit the NVE of infants. (There is also considerable support in Belgium for extending the law to allow NVE.) One of the many trenchant observations made by liberal law professor Yale Kamisar in his classic paper arguing, on utilitarian grounds, against legalising VE/PAS remains as true today as it was almost sixty years ago: the arguments against *further* legalization are weaker than the arguments against *initial* legalization, which is itself an argument against initial legalization.⁶³ Experience with legalization has served only to confirm the validity of Kamisar’s observation. The Netherlands and Belgium have been text-book illustrations of “bracket creep.”⁶⁴ Indeed, only a few months after the Parliamentary Report was published the Dutch Government announced its proposal to permit assisted suicide for elderly people who do not have a serious medical condition but who are suffering from a “completed life.”⁶⁵

Leading advocates of PAS in the US and the UK have openly admitted that their proposals are merely a first step, and a Bill to permit VE has, predictably, now been introduced in Oregon.⁶⁶ A push to extend the 2016 Canadian legislation allowing VE/PAS is already under way in the courts: the statute’s requirements that the illness be incurable; that the patient be in an advanced state of irreversible decline, and that their natural death has become “reasonably foreseeable” are all being challenged as too restrictive.⁶⁷ The same will surely happen in any jurisdiction, including Victoria, which relaxes its law. The Panel Report noted that the Victorian Charter of Human Rights and Responsibilities Act 2006 contained rights which were particularly relevant to the

⁶³ Yale Kamisar, *Some Non-Religious Views against Proposed “Mercy-Killing” Legislation*, 42 MINN L REV 969, at 1030 (1958).

⁶⁴ See generally KEOWN2 Part III, and 2nd ed (forthcoming, 2018), chapters 7-19.

⁶⁵ Government of the Netherlands, *Government: scope for assisted suicide for people who regard their life as completed* (12th October 2016). <http://bit.ly/2F9L0Zo>, (accessed 26 January 2018).

⁶⁶ Senate Bill 893. <http://bit.ly/2n6POHJ> (accessed 26 January 2018). See Daniel Bergner, *Death in the Family*, NEW YORK TIMES MAGAZINE (2 December 2007), reporting that Booth Gardner, the former governor of Washington state, described the proposed PAS law he supported as a first step that would help weaken the nation’s resistance and produce a cultural shift resulting in even laxer laws.

⁶⁷ *Julia Lamb and British Columbia Civil Liberties Association v. The Attorney General of Canada*, SCBC, Vancouver Registry, S-165851 (27 June 2016). Even if these conditions are upheld, the question of what, precisely, they mean will remain. In June 2017 a judge ruled that death was “reasonably foreseeable” even if the patient’s death was not imminent or within a particular time frame or the result of a terminal condition. The legislation, he held, applied to a patient who was “on a trajectory toward death because he or she: (a) has a serious and incurable illness, disease or disability; (b) is in an advanced state of irreversible decline in capability; and (c) is enduring physical or psychological suffering that is intolerable and that cannot be relieved under conditions that they consider acceptable.” *A.B. v. Canada (Attorney General)*, ONSC 3759 (2017) (at [83]).

formulation of the legislation the Panel proposed.⁶⁸ “Right to die” groups will waste no time briefing their lawyers and their legislative supporters to invoke those very same Charter rights—especially to “equality”; protection from “cruel, inhuman or degrading treatment”; “privacy” and “liberty and security of person”⁶⁹—to challenge limitations in the legislation. Nor should this be surprising: once the law is relaxed, the principled arguments for its extension prove unanswerable. Well-intentioned but essentially arbitrary limitations stipulated in statute sooner or later (usually sooner) prove mere lines in the sand. This brings us to the second key objection which was not adequately answered by the Parliamentary (or Panel) Report: even if VE/PAS were ethical in certain “hard cases,” they could not, if legalized, be effectively controlled.

The Unfeasibility of Effective Control

There is every reason to conclude that effective legal control of VE/PAS is practically impossible. This “empirical slippery slope” argument points to intractable practical problems, not least of definition and enforcement. As for definition, what is meant by terms like “end of life” and “intolerable suffering”?

Vagueness

The Panel Report recommended that to access VE/PAS patients should have an incurable disease, illness or medical condition that is advanced, progressive and expected to cause death within 12 months, and which is causing suffering that cannot be relieved in a manner the person deemed tolerable.⁷⁰ It thought these criteria “clear and precise.”⁷¹ But what is meant by “advanced”? (When is a person of “advanced” age?) Is a condition “incurable” if the patient refuses a cure, or if a cure is unlikely? Would an anorexic patient qualify for PAS?⁷² Or a patient with a chronic physical illness who threatened suicide if denied PAS? Why couldn’t their illness be a prospective “cause” of death (by suicide)? The Panel Report recommended that in cases of VE/PAS the cause of death be certified as the patient’s underlying illness or condition?⁷³ Why shouldn’t it equally be regarded as the cause of death if PAS were denied and the patient were to

⁶⁸ Panel Report at 43.

⁶⁹ *Id.*

⁷⁰ *Id.* at 13.

⁷¹ *Id.* at 14.

⁷² The Panel Report stated: “if a person fulfils all the eligibility criteria, the fact that they have a mental illness or a disability should not exclude them from accessing voluntary assisted dying.” *Id.*

⁷³ *Id.* at 150-51. The Panel reasoned (*id.* at 150) that other medical treatments or actions that may hasten death are not currently included on death certificates and it would therefore be inconsistent to include “voluntary assisted dying.” Those other actions, however, are not included because they are not intended to hasten death. The Panel Report added, no less strangely, that “voluntary assisted dying” should not affect insurance payments as “[t]he person has not made a decision to end their life prematurely, they have made a decision about the manner of their death....” (*id.* emphasis added). The claim that taking poison to kill oneself is not making a decision to end one’s life prematurely is remarkable. If the Panel’s belief were true, and the patient were not making a decision to end their life prematurely, and were not, therefore, engaging in suicide, what would prevent anyone from assisting them to do so and claiming that the assistance did not breach the current criminal prohibition on assisting suicide?

take a lethal overdose of sleeping-pills? Moreover, prognoses of death are notoriously unreliable. A recent study in the UK National Health Service found that more than half of those predicted to die lived longer than expected. The Medical Director of Marie Curie, which funded the study, commented that trying to predict the time of death was “like predicting the weather.”⁷⁴ He added: “An accurate prognosis concerning the length of a terminal illness can be a really difficult thing for clinicians to get right, even for people in the advanced stages.”⁷⁵ Further, the Panel Report, like the Parliamentary Report, took the position that suffering was to be judged by the patient: perceptions of suffering were inherently individual and subjective.⁷⁶ The Panel (itself sliding down the greasy slope) even watered down the Parliamentary Report’s “essential” requirement that the suffering be “enduring and unbearable”⁷⁷ as the Panel thought the word “suffering” by itself denoted a “sufficiently high threshold” for eligibility and that suffering deemed intolerable by the patient was an “important safeguard.”⁷⁸ But if the question whether the patient is suffering intolerably is entirely a matter for the patient, what limit, let alone “safeguard,” does the requirement of suffering place on eligibility?

Enforceability

As for requests, the Panel claimed that the request and assessment process it recommended was designed “to ensure voluntary and informed decisions and to identify and prevent potential abuse.”⁷⁹ But it is far from clear how its process, similar to that in Oregon’s Death with Dignity Act, would ensure anything of the sort. How is either of the two proposed doctors to *know* whether the patient’s request is truly free and properly informed, especially if neither doctor knows the patient or has any expertise in psychiatry or palliative care? There is an allegedly “important safeguard,” to “ensure requests are voluntary and free from abuse,”⁸⁰ of two “independent witnesses” to the patient’s written request, one of whom may not be a “family member” and neither of whom may “know or believe” they will benefit materially from the patient’s demise.⁸¹ What if they do not know or believe they will benefit but very much hope to? What if they are two strangers invited in off the street? What would prevent two homeless people being paid for their witnessing services on a regular basis?

The Panel also recommended that to prevent “coercion or inadvertent pressure” a health practitioner would not be allowed to raise or initiate a discussion about VE/PAS

⁷⁴ Henry Bodkin, ‘*Surprise question*’ sees thousands wrongly told they will die under faulty NHS system, THE DAILY TELEGRAPH (2 August 2017).

⁷⁵ *Id.* The Panel Report stated that although many doctors said they used the “surprise question” (“Would I be surprised if my patient died in the next 12 months”) when planning treatment and care, it would not be “appropriate” to use it in relation to VE/PAS. Panel Report at 73. But would it be unlawful for them to use it and, even if so, how could the law effectively prevent doctors from using it?

⁷⁶ *Id.* at 14.

⁷⁷ PR at 217.

⁷⁸ Panel Report at 79.

⁷⁹ *Id.* at 17.

⁸⁰ *Id.* at 127.

⁸¹ *Id.* at 128

with a person with whom they had a therapeutic relationship.⁸² If doctors cannot be trusted *even to raise* the issue with their patients for fear of coercing them, why should they be trusted with *processing, approving and implementing* a request, especially when it is well known (as the Panel recognized) that doctors can easily, consciously or unconsciously, influence patient's choices? And what would constitute raising or initiating a discussion? (Hanging a portrait of the euthanasia activist Dr. Nitschke in the office?) And why should doctors who do not have a therapeutic relationship with the patient be trusted more than the patient's regular doctor? Again, if a physician is not present when the patient takes the lethal substance,⁸³ how is the physician to know whether the patient was making a free decision when they ingested it (or whether it was poured down the patient's throat by a relative or a volunteer from a euthanasia pressure group)? There are, needless to say, more questions that could be raised of the supposed safeguards in the Panel Report, safeguards which would prove no more capable of ensuring effective legal control in Victoria than they have elsewhere. Labelling something a "safeguard" does not make it one, any more than clothing it with legislative form ensures it will operate as such in practice.

Evidence from jurisdictions with relaxed laws

The evidence from those jurisdictions which allow VE/PAS confirms that their laws have proved incapable of effective control. "Effective" means sufficient to achieve the degree of control and protection that is warranted by the importance of the rights and interests to be protected, and that has been regularly accepted by proponents of these laws to be desirable and asserted by them to be attainable in virtue of the safeguards stipulated in the laws themselves.

The Netherlands legalized VE/PAS in 1984. Despite the legal requirement that physicians end life only at the explicit request of the patient and report all cases, six large-scale official Dutch surveys have disclosed that since 1984 physicians have, with virtual impunity, failed to report thousands of cases, and have given lethal injections to thousands of patients without request.⁸⁴ Dutch assurances when the law was relaxed in the 1980s that euthanasia without request would not take place, and would be prosecuted as homicide if it did, have long rung hollow. In 2016 Professor Boer, a former euthanasia review committee member, observed that of 45,000 cases reported to the review committees since 2002 only 75 had been referred to the prosecutors for

⁸² *Id.* at 15. The Panel's reason was that healthcare practitioners "have considerable influence over the decisions and treatment options their patients may consider." *Id.* at 92-93.

⁸³ The Panel Report recommended that healthcare practitioners should not be precluded from being present if the patient wished. *Id.* at 27.

⁸⁴ The first survey disclosed that in 1990 doctors intentionally administered lethal injections in some 1,000 cases without an explicit request from the patient and that 80% of all cases of VE/PAS were not unreported. See KEOWN2, chapters 9-10. The reporting rate has since improved, but still some 20% of cases are not reported, and cases of lethal injections without request, all of which are murder in Dutch law, still run to over 400 per year. See Agnes van der Heide et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 NEW ENGL J MED 492 (2017); KEOWN2 (2nd ed, 2018) chapters 14-15.

breaching the criteria and none had resulted in prosecution.⁸⁵ The Parliamentary Report asserted: “Instances of assisted dying are rare, even in jurisdictions where it is legal.”⁸⁶ Rare? In the Netherlands in 2016 VE/PAS accounted for some 6,000 deaths or 1 in 25 of deaths from all causes.⁸⁷ The Dutch government’s proposals in 2016 to extend the law to allow elderly people with “completed lives” to access assisted suicide promises to lead to a further substantial increase in numbers, involving many people who could live for years.

In June 2017, in the wake of the publication of the sixth national survey of end-of-life decision-making, even Dr. Chabot, the Dutch pioneer of PAS for psychiatric reasons, expressed concerns. He wrote that although the survey concluded, like the previous surveys, that the law was meeting its goals and all was well, it was not.⁸⁸ There were problems that the researchers failed to mention. In the last ten years the numbers had risen from 2,000 to 6,000 cases: people requested it more often, doctors were more willing to provide it and consultants were more willing to approve it. There had also been a rise in demented patients and chronic psychiatric patients, and the travelling “End-of-Life Clinic” (which considers requests from patients who have been turned down by their own doctors) accounted for 500 cases in 2016. Chabot’s concerns illustrate the reality that legalization produces a cultural shift in which VE/PAS soon become normalized. The increase in numbers also confirms the observation of Dr. Neil Gorsuch (now Justice Gorsuch of the United States Supreme Court) about the “law of demand” in relation to euthanasia and assisting suicide: when the costs associated with an activity are reduced (and legalization removes an important cost: the threat of prosecution) one can expect a corresponding increase in that activity.⁸⁹

⁸⁵ Interview with author, Cologne (16 August 2016). See also JOHN GRIFFITHS, *EUTHANASIA AND LAW IN EUROPE* 136 (2008).

⁸⁶ PR at xx.

⁸⁷ See REGIONALE TOETSINGSCOMMISSIES EUTHANASIE, *JAVERSLAG 2016 5* (2017). <http://bit.ly/2E72VRL> (accessed 26 January 2018). And there are thousands of additional cases of intentional life-shortening which are not counted as VE/PAS because they are carried out without the patient’s consent or by deliberate omission.

The Parliamentary Report added: “Assistance in dying is, in the vast majority of cases, provided to people in what would otherwise be the final weeks of their lives.” (PR at xx; see also Panel Report at 44: “Experience in other jurisdictions suggests that even with more liberal eligibility criteria, people will only request access to voluntary assisted dying when they are seriously ill and approaching the end of their lives.”) However, Boer reports that while initially around 95 per cent of patients were terminally ill, an increasing number of patients were seeking death for dementia, psychiatric illness and age-related complaints. Terminal cancer now accounted for less than 75 per cent of cases and the remaining 25 per cent could have lived for months, years or even decades. Theo A. Boer, *Rushing toward death? THE CHRISTIAN CENTURY* (28 March 2016) 24 at 25. See also Theo A. Boer, *Dialectics of Lead[ing]: fifty years of Dutch euthanasia and its lessons*, 78(2) *INTERNATIONAL JOURNAL OF ENVIRONMENTAL STUDIES* (2018) (forthcoming).

⁸⁸ Boudewijn Chabot, *Worrisome Culture Shift in the Context of Self-Selected Death*, *NRC HANDELSBLAD* (16 June 2017). Translated by Professor Trudo Lemmens at: <http://bit.ly/2EIGmBf> (accessed 26 January 2018).

⁸⁹ NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 133 (2006).

The evidence from Belgium, which followed the Netherlands in 2002 (and which was, strangely, not discussed in the Parliamentary Report⁹⁰) has been no less disturbing. Only 50% of cases have been reported to the review commission⁹¹ and the “bracket creep” has been at least as swift as in the Netherlands. The disturbing Special Broadcasting Service documentary broadcast in 2015,⁹² about an elderly mother being assisted in suicide by her physician because of her grief at the death of her daughter, illustrates where legalization leads.

The Parliamentary Report claimed that its research in Victoria and internationally satisfied it that “assisted dying” helped the “small cohort” of patients who wanted it.⁹³ One in twenty-five of all deaths in the Netherlands is hardly a “small cohort.” Many are those who want, and obtain, VE/PAS in the Netherlands and Belgium, from the terminally ill to the chronically ill, to the psychiatrically ill, and to those with early dementia. In the Netherlands, the popular campaign for assisted suicide for those with “completed lives” shows that many thousands of elderly folk want to be able to access a hastened death too.

The evidence from Oregon, where no comprehensive surveys like those in the Netherlands have been carried out, is far more limited and is certainly insufficient to substantiate claims that legal control is effective and that the law has prevented abuse. We simply do not know how many physicians have practiced PAS outside the Death with Dignity Act, or how reliable the reports filed by physicians with the Oregon Public Health Division have been. Professor Alexander Capron, the leading US health lawyer, aptly concluded that the Act’s safeguards are “largely illusory.”⁹⁴ Moreover, the reporting procedure in Oregon—essentially a process of data collection—is even weaker than the review procedures (ineffectual though they are) in the Netherlands and Belgium, and all three jurisdictions rely on self-reporting by physicians. Which physician is going to report that he or she has failed to comply with the law? Any system based on self-reporting (and they all are) is intrinsically ineffective. And one Oregon study, which found that some patients accessed lethal drugs under the Act even though they were depressed, concluded that: “the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a

⁹⁰ It is curious that the committee delegation should have visited Switzerland (where assisting suicide is permitted not as a result of legalization, but a gap in its criminal law, which does not punish altruistic assistance in suicide by anyone) and Canada (before its federal euthanasia legislation had come into force), but not Belgium, with its (then) 14 years’ experience of legalized VE/PAS.

⁹¹ K. Chambaere et al., *Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium* 372(12) *NEW ENGL J MED* 1179 (2015).

⁹² SBS, “Allow Me to Die,” <http://bit.ly/2F8NHup> (accessed 26 January 2018). See also Charles Lane, *Europe’s sinister expansion of euthanasia*, *WASH. POST* (19th August 2015); Charles Lane, *Where the prescription for autism can be death*, *WASH. POST* (24th February 2016).

⁹³ PR at xxviii.

⁹⁴ Alexander M. Capron, *Legalizing Physician-Aided Death*, 5 (1) *CAMBRIDGE Q. OF HEALTH CARE ETHICS* 10 (1996).

prescription for a lethal drug.”⁹⁵ This is hardly surprising, given that ordinary physicians lack expertise in diagnosing and treating depression.

Several eminent expert committees which have considered the case for legalization, including the New York State Task Force on Life and the Law⁹⁶ and the House of Lords Select Committee on Medical Ethics,⁹⁷ have rejected VE/PAS because of the risks of abuse, especially in relation to vulnerable groups. In 2015 the UK House of Commons rejected an Oregon-style Bill by a large majority.⁹⁸ This was the latest in a series of failed attempts over the past twenty years to persuade UK legislators to legalize PAS. In the light of the above evidence, it is not difficult to see why all those attempts have failed.⁹⁹

Missing evidence, counter-arguments and sources

The Parliamentary Report’s recommendation that VE/PAS should be legalized rested to a significant degree on the committee’s conclusion, resulting from its research into those few jurisdictions which have relaxed their laws, “that assisted dying is currently provided in robust, transparent, accountable frameworks.”¹⁰⁰ It noted that a delegation from the committee had met with experts in those jurisdictions “who highlighted the rigorous safeguards, monitoring procedures and high levels of compliance” in their jurisdictions.¹⁰¹ This prompts at least three questions.

First, where in the Parliamentary Report was the *substantive evidence* to substantiate its controversial assertion? Victorian legislators are entitled to more than hearsay. The committee’s research into the Dutch experience included a four-day visit to the Netherlands by five of its members in March/April 2016.¹⁰² Its record of that visit lists interviews with 14 people from the political, medical and academic establishment and from the Dutch Voluntary Euthanasia Society. Only one of those 14 (Professor Boer) is known¹⁰³ to be a critic of the Dutch law. The delegation’s visit appears to have ascertained little more than if you ask the Dutch establishment whether their law is working well they will tell you that it is.¹⁰⁴ This is not to suggest those Dutch spokespersons do not

⁹⁵ Linda Ganzini et al., *Prevalence of depression and anxiety in patients requesting physicians’ aid in dying: cross-sectional survey*, 337 BRITISH MEDICAL J. a1682 (2008).

⁹⁶ *Supra* note 1.

⁹⁷ *Id.*

⁹⁸ Assisted Dying (No.2) Bill, Parl. Deb., H.C., (11 September 2015).

⁹⁹ Although PAS is now allowed in six states (Oregon, Washington, Montana, Vermont, California and Colorado) and the District of Columbia, it has been reported that over two hundred attempts in over thirty-five US states have failed since the voter referendum in 1994 which led to the relaxation of the law in Oregon. Patients Rights Council, *Attempts to Legalize Euthanasia/Assisted Suicide in the United States*, <http://bit.ly/2GeS8VM> (accessed 26 January 2018)

¹⁰⁰ PR at 212. “The evidence is conclusive that assisted dying can be provided in a way that guards against abuse and protects the vulnerable in our community in a way that unlawful and unregulated assisted dying does not.” *Id.* at xxviii.

¹⁰¹ *Id.* at 213.

¹⁰² *Id.*, xvii, Appendix 2 at 263-4.

¹⁰³ To the author.

¹⁰⁴ As John Griffiths (a defender of Dutch euthanasia) has noted: “To a large extent, the Dutch tend simply to ignore foreign criticism. The more or less ‘official’ Dutch reaction, when there is one, amounts

honestly believe it is working well, simply that their assurances should not be taken at face value, especially as the Dutch experience has been widely and trenchantly criticized.

Second, where was the committee's *response* to the criticisms that have been made about the ineffectiveness of the safeguards in jurisdictions like the Netherlands? Professor Boer, the former review committee member, previously thought that the euthanasia law and its review procedure could prevent a slide but he has, in the light of the "explosive" increase in numbers and significant "bracket creep," changed his mind: "Some slopes," he now warns, "truly are slippery."¹⁰⁵ The Report rejected concerns, including those of Boer, about the risk to the vulnerable because it did not find evidence to support them.¹⁰⁶ It should have looked harder. What of the evidence indicating a significant incidence of NVE (by both act and by omission), and of the endorsement of NVE by the courts? What of the steep increase in cases of VE, the continual stretching of the criteria and the ineffectiveness of the control system? If the control system is ineffective, how can it protect patients, especially the vulnerable? Nor did the Report mention the popular campaign to extend the law to allow assisted suicide for elderly folk with "completed lives," a campaign which was in full swing during the delegation's visit in 2016 and which persuaded the government to publish legislative proposals six months later.

The Report boasted "an extensive research and consultation process" which was "guided by a review of academic literature and reports from similar inquiries" in Australia and internationally¹⁰⁷ and an "extensive evaluation of material from other jurisdictions."¹⁰⁸ However, the Report overlooked several important sources.¹⁰⁹ Where, for example, was the Report's response to the concerns about Dutch law and practice expressed by the United Nations Human Rights Committee in 2001 and again in 2009 (concerns which included the extension of the Dutch law in 1996 to permit infanticide, an extension about which, we will recall, the Report was silent)?¹¹⁰ Where was the Report's response to criticisms of the Dutch experience made in the scholarly books by Dr. Carlos Go-

essentially to denial." JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS at 28-9 (2008).

¹⁰⁵ *Assisted Dying: Don't Go There: Dutch Ethicist Theo Boer's Thoughts on Euthanasia in Full*, THE DAILY MAIL (10 July 2014). See also Theo A. Boer, *Rushing toward death?* THE CHRISTIAN CENTURY (28 March 2016); Theo A. Boer, *Dialectics of Lead[ing]: fifty years of Dutch euthanasia and its lessons*, 78(2) INTERNATIONAL J. OF ENVIRONMENTAL STUDIES (2018) (forthcoming).

¹⁰⁶ PR at 213.

¹⁰⁷ *Id.* at 2.

¹⁰⁸ *Id.* at 13.

¹⁰⁹ Several of which are included in the far superior minority report of Mr. Mulino. *Id.* at 343.

¹¹⁰ U.N. Human Rights Committee, Seventy-second session, *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, Concluding Observations of the Human Rights Committee: Netherlands*, at C. para 5(a). CCPR/CO/72/NET (27 August 2001). (GO144374) <http://bit.ly/2A7NZmV> (accessed 26 January 2018); Ninety-sixth session, *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, Concluding Observations of the Human Rights Committee: Netherlands* para. 7 CCPR/C/NLD/CO/4 (25 August 2009). (GO944562) <http://bit.ly/2ASAPKp> (accessed 26 January 2018).

mez;¹¹¹ Dr. Herbert Hendin;¹¹² Professor Raphael Cohen-Almagor;¹¹³ Dr. (now Justice) Neil Gorsuch¹¹⁴ and by myself?¹¹⁵ Where was its response to Professor Montero's book criticising the Belgian law and practice since 2002?¹¹⁶ (None of these significant works was listed in the bibliography of the Report or of the Panel Report). And where were the responses to the reports of far more eminent and expert committees which have recommended against legalization, not least the New York State Task Force (1994) and the House of Lords Select Committee on Medical Ethics (1994)?

Third, if the empirical evidence from abroad disclosed "rigorous safeguards, monitoring procedures and high levels of compliance"¹¹⁷ why did the Report not follow the Netherlands, Belgium and Canada and recommend that patients be given a choice between PAS and VE?¹¹⁸

The committee's terms of reference included a direction to "review the current framework of legislation, proposed legislation and other relevant reports and materials" in Australia and in overseas jurisdictions.¹¹⁹ To review means formally to assess. Leaving aside the Report's failure to take important reports and materials into account, *where was the Report's formal assessment of the competing claims of the defenders and the critics of the important experience overseas?*¹²⁰ Its treatment of the experiences of jurisdictions with relaxed laws was as cursory as it was defective and provided no basis for concluding that effective control is a feasible as opposed to an elusive or illusory goal.¹²¹

¹¹¹ CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991).

¹¹² HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS AND ASSISTED SUICIDE* (1998).

¹¹³ RAPHAEL COHEN-ALMAGOR, *EUTHANASIA IN THE NETHERLANDS: THE POLICY AND PRACTICE OF MERCY KILLING* (2004).

¹¹⁴ NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* (2006).

¹¹⁵ JOHN KEOWN, *EUTHANASIA, ETHICS AND PUBLIC POLICY* (2002).

¹¹⁶ ETIENNE MONTERO, *RENDEZ-VOUS AVEC LA MORT: DIX ANS D'EUTHANASIE LEGALE EN BELGIQUE* (2013). *See now also* Trudo Lemmens, *The Conflict Between Open-ended Access to Physician-Assisted Dying and the Protection of the Vulnerable: Lessons from Belgium's Euthanasia Regime in the Post Carter Era*, in CATHERINE REGIS ET AL., *LES GRANDS CONFLITS EN DROIT DE LA SANTE* 263 (2016); DAVID JONES ET AL., *EUTHANASIA AND ASSISTED SUICIDE: LESSONS FROM BELGIUM* (2017).

¹¹⁷ PR at 213. "Each framework has rigorous safeguards to protect patients from potential abuse." *Id.* at 8.

¹¹⁸ The Parliamentary Report stated that its proposals combined elements which it regarded as "best practice" as well as an "appropriate cultural fit" in the context of Victoria's medical and legal systems. *Id.* at 14. However, if each framework abroad had "rigorous safeguards," why not choose the least restrictive? Why would that not be a good "cultural fit"? Do Victorians prefer unnecessary restrictions? And did the Report itself not cite polls claiming from 73% to 85% support for "voluntary euthanasia" in Australia, including at least one showing 76% support in Victoria? *Id.* at 308. Why, moreover, did the Panel Report propose an additional bureaucratic requirement of a prior authorisation permit? Panel Report, 131-34.

¹¹⁹ *Id.* at xiii.

¹²⁰ Nor did the Panel Report remedy this deficiency.

¹²¹ Defenders of the Report might point out that the first instance judge in the Carter case in Canada, having reviewed the empirical evidence, concluded that the risks of decriminalization can be very largely avoided by well-designed, carefully-monitored safeguards (*Carter v. Canada (Attorney-General)* (2012), 287 CCC (3d) 1 (BCSC)), and that her finding was upheld by the Supreme Court of Canada (in *Carter v. Canada (Attorney-General)* [2015], 1 SCR 331 (SCC)). However, her finding was not supported by the

Moreover, why would the “safeguards” proposed in the Panel Report, largely modelled on those in other jurisdictions with some added form-filling,¹²² prove any more effective in Victoria than they have abroad? Why, for example, would the proposed Assisted Dying Review Board¹²³ prove any more effective than the Dutch review committees or the Oregon Public Health Division? If physicians were to certify that the stipulated conditions had been met, how would the Board know otherwise? Professor Boer, who has himself reviewed thousands of reports, has observed that a system’s reliance on self-reporting is a “major flaw.” How, he has asked, can you judge a physician on the basis of information provided by the physician?¹²⁴ Further, why should doctors in Victoria be any the readier to comply with bureaucratic requirements than many doctors in the Low Countries have shown themselves to be? Indeed, to the extent that the Victorian proposal involved even more form-filling, there is little reason to assume that compliance levels would be any higher.

In sum, the experience of those few jurisdictions which have relaxed their laws indicates that the Report’s complacency was unwarranted.

Conclusion

The criminal prohibition on VE, as the House of Lords Select Committee put it, “protects each one of us impartially, embodying the belief that all are equal.”¹²⁵ To allow VE and/or PAS is reject a fundamental principle of criminal law and professional medical ethics which holds that we all, terminally ill or not, suffering or not, able-bodied or not, share an ineliminable equality. It is to embrace the contrary notion that we can be divided into two categories: those whose lives are “worth living” and those whose lives are not.

Moreover, once one has abandoned that bright, principled and workable line (whose key distinction between intending and merely foreseeing death has long been endorsed both by the criminal law and by professional medical ethics) one is left with little more than arbitrary limitations (“over 18,” “competent,” “up to 12 months to live,” “unbearable suffering,” etc.), limitations which will be stretched to breaking-point on the logical rack of the newly-recognized “right to die.” We will recall Kamisar’s trenchant observation that the arguments against further legalization are weaker than the arguments against initial legalization, which is itself an argument against initial legalization.¹²⁶

evidence: *which* jurisdiction did she think had well-designed, carefully-monitored safeguards? Nor was her finding supported by three judges of the Irish Divisional Court, who later scrutinized the same empirical evidence: *see* Fleming v. Ireland, IEHC 2 (2013). Remarkably, the Supreme Court of Canada did not even mention their judgment, let alone seek to controvert it. On the first instance judgment, *see* John Keown, *A Right to Voluntary Euthanasia? Confusion in Canada*, in Carter 28 NOTRE DAME J.L. ETHICS & PUB. POL’Y 1 (2014). On the Supreme Court judgement, *see* KEOWN2 (2nd ed, 2018), chapter 23.

¹²² For the Panel’s recommendations, *see* Panel Report at 22-32.

¹²³ PR at 231. *See also* Panel Report at 28-30.

¹²⁴ Interview with author, Cologne (16 August 2016).

¹²⁵ *Supra* text at note 50.

¹²⁶ *Supra* text at note 63.

Second, effective control is not feasible. Practical problems, not least of those of precise definition and proper enforcement, are intractable, as the evidence from those few jurisdictions which have taken the radical step of relaxing their laws has amply confirmed. If a state legislates to follow those jurisdictions which have relaxed their laws, then its experience will follow those jurisdictions which have relaxed their laws. As the Senior Law Lord, Lord Bingham, concluded:

If the criminal law sought to proscribe the conduct of those who assisted the suicide of the vulnerable, but exonerated those who assisted the suicide of the non-vulnerable, it could not be administered fairly and in a way which would command respect.¹²⁷

Several committees have produced reports which have deeply enriched our understanding of the issues at the heart of the euthanasia debate. The report of the New York State Task Force was outstanding, and the report of the House of Lords Select Committee on Medical Ethics was impressive. The report of the Victorian Parliamentary committee, which is both superficial and selective, pales by comparison. Any Act based on its recommendations (and those of the Panel Report) will stand on shaky foundations.

Postscript

In November 2017 the Parliament of Victoria passed the Voluntary Assisted Dying Act 2017.¹²⁸ The Act, which permits PAS and, in narrower circumstances, VE, runs to no fewer than 143 sections and a schedule containing 8 forms. The casual reader may be misled by the Act's length, its prolix bureaucratic requirements and its creation of a Voluntary Assisted Dying Review Board into thinking that its safeguards are precise, rigorous and capable of ensuring effective control. However, as the Act is largely the child of the flawed Parliamentary and Panel Reports, the casual reader would be mistaken.

The Act is, in its essentials, broadly similar to Oregon's Death with Dignity Act that permits PAS.¹²⁹ In brief, the Victorian Act allows PAS for competent Australian citizens or permanent residents over 18 who have been ordinarily resident in Victoria for 12 months and who have been diagnosed with a disease, illness or medical condition that is incurable; that is advanced, progressive and expected to cause death within six months (12 months if it is neurodegenerative), and that is causing suffering that cannot be relieved in a manner the person considers tolerable.¹³⁰ The Act allows VE if the person is "physically incapable of the self-administration or digestion" of the lethal substance.¹³¹ Although, therefore, the Act is, by requiring suffering merely than a "terminal illness," more restrictive than the Oregon law, the requirement is subjective. The suffering need

¹²⁷ R(Pretty) v. DPP UKHL 61, 2 AC 800, at [36] (2001).

¹²⁸ Act No. 61 of 2017, available at: <http://www.legislation.vic.gov.au/> (accessed 26 January 2018). Section 2 provides that the Act comes into force on 19 June 2019. A former Attorney-General of Victoria has described the unedifying process of enactment: Robert Clark, *Making Victoria's euthanasia laws: a process to be shunned*, THE SPECTATOR AUSTRALIA ONLINE, 7 December 2017. <http://bit.ly/2FQZGxQ> (accessed 26 January 2018).

¹²⁹ See KEOWN2, chapter 15.

¹³⁰ Voluntary Assisted Dying Act 2017, section 9.

¹³¹ Section 46(c)(i).

not be serious and could include, for example, feeling a burden on others, and qualifies even if it could be alleviated, albeit not in a manner the patient thinks “tolerable.” Moreover, the Act is laxer than the Oregon law in that it allows a hastened death for patients with neurodegenerative conditions who are not expected to die for 12 months, and also allows VAE.¹³² The procedure for obtaining a hastened death is again similar to that in Oregon in that the patient makes a request to a first (“co-ordinating”) medical practitioner and then to a second (“consulting”) medical practitioner.¹³³ If they are “satisfied” that the patient meets the statutory criteria the patient makes a witnessed written declaration requesting “voluntary assisted dying” in the presence of the co-ordinating doctor and two witnesses.¹³⁴ Then, at least nine days after making the initial request, and at least one day after the consulting practitioner adjudged the patient eligible, the patient makes a “final” request to the co-ordinating practitioner.¹³⁵ On receipt of this request this practitioner reviews the forms and certifies that the request and assessment process has been completed as required by the Act.¹³⁶ There are a number of additional bureaucratic requirements. Within seven days of completing their assessments the two practitioners must send their completed assessment forms to the Assisted Dying Review Board¹³⁷ and within seven days of completing the final review form the co-ordinating practitioner must send copies of all relevant forms to the Board.¹³⁸ This practitioner, having certified that the request and assessment process has been completed in accordance with the Act, may apply for a “voluntary assisted dying permit” from the Secretary of the Department of Health and Human Services.¹³⁹ The permit authorizes the practitioner to provide PAS or VE, as the case may be, to the patient.¹⁴⁰ The Secretary may issue a permit or may refuse to if he or she is not satisfied that the request and assessment

¹³² If a patient’s refusal to take anti-nausea drugs (to prevent regurgitation of the lethal drug) were to render the patient “physically incapable” of self-administration or digestion of lethal drugs, the door would appear to be open to VE for anyone who would prefer it to PAS.

¹³³ Part 3, Divisions 2-4. Section 8 of the Act provides that a registered health practitioner must not “in the course of providing” health or professional care services to a person initiate a discussion with that person about, or suggest, “voluntary assisted dying.”

¹³⁴ Part 3, Division 5.

¹³⁵ Part 3, Division 6. Section 38(2) provides that the nine day period does not apply if the practitioners think the patient will die before the expiration of that period.

¹³⁶ Section 41. Section 68 of the Act provides for the possibility of review by the Victorian Civil and Administrative Tribunal (VCAT) of practitioners’ decisions, but only in respect of residence and competence.

¹³⁷ Sections 21(2) and 30(2).

¹³⁸ Section 41(2). Having made the “final” request, the patient must (section 39) appoint a “contact person” to return to the pharmacist any lethal substance which has been prescribed but remains unused. Within seven days of dispensing the lethal drug a pharmacist must (section 60(2)) send a copy of the dispensing form to the Board.

¹³⁹ Section 43.

¹⁴⁰ Part 4, Division 1 and 2.

process has been completed as required by the Act¹⁴¹ and must within seven days notify the Board of his or her decision.¹⁴²

It is difficult to see how the Act can ensure effective control. First, what checks, if any, will the Secretary carry out to ensure that the requirements have been met before issuing a permit? If the required forms have been submitted with the appropriate boxes ticked, will the application not automatically be approved? Second, although the Parliamentary Report envisaged the role of the Board as being similar to that of the Dutch review committees in examining each reported case,¹⁴³ it is not clear from the Act¹⁴⁴ that its role will be similar to those committees. The Act provides that the Board's functions include promoting "continuous improvement in the quality and safety of voluntary assisted dying" to those exercising functions or powers under the Act; conducting analysis of information or forms submitted to it in accordance with the Act; providing information about "voluntary assisted dying"; collecting, using and disclosing forms and information provided in accordance with the Act for the purposes of carrying out a function of the Board; consulting and engaging with persons or groups in relation to "voluntary assisted dying" and providing advice and reports to the Minister or the Secretary of the Department of Health and Human Services in relation to the operation of the Act.¹⁴⁵ The Board is to record, retain and make public specified (and rather limited) statistical information.¹⁴⁶ It must also produce annual reports.¹⁴⁷ Its functions also include monitoring matters relating to "voluntary assisted dying" and reviewing the exercise of any function or power under the Act¹⁴⁸ and the Act states that the Board has all the powers that are "necessary or convenient" to perform its functions.¹⁴⁹ It is, however, unclear what these powers are, let alone whether they are sufficient to ensure that the requirements of the Act are met in any individual case or in general. The Board is to "promote compliance with the requirements" of the Act "by the provision of information" to doctors and members of the community,¹⁵⁰ but what *other* powers and duties does it have in order to ensure compliance? It is to refer any "issue" identified by the Board that is relevant

¹⁴¹ Section 49(2) and (3).

¹⁴² Section 49(4)(b).

¹⁴³ PR at 219; 230-231. The Panel Report stated that one of the core functions of the Board would be to review each case of "voluntary assisted dying," as well as each application, to ensure compliance with the statutory requirements. Panel Report, 162. However, the Report observed (*id.* at 163) that the Board would have no investigatory role and (*id.* at 162) that "Eligibility assessment for voluntary assisted dying is determined through clinical judgment embedded in a therapeutic relationship, and is not a legal matter." If, then, the paperwork submitted to the Board states that the criteria have been satisfied, how is the Board to know otherwise? And how is the Board to know anything about cases which are not reported?

¹⁴⁴ See generally Part 9.

¹⁴⁵ Section 93(1)(f) – (l).

¹⁴⁶ Section 117.

¹⁴⁷ Part 9, Division 5.

¹⁴⁸ Section 93(1) (a) and (b).

¹⁴⁹ Section 93(2).

¹⁵⁰ Section 93(1) (d).

to specified authorities, including the police and the coroner,¹⁵¹ but how is the Board to identify issues? Section 103 provides that the Board may request information to assist it in discharging its functions but what if a request is refused?

In short, the Board may well prove a toothless body which serves largely as a checker and depository of forms, a publisher of statistics and a promoter of VE and PAS, more akin to the Oregon Public Health Division than the Dutch or Belgian review bodies. The likelihood of any abuse being detected by the Board is further reduced by the Act providing that deaths from “voluntary assisted dying” are to be registered as natural deaths caused by the patient’s medical condition¹⁵² and not as deaths which must be reported to the coroner. Indeed the coroner’s capacity to investigate a death is specifically excluded when a lethal drug has been taken in accordance with the Act.¹⁵³ It is evident that the Victorian law shares a key failing of all other relaxed laws: its reliance on the intrinsically ineffective mechanism of self-reporting by physicians. The Act is incapable of effectively controlling PAS and VE either by ensuring that cases are reported or that each reported case complies with the requirements of the Act. Far from being designed to detect abuse or abuse it could not unreasonably be described as being designed not to.

Moreover, many questions of the sort raised in relation to the relaxed laws in other jurisdictions, particularly Oregon, could equally be asked of the requirements of the Victorian Act. For example, would a patient who refused life-prolonging treatment, such as a diabetic who refused insulin, qualify for “voluntary assisted dying”? How are two medical practitioners, who need not be independent,¹⁵⁴ or have any expertise in psychiatry or palliative care¹⁵⁵ or have any previous knowledge of a patient, to ensure, on the basis of minimal contact with the patient¹⁵⁶ over little more than a week, that the patient’s request is truly voluntary and informed, not the result of depression, coercion or undue influence?¹⁵⁷ How are they to know the patient’s suffering cannot be alleviated by palliative or social care? And even if the patient’s initial request was voluntary and

¹⁵¹ Section 93(1)(e).

¹⁵² Section 119.

¹⁵³ Section 121.

¹⁵⁴ The Parliamentary Report stated that it was “essential” that the second doctor be independent of the first doctor and of the patient. PR at 226.

¹⁵⁵ They need merely to have completed currently unspecified “assessment training” (sections 17, 26 and 114); one must have been in practice for at least five years and one must have “relevant expertise and experience” in the patient’s condition (section 10).

¹⁵⁶ Although the patient must sign the written declaration in the presence of the co-ordinating practitioner it is not clear that either practitioner must even see the patient in order to assess whether the patient meets the criteria. A request for “voluntary assisted dying” must be made “personally” (section 11(2)(b)), but why could the patient not do this by phone and email his or her medical records so that the two doctors can carry out their assessments?

¹⁵⁷ The physicians must be satisfied (sections 20 and 29) that the patient is acting “voluntarily and without coercion” but what about undue influence? It is an offence under section 85 to induce a person by dishonesty or undue influence to request “voluntary assisted dying,” but neither “dishonesty” nor “undue influence” is defined. The medical practitioners must also be satisfied that the request is “enduring” (sections 20 and 29), but what does this mean?

informed, how is anyone to know that when the patient takes the poison, perhaps up to a year (or more) later, the patient's decision is still voluntary and informed, or that a relative has not crossed the (blurry) line between assisting the patient to self-administer the lethal drug and actually administering the lethal drug?¹⁵⁸ The key points need not be labored: the Victorian Act, like the relaxed legislation in other jurisdictions, fails adequately to protect patients; is not capable of ensuring effective control of PAS and VE, and invites logical extension.¹⁵⁹

Legislators who ignore history are condemned to repeat it.

¹⁵⁸ See section 79.

¹⁵⁹ We will recall that significant extension occurred even as between the publication of the reports of the Parliamentary Committee and that of the Ministerial Advisory Panel, the latter rejecting the former's recommendations that suffering be "enduring and unbearable": see text at nn.77-78.

