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LEGISLATIVE OPTIONS TO ADDRESS INSTITUTIONAL OBJECTIONS TO VOLUNTARY ASSISTED DYING IN AUSTRALIA

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Voluntary assisted dying is being considered by parliaments and law reform bodies across Australia. Although individual conscientious objection is routinely considered in these deliberations, an institution's desire to object to providing voluntary assisted dying has received very little attention. After briefly considering the concept of institutional objection in voluntary assisted dying, this article examines the available (albeit limited) Australian evidence on this practice. Institutional objection is happening in Victoria (where voluntary assisted dying is lawful) and is likely to occur in other Australian states. The article proposes that regulation is needed and presents three models for parliaments and law reformers to consider. The first is 'conscientious absolutism', which grants institutions unrestricted ability to object to voluntary assisted dying. The second

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We disclose that Ben White and Lindy Willmott were engaged by the Victorian and Western Australian Governments to design and provide the legislatively-mandated training for doctors involved in voluntary assisted dying in those States. Both have also developed a model Bill for voluntary assisted dying for parliaments to consider. Eliana Close was employed on both voluntary assisted dying training projects. Jocelyn Downie was a member of the Royal Society of Canada Expert Panel on End of Life Decision-Making, a member of the plaintiffs' legal team in *Carter v Canada (A-G)* [2015] 1 SCR 331, a member of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying and a member of the Council of Canadian Academies Expert Panel on Medical Assistance in Dying. Ben White is a recipient of an Australian Research Council Future Fellowship (project number FT190100410: Enhancing End-of-Life Decision-Making: Optimal Regulation of Voluntary Assisted Dying) funded by the Australian Government.

is a 'compromise or reasonable accommodation' model, which aims to accommodate both institutional objection and a person's wish to access voluntary assisted dying. Different balances can be struck; we propose a model that prioritises a patient's interests. The third model is 'non-toleration', which would refuse to allow an institution to object at all. While there can be debate about the optimal model, the issue of institutional objection to voluntary assisted dying must be addressed.

I INTRODUCTION

After decades of unsuccessful attempts to legalise voluntary assisted dying ('VAD'),[1] the past few years have witnessed a flurry of reform activity in Australia. In Victoria, the *Voluntary Assisted Dying Act 2017* (Vic) ('*Victorian VAD Act*') commenced operation in June 2019. Western Australia largely followed the Victorian model and its *Voluntary Assisted Dying Act 2019* (WA) is due to commence operation on 1 July 2021. As this article was being published, Tasmania also passed its *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) which is anticipated to commence in 2022. A VAD Bill has been introduced in South Australia,[2] one will be considered in Queensland in May 2021,[3] and New South Wales is likely to see such a Bill tabled in 2021 as well.[4]

Reflecting the contested nature of VAD legislation, such laws almost universally contain provisions to respect conscientious objections by individual health professionals. Both the Victorian and Western Australian laws state that a health professional has a right to refuse involvement with any aspect of the VAD process.[5] A more controversial issue, which has received limited consideration in Australia, is whether an *institution* should be able to prohibit access to VAD or any VAD-related activities (which include eligibility assessments and providing

1 A detailed discussion of attempts at law reform in Australia is available in: Lindy Willmott et al, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1. See also further Bills in Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42(6) *Australian Health Review* 616.

2 Voluntary Assisted Dying Bill 2020 (SA).

3 The Queensland Premier referred the issue to the Queensland Law Reform Commission to draft a Bill for the Government's consideration: Queensland Law Reform Commission, *Queensland's Laws Relating to Voluntary Assisted Dying* (Terms of Reference, 2020) <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0004/651379/vad-tor.pdf>. See also Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (Consultation Paper No 79, October 2020) <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0003/658506/qlrc-wp-79-2020.pdf>.

4 Michael Koziol, 'Fresh Bid to Legalise Assisted Dying Set to Test NSW Government', *The Sydney Morning Herald* (online, 13 December 2020) <https://www.smh.com.au/politics/nsw/fresh-bid-to-legalise-assisted-dying-set-to-test-nsw-government-20201209-p56m2t.html>.

5 *Voluntary Assisted Dying Act 2017* (Vic) s 7 ('*Victorian VAD Act*'); *Voluntary Assisted Dying Act 2019* (WA) s 9.

information about VAD) within its facility.[6] The Victorian and Western Australian Acts are silent on this issue. However, this is important because institutions that object have the power to significantly curtail individuals' ability to access what is a lawful medical service.[7] When this occurs for reasons of conscience, this is problematic, particularly when these institutions are the sole providers of specialist end-of-life care in a particular geographic area.[8] This effectively creates barriers to access and the impact on patients can be extreme; those who are eligible for VAD are already experiencing intolerable suffering and such institutional objections can compound this.

Although the Victorian and Western Australian Acts do not address institutional objection, it is possible for legislation to regulate it. The Voluntary Assisted Dying Bill 2019, a model Bill that was recommended by the Queensland parliamentary inquiry considering VAD as the proposed basis for reform,[9] contains such a provision.[10] A proposed amendment to regulate institutional objections was also debated, though ultimately not passed, in the Legislative Council of Tasmania during debate on the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas).[11]

During the debates in Tasmania, many parliamentarians expressed grave concern that institutions (particularly residential aged care facilities) would create unjustified barriers for individuals who were approaching the end of their lives, suffering intolerably, and seeking VAD. For example, Ms Forrest stated: 'I am really struggling with why we would require someone to be moved from their home because an organisation's policy was that they did not want to be involved in the matter'.[12] Indeed, several politicians expressed surprise that institutions

6 See, eg, Philip Shadd and Joshua Shadd, 'Institutional Non-Participation in Assisted Dying: Changing the Conversation' (2019) 33(1) *Bioethics* 207; LW Sumner, 'Institutional Refusal to Offer Assisted Dying: A Response to Shadd and Shadd' (2019) 33(8) *Bioethics* 970.

7 See, eg, Sumner (n 6) 971.

8 See, eg, Udo Schuklenk, 'Conscience-Based Refusal of Patient Care in Medicine: A Consequentialist Analysis' (2019) 40(6) *Theoretical Medicine and Bioethics* 523; Sumner (n 6) 971.

9 Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying* (Report No 34, 31 March 2020) <https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf> ('Queensland Parliamentary Report'). In Recommendation 1, the Committee recommended the Queensland Government use a draft voluntary assisted dying ('VAD') Bill written by two of the authors as the basis for legalising VAD in Queensland. For the model Bill, see: Ben White and Lindy Willmott, 'A Model Voluntary Assisted Dying Bill' (2019) 7(2) *Griffith Journal of Law and Human Dignity* 1, 15–43.

10 White and Willmott (n 9) 36.

11 The amendment proposed by Dr Bastian Seidel would require institutions that object to VAD to transfer a patient to a healthcare facility that does not object: Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 2 (Bastian Seidel). Note also that clause 19(3) in the (defeated) Death with Dignity Bill 2016 (SA) addressed institutional objection to VAD. This clause indicated that an institution could refuse to provide VAD, but if it did so it must ensure the refusal is brought to the attention of individuals before being admitted, and if the person had already entered the institution without being aware of the objection, arrange a transfer.

12 Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 5 (Ruth Forrest).

could legally prevent health professionals from entering facilities for this purpose.[13]

This article explores how institutional objections to VAD in Australia are currently regulated, the potential consequences of such objections, and possible legislative responses. We commence by examining the concept of institutional objection, including a comparison with conscientious objection by individuals. We then outline how institutional objection is regulated in Victoria (by policy), evidence of the impact of such objection on individuals in Victoria, and likely outcomes in other parts of Australia if VAD is enacted. We also consider the recent Canadian experience to identify potential outcomes of institutional objections. We conclude by offering some regulatory options to govern institutional objection for parliaments and other bodies deliberating on VAD reform.

II THE CONCEPT OF INSTITUTIONAL CONSCIENTIOUS OBJECTION[14]

Conscientious objection in medicine can refer to a desire not to participate in providing a healthcare service based on concerns to 'preserve or maintain moral integrity'.[15] It is conceptually distinct from non-participation based on clinical judgment – that to provide a particular treatment would not be in accordance with good medical practice.[16] It is also to be distinguished from pragmatic reasons for non-participation, based on lack of expertise, financial or technological resources.[17]

13 See, eg, Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 5–6 (Ruth Forrest), 10 (Meg Webb), 15–16 (Bastian Seidel).

14 This article does not consider institutional objections made on the basis of institutional capacity (eg, not having the required human resources or equipment). We do briefly note here, though, that such objections may be difficult to sustain as VAD does not require specialised equipment or human resources that cannot be brought into a facility.

15 Mark R Wicclair, 'Conscientious Objection in Medicine' (2000) 14(3) *Bioethics* 205, 213. See generally Morten Magelssen, 'When Should Conscientious Objection Be Accepted?' (2012) 38(1) *Journal of Medical Ethics* 18; Sara Fovargue and Mary Neal, '"In Good Conscience": Conscience-Based Exemptions and Proper Medical Treatment' (2015) 23(2) *Medical Law Review* 221, 222. See also Stephen Smith, who defines conscience from an individual perspective as 'an internal mental process focused on an inward-looking choice to engage in particular behaviour on the basis of a moral value': Stephen W Smith, 'The Responsibilities of Conscience in Healthcare Decisions: Moving Towards a Collaborative Framework' (2020) 79(1) *Cambridge Law Journal* 120, 124. While these authors defend the right to conscientiously object on the basis of preserving moral integrity, others frame the issue in terms of harm to the doctor and the health service: see, eg, Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332(7536) *British Medical Journal* 294.

16 See Fovargue and Neal (n 15) 224–5; Smith (n 15) 129; Nadia N Sawicki, 'Mandating Disclosure of Conscience-Based Limitations on Medical Practice' (2016) 42(1) *American Journal of Law and Medicine* 85, 91–2.

17 Shadd and Shadd (n 6) 208, 211.

While an individual's right to conscientiously object is traditionally recognised in law and policies,[18] it is more contentious whether an institution itself can have a 'conscientious objection'. Individuals are self-evidently moral agents, and possess human rights, including the right to freedom of religion, thought and conscience.[19] The status of institutions is less clear. Some argue there is no basis for an institution to have such an objection, as 'bricks and mortar' cannot have moral beliefs as people do.[20] Others consider a healthcare institution to be more than just a building, and view it as 'a group of people organized according to a series of roles and relationships designed to deliver the social good of healthcare'.[21] According to this view, institutions may have a distinctive mission, ethos and moral values, and should be recognised as having a conscience.[22] A middle ground, advanced by Wicclair, is to argue that while hospitals do not possess a conscience like individuals do, they could still justify claims to refuse a service on the basis of their identity and integrity. Nevertheless, they have obligations to prevent harm to patients, promote health and respect autonomy, which can outweigh identity or integrity-based claims.[23]

Institutional objections to VAD may be made by a range of different institutions, including hospitals, residential aged care facilities and other long-term care facilities, and hospices or other short-term care facilities.[24] Institutions may object to participating in VAD on at least three levels: 1) VAD administration; 2) eligibility assessments; and 3) providing information or referring individuals to facilitate VAD.[25] Firstly, an institution may not wish to have administration of

18 Wicclair, 'Conscientious Objection in Medicine' (n 15). For the contrary view, that an individual health practitioner should not be able to object on conscientious grounds, see Savulescu (n 15) 294; Julian Savulescu and Udo Schuklenk, 'Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception' (2017) 31(3) *Bioethics* 162, 165.

19 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 18. See also Sumner (n 6) 972.

20 Daphne Gilbert, 'Faith and/in Medicine: Religious and Conscientious Objections to MAiD' (2020) 43(2) *Dalhousie Law Journal* 1, 38. Gilbert argues that under Canadian law, religious institutions do not have the right to refuse to offer medical assistance in dying ('MAiD': the Canadian term for VAD), a publicly-funded and legal health service. See also George J Annas, 'At Law: Transferring the Ethical Hot Potato' (1987) 17(1) *The Hastings Center Report* 20, 21: 'Hospitals are corporations that have no natural personhood, and hence are incapable of having either "moral" or "ethical objections" to actions. … [H]ospitals don't practice medicine, physicians do'. Sumner (n 6) says it is 'debatable' whether institutions can have conscience rights: at 972 n 14.

21 Shadd and Shadd (n 6) 208.

22 See Cameron Flynn and Robin Fretwell Wilson, 'Institutional Conscience and Access to Services: Can We Have Both?' (2013) 15(3) *American Medical Association Journal of Ethics* 226, 227; Daniel P Sulmasy, 'What Is Conscience and Why Is Respect for It So Important?' (2008) 29(3) *Theoretical Medicine and Bioethics* 135; Kevin W Wildes, 'Institutional Identity, Integrity, and Conscience' (1997) 7(4) *Kennedy Institute of Ethics Journal* 413, 416. In New Zealand, a court has held that institutions may have 'an entrenched moral ethos through which it operates' and have a right to freedom of conscience: *Hospice New Zealand v A-G* [2020] NZHC 1356, [103] (Mallon J). Mallon J held that there is nothing in the *End of Life Choice Act 2019* (NZ) that requires institutions to offer VAD: at [103]–[117], [214].

23 Mark R Wicclair, 'Conscientious Refusals by Hospitals and Emergency Contraception' (2011) 20(1) *Cambridge Quarterly of Healthcare Ethics* 130.

24 See Shadd and Shadd (n 6) 208.

25 Carpenter and Vivas note three types of individual objection to VAD: objection to administration, objection to participation in consultation and assessment, and, less commonly, objection to providing a direct referral: Travis Carpenter and Lucas Vivas, 'Ethical Arguments Against Coercing Provider

VAD occur in its facility.[26] It may achieve this by forbidding its staff or outside health professionals from administering or prescribing VAD medication to patients, and/or it may prohibit individuals themselves from taking it in the facility. Secondly, an institution may prohibit consultations or eligibility assessments for VAD occurring within the facility, whether conducted by staff or outside health professionals.[27] Thirdly, an institution may refuse to refer a patient to other institutions or health professionals who provide VAD services or object to providing information about VAD.

A common basis for institutional objection is religious belief. The Catholic Church has made prominent statements on VAD, with its most recent pronouncement concluding that 'euthanasia … is an intrinsically evil act',[28] and that complicity by '[a]ny formal or immediate material cooperation in such an act is a grave sin against human life'.[29] This is significant as Catholic hospitals and institutions (eg, hospices and long-term care facilities) provide a significant proportion of end-of-life care in Australia.[30] Other religions, including Judaism and Islam, have expressed the same viewpoint.[31] This has led some religious organisations to refuse to permit VAD assessments or administration in their

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Participation in MAiD (Medical Assistance in Dying) in Ontario, Canada' (2020) 21 *BMC Medical Ethics* 46:1–5, 1–2. Institutional objections may also extend to a refusal to allow individuals to complete paperwork relating to VAD onsite: see, eg, Jennie Russell, 'Paralyzed, Terminally Ill Man Had to Sign Assisted-Dying Papers in Bus Shelter', *CBC News* (online, 2 November 2018) <https://www.cbc.ca/news/canada/edmonton/convenant-health-assisted-dying-edmonton-1.4888114> ('CBC Coverage of Bob Hergott'); Jennie Russell, 'Unassisted Death', *CBC News* (online) <https://newsinteractives.cbc.ca/longform/unassisted-death> ('CBC Coverage of Doreen Nowicki').

26 See, eg, the case of a Victorian patient discussed below: Eswaran Waran and Leeroy William, 'Navigating the Complexities of Voluntary Assisted Dying in Palliative Care' (2020) 213(5) *Medical Journal of Australia* 204.

27 In Victoria, some institutions (such as facilities run by Catholic Health Australia, discussed below) have indicated that they will refuse to participate in assessment or administration of VAD.

28 Congregation for the Doctrine of the Faith, '*Samaritanus Bonus*: On the Care of Persons in the Critical and Terminal Phases of Life' (Letter, 22 September 2020) 8 <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html>. This position is also reflected in Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* (2001). The Code states in its section on euthanasia: 'It is never permissible to end a person's life (whether that decision is made to relieve a patient's suffering by euthanasia, to comply with the wishes of the family, to assist suicide, or to vacate a bed)': at 46 [5.20].

29 Congregation for the Doctrine of the Faith (n 28) 9 (emphasis omitted).

30 The South Australia End of Life Choices Report notes that approximately 13% of palliative care in Australia is provided in Catholic hospitals, and in South Australia the Catholic Church is the largest provider of private palliative care beds: Joint Committee on End of Life Choices, Parliament of South Australia, *Report of the Joint Committee on End of Life Choices* (Report, 13 October 2020) 12.

31 Rhiannon Shine, 'Voluntary Euthanasia Legislation Leaves WA's Religious Communities Debating Doctrine and Death', *ABC News* (online, 10 August 2019) <https://www.abc.net.au/news/2019-08-10/where-do-different-religions-stand-on-voluntary-euthanasia/11399138>; Jewish Care, 'Voluntary Assisted Dying' (Position Statement, April 2019).

facilities.[32] They may, however, be willing to provide information about VAD, refer to an external source of information,[33] or facilitate a transfer of care.[34]

Institutional objections need not be grounded in religion.[35] An example of this is an objection based on an institution's philosophy of palliative care, which for some[36] (but not others)[37] warrants a strict separation from VAD. For other institutions, objections to VAD may be grounded in their view about the purpose of medicine; namely, to promote health and preserve life, rather than to take life.

III EXISTING EVIDENCE ABOUT LAW AND POLICY RESPONSES

A Victoria

The *Victorian VAD Act* is silent on institutional objection.[38] Instead, the Department of Health and Human Services ('DHHS') has addressed this issue using a series of policy documents aimed directly at institutions.[39] The DHHS

32 Catholic Health Australia, 'Our Enduring Commitment to End of Life Care: Catholic Health and Aged Care Services in Australia' (Report, February 2019) ('CHA Taskforce Document'); Catholic Health Australia, 'CHA VAD Response Taskforce: Clinical Governance Recommendations' (Report, February 2019) ('CHA Clinical Governance Recommendations'); Catholic Health Australia, 'Catholic Health and Aged Care Services Response to the "Voluntary Assisted Dying Act"' (Media Statement, 19 June 2019) ('CHA Media Statement'); Jewish Care (n 31).

33 Jewish Care (n 31).

34 CHA Media Statement (n 32) 1.

35 Andrew McGee, 'Voluntary Assisted Dying: Should Conscientious Objection Be Unconditional?' (2020) 50(2) *Journal of Pharmacy Practice and Research* 117, 118.

36 Australian and New Zealand Society of Palliative Medicine, 'The Practice of Euthanasia and Physician-Assisted Suicide' (Position Statement, September 2020); Waran and William (n 26) 205. This position was also advanced by Hospice New Zealand in *Hospice New Zealand v A-G* [2020] NZHC 1356, [18] (Mallon J).

37 Palliative Care Australia, 'Palliative Care and Voluntary Assisted Dying' (Position Statement, September 2019) ('PCA Position Statement'). The PCA Position Statement also draws a distinction between VAD and palliative care, but suggests palliative care practitioners may decide whether to be involved in VAD.

38 Conscientious objection is addressed in section 7 of the *Victorian VAD Act 2017* (Vic), but this is limited to registered health practitioners. Section 7 indicates registered health practitioners may refuse to: provide information; participate in the request and assessment process; apply for a VAD permit; supply, prescribe, or administer the medication; be present at the time of administration; or dispense a VAD prescription. The *Victorian VAD Act 2017* (Vic) does not specify whether the health practitioner must refer the patient or disclose their conscientious objection.

39 Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Model of Care Pathways for Health Services' (Guidance, January 2019) <https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Policies%20and%20guidelines/V/VAD%20Model%20of%20care%20pathways%20for%20health%20services> ('DHHS Model of Care Pathways'); Department of Health and Human Services, State Government of Victoria, 'Preparing for Voluntary Assisted Dying: *Voluntary Assisted Dying Act 2017*' (Guidance, 24 April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/preparing-for-voluntary-assisted-dying>; Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Guidance for Aged Care Providers' (Guidance, 17 April 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-guidance-aged-care-providers>; Department of Health and Human Services, State Government of Victoria, 'Voluntary Assisted Dying Safety and Quality Guidance for Health Services' (Guidance, January 2019); Department of Health and Human Services, State Government of Victoria, 'Health Service Participation in Voluntary

instructs health services to assess their capacity to provide VAD, and determine whether it is congruent with their 'staff or service mix' and the health service's values.[40] The guidance indicates that 'most health services will fall into one of three high-level pathways':[41]

- Pathway A: Single service – Health services that are willing and able to provide VAD within their facilities;
- Pathway B: Partnership service – Institutions that can provide access to some elements of VAD but require assistance from existing external partnerships and referral pathways;[42] and
- Pathway C: Information and support service – Health services that either choose or are not able to provide VAD, including those that do not provide end-of-life care. The DHHS guidance indicates that organisations who adopt Pathway C 'will be able to provide' support and information about VAD and '[a]ll health services should be prepared to respond to requests for information about, or access to, voluntary assisted dying'.[43]

The DHHS guidance characterises institutional objection both as a matter of conscience and as a matter of self-governance.[44] It suggests an institution that objects to VAD will typically fall under Pathway C.[45] A health service is not obliged to refer the patient to a VAD provider, but must not 'inhibit a person's

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Assisted Dying' (Guidance, August 2018) <https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Factsheets/V/VAD-health-service-participation> ('DHHS Health Service Participation'); Department of Health and Human Services, State Government of Victoria, 'Health Service Policy Guidance for Voluntary Assisted Dying' (Guidance, 12 June 2019) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-service-policy-guidance-for-voluntary-assisted-dying>. All Department of Health and Human Services policy documents aimed at institutions can be found here: 'Health Services Information', *Department of Health and Human Services, State Government of Victoria*, (Web Page) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>.

40 DHHS Model of Care Pathways (n 39) 3. See also DHHS Health Service Participation (n 39) 1.

41 DHHS Model of Care Pathways (n 39) 9.

42 For example, partnering with general practitioners to conduct VAD assessments.

43 DHHS Model of Care Pathways (n 39) 3, 9.

44 The DHHS Model of Care Pathways (n 39) document invites institutions to assess their staff or service mix and their organisational values. It states: 'After assessing the capacity of their service to provide voluntary assisted dying, a health service may determine they do not have the appropriate staff or service mix to provide access to voluntary assisted dying, or that providing access to voluntary assisted dying would not be consistent with the values of the health service': at 3. See also Shadd and Shadd (n 6). Cf Sumner (n 6).

45 The DHHS Model of Care Pathways (n 39) document states that Pathway C 'is likely to include health services that do not provide care to people who are at the end of their life as well as health services that have chosen not to provide voluntary assisted dying': at 9. Note, however, that Pathway B may apply depending on the nature of the objection (eg, if the objection extends only to providing access to VAD and does not include the provision of information or eligibility assessment). For example, an aged care facility might choose to partner with general practitioners to provide VAD assessments but object to their residents consuming the VAD medication onsite.

access to treatment'.[46] Additionally, health services should inform the patient 'as soon as practicable that they will not assist them'[47] and health professionals (in accordance with professional codes of conduct) must not use their objection to 'impede access to treatments that are legal'.[48] The policies strongly suggest (but do not require) that organisations nominate a VAD contact, but if no one is designated, organisations may direct patients to the Statewide Care Navigator Service ('VAD Navigators'), which can provide information, support and referrals.[49]

On its face, the DHHS policy position suggests, at a minimum, that objecting institutions should provide information and support to those seeking VAD, and should consider how to provide 'compassionate person-centred care' to those who request information or access to VAD.[50] However, the policies allow latitude for institutions to depart from this, with the DHHS indicating that '[h]ealth services may adapt the care pathways'.[51]

Some organisations have created specific policies stating that they will not permit access to VAD. For example, Catholic Health Australia ('CHA'), the largest non-governmental grouping of hospitals and aged care providers in Australia, will not provide VAD in its facilities.[52] Their taskforce document in response to the *Victorian VAD Act* does not explicitly mention referral, but indicates that organisations under the CHA umbrella 'will not facilitate or participate in assessments' for the purpose of VAD.[53]

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46 DHHS Health Service Participation (n 39) 1.

47 Ibid.

48 DHHS Model of Care Pathways (n 39) 6. The DHHS Model of Care Pathways document puts forward this language from the Medical Board of Australian Code of Conduct. It also addresses nursing and pharmacy professional codes of conduct.

49 Department of Health and Human Services, State Government of Victoria, 'The Statewide Voluntary Assisted Dying Care Navigator Service' (Fact Sheet, September 2019) <https://www2.health.vic.gov.au/Api/downloadmedia/%7B443D45A2-9F81-4BCB-9D3A-EE3B36FD3306%7D> ('DHHS VAD Care Navigators').

50 DHHS Model of Care Pathways (n 39) 3.

51 Ibid 7.

52 CHA Taskforce Document (n 32). This statement was contributed to by CHA member organisations: Calvary Health Care; Cabrini; Mercy Health; St John of God; St Vincent's Health; and Vita Maria Catholic Homes ('VMCH'). See also CHA Media Statement (n 32).

53 CHA Taskforce Document (n 32) 2. It appears that at least some organisations under the Catholic Health umbrella will facilitate referrals or transfers of care. The CHA Media Statement (n 32) that accompanied the commencement of the *Victorian VAD Act 2017* (Vic) indicates that '[e]ach of our services has a system in place that will respond respectfully and compassionately to any questions about "VAD". This includes coordinating transfer of care to other providers if a patient/resident wishes to seek "VAD". We will not impede access to the provision of "VAD" elsewhere': at 1. Note, also, that guidance has been issued by the Australian Medical Association in its broad statement on conscientious objection in medicine. The statement also addresses institutional objection and may inform Victorian health providers' responses. It states that institutions may object to providing certain services, and if this occurs the institution should visibly inform the public so potential patients can seek care elsewhere. It indicates that where a patient admitted to an institution requests VAD, doctors should still be allowed to refer the patient to a VAD provider outside the facility. In other words, the organisation should not limit its staff from making appropriate referrals. This guidance is likely to pose difficulties for religious organisations that would seek to limit VAD referrals: see 'Conscientious Objection: 2019', *Australian Medical Association* (Web Page, 27 March 2019) [3.1]–[3.2] <https://ama.com.au/position-statement/conscientious-objection-2019>.

To date, evidence of how VAD is operating in practice is limited. Waran and William describe a transfer of care due to an institutional objection to VAD.[54] A 53-year-old woman sought VAD for metastatic breast cancer, but after she was assessed as eligible, she required admission to a palliative care unit to manage her worsening symptoms. Since the woman could not return home, she sought to take the VAD substance in the unit but was refused because of the organisation's policy against providing VAD.[55] She was then referred to another site within the same health service, which also objected. She was eventually transferred to a third venue in the service and was able to take the VAD substance on her preferred date. In describing the case, the authors emphasise the position taken by the DHHS: there is no duty for a health service to refer a patient, but health services must not actively inhibit a patient's access. It is not clear from the article whether the original palliative care unit facilitated the referral or used the VAD Navigators.

There has also been a media report of institutional objection where a patient in a Catholic hospice was not permitted to take delivery of their VAD substance after pharmacists were refused entry to the premises.[56] As a result, the patient needed to be transported out of the hospice and to a hospital where they were then able to receive their VAD substance. In addition, although not an institutional objection of the type discussed in this article, that media report also described a decision by a large palliative care service to decline to certify deaths of patients who had died at home from VAD. Although at this early stage there is only anecdotal evidence that institutional objection is occurring in Victoria, given that there is no legislative requirement for institutions to permit access or make a referral, and that the government policy confirms this, we anticipate that institutions will continue to object to VAD.

B Other Australian Jurisdictions

There is no reason to believe the situation in relation to institutional objections will be different in other Australian states if and when VAD legislation is enacted. Some religious institutions have adopted a position at a national level, so institutions affiliated with these entities can reasonably be expected to have similar objections.[57]

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54 Waran and William (n 26).

55 Waran and William (n 26) describe that the policy was also grounded in 'the need to minimise misperceptions' about the role of the palliative care unit: at 204. The Royal Australasian College of Physicians ('RACP') statement on VAD was cited to justify this stance, which recommends 'voluntary assisted dying must not be seen as part of palliative care': Royal Australasian College of Physicians, 'Statement on Voluntary Assisted Dying' (Position Statement, November 2018) 2 (emphasis omitted).

56 Melissa Cunningham, '"Discriminatory and Unethical": Palliative Care Service Criticised Over Failure to Verify Euthanasia Deaths', *The Age* (online, 17 April 2021) <https://www.theage.com.au/national/discriminatory-and-unethical-palliative-care-service-criticised-over-failure-to-verify-euthanasia-deaths-20210415-p57jif.html>.

57 See, eg, CHA Clinical Governance Recommendations (n 32); CHA Taskforce Document (n 32).

As mentioned, the VAD legislation in Western Australia is silent on whether a non-participating institution must refer or facilitate transfer of a patient who wishes to access VAD. The Catholic Church is committed to ensuring Catholic hospitals, aged care facilities and palliative care facilities in Western Australia remain 'VAD free spaces',[58] suggesting they will permit neither VAD assessment nor administration. Anglican, Jewish and Muslim leaders in Western Australia have also expressed opposition to VAD.[59] It is anticipated that healthcare and aged care facilities run by these religious institutions may well prohibit the assessment or administration of VAD, or provision of information about VAD, or referrals out occurring within their facilities.

In Queensland, members of the Presbyterian Church, the Anglican Church, the Baptist Church and the Catholic Church all expressed their opposition to VAD before the parliamentary inquiry.[60] Similarly, in Tasmania, CHA has stated that Catholic hospitals and aged care facilities will not provide VAD prescriptions nor administer a lethal injection.[61] They will also not allow external providers to enter the facility to conduct VAD consultations, and will not be making specific referrals to non-objecting institutions.[62]

It seems, however, that some institutions which object to VAD on the ground of conscience will refer individuals to a central government coordination and referral agency, rather than provide a direct referral to a known VAD provider.[63]

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58 Don Sproxton, 'Euthanasia in Western Australia' (Speech, 2019 Australian Catholic Youth Festival, 8 December 2019) <http://perthcatholic.org.au/Our_Archdiocese-Bishop-Speeches_Statements_and_Letters-2019-Speech__Euthanasia_in_Western_Australia.htm>.

59 Shine (n 31). However, not all religious institutions in Western Australia are opposed to VAD. The Buddhist Council expressed support for the legislation, and the Uniting Church has put forward a resolution to allow VAD assessment and administration to occur within its facilities: see, eg, Synod of the Uniting Church in Western Australia, 'Proposal 9: Voluntary Assisted Dying Task Group' (Policy Proposal, September 2020) <https://unitingchurchwa-startdigital.netdna-ssl.com/wp-content/uploads/2020/09/VAD-Task-Group-3.pdf>.

60 Queensland Parliamentary Report (n 9) 50. Similar views were expressed by religious groups to other parliamentary inquiries: see, eg, Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report No 174, June 2016) 213 <https://www.parliament.vic.gov.au/file_uploads/LSIC_pF3XBb2L.pdf>; Select Committee on End of Life Choices in the ACT, Parliament of the Australian Capital Territory, *End of Life Choices in the ACT* (Report, March 2019) 89–90 <https://www.parliament.act.gov.au/__data/assets/pdf_file/0004/1334992/9th-EOLC-Report.pdf>.

61 This includes the four hospitals run by Calvary Healthcare and around nine aged care facilities operated by Southern Cross Care in Tasmania: Marilyn Rodrigues, 'Peak Health Group Rejects Dying Bill', *Catholic Weekly* (online, 17 September 2020) <https://www.catholicweekly.com.au/peak-health-group-rejects-dying-bill/>.

62 Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 15 (Bastian Seidel). The Anglican Church has also publicly voiced its opposition to VAD: Sue Bailey, 'Two Churches Have Strongly Opposed an Assisted Dying Bill Being Prepared for Parliament', *The Advocate* (online, 22 September 2019) <https://www.theadvocate.com.au/story/6399252/assisted-dying-proposal-rebuffed-by-churches/>.

63 In Victoria, the Department of Health and Human Services established a Statewide Voluntary Assisted Dying Care Navigator Service to provide this referral function: DHHS VAD Care Navigators (n 49). In the first year of the *Victorian VAD Act 2017* (Vic), this service provided support to 613 people (the data does not state whether these supports were a result of institutional objections): Voluntary Assisted Dying Review Board, 'Report of Operations: January–June 2020' (Report, 31 August 2020) 5

C Some Illustrative Canadian Examples

Allowing institutional objections to VAD can sometimes result in patients being transferred seamlessly and painlessly to another institution, community space, or home for assessments and provision of VAD. However, as the longer Canadian experience with VAD has shown,[64] it can also result in indignity, extreme pain, and loss of access. There is insufficient scope here to report all such reported cases, but those described below are illustrative.[65]

Two cases that resulted in indignity were Doreen Nowicki and Bob Hergott. Doreen Nowicki was a woman in her late 60s with advanced motor neurone disease.[66] She was living in a continuing care facility run by a Catholic provider. She was taken from her bed with a mechanical lift, put in a wheelchair, and brought out of the facility to benches situated across the street (off the property) for her VAD eligibility assessment. This was intensely distressing for her. Bob Hergott, a 72-year-old man also with motor neurone disease, had to leave the hospital where he had been an in-patient for five years, cross the street in the rain to a bus shelter, and meet the two witnesses required as he signed his form requesting VAD.[67]

An institutional objection can also result in extreme pain to the patient. Ian Shearer was an 87-year-old man with spinal stenosis.[68] His pain medications were reduced to ensure he would have decision-making capacity following the transfer. The ambulance was more than three hours late. The time waiting for the ambulance was increasingly painful and the trip across the streets of Vancouver was agonising.

Institutional objections have also resulted in limitations or removal of access. Gerald Wallace was an 80-year-old man with pancreatic cancer in a rural hospital run by a Catholic organisation.[69] He was prevented from accessing VAD and died

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<https://www.bettersafercare.vic.gov.au/sites/default/files/2020-08/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf>. The *End of Life Choice Act 2019* (NZ) has mandated the creation of a support and referral group in its legislation: at s 25.

64 As noted above, in Canada, VAD is referred to as 'medical assistance in dying' ('MAiD'), but we use the term VAD in this section for consistency with the rest of the article.

65 We do not have full information on the scope of the problem as the data is not collected in all jurisdictions. However, in Alberta, a province that collects and publishes data on this issue, between 17 June 2016 and 30 April 2020 (noting, though, that the website states it is current as of April 2020 but actually only includes data up to end of 2019), 125 patients were transferred from faith-based (109) or non-participating (16) sites to a participating facility or the patient's home. This data suggests that 10% of VAD deaths in Alberta follow a transfer from a faith-based site: 'Data & Statistics: Medical Assistance in Dying', *Alberta Health Services* (Web Page, 28 February 2021) <https://www.albertahealthservices.ca/info/Page14930.aspx>.

66 CBC Coverage of Doreen Nowicki (n 25).

67 CBC Coverage of Bob Hergott (n 25).

68 Tom Blackwell, 'BC Man Faced Excruciating Transfer after Catholic Hospital Refused Assisted-Death Request', *National Post* (online, 27 September 2016) <https://perma.cc/DE36-V9TA>.

69 Jennie Russell, 'Camrose Man Died in Pain after Covenant Health Hindered Access to Assisted-Dying Services, Son Says', *CBC News* (online, 1 December 2018)

in pain. Additionally, Horst Saffarek, an elderly man whose lungs were failing, was admitted to a Catholic hospital.[70] He was found eligible for VAD but the hospital refused to allow it to be provided on their premises. He had to be transferred to a city more than an hour away, but he died before he was able to access VAD.

IV THREE POSSIBLE MODELS OF LEGAL REGULATION

The limited evidence in Australia about institutional objection, as discussed in Part III(A) and (B), reveals that some institutions in Victoria are currently objecting to VAD in various ways and this is likely to occur in other states that legalise VAD. These objections, as also shown in the longer Canadian experience, can adversely affect individuals who are eligible for VAD but cannot access it in such institutions. Governments exploring VAD reform must consider this issue and the appropriate regulatory response, whether that is prohibiting institutions from conscientiously objecting, not restricting this ability in any way, or a compromise of these two extremes. Ultimately, a government's position will depend on how it balances institutional and individual interests. At the heart of this decision is how best to weigh an individual's ability to access VAD against an institution's desire not to permit access to VAD within its facility.[71]

This balancing exercise has been subject to extensive debate[72] and there is not scope in this article to engage further with those arguments. Instead, our goal is to describe possible regulatory models that chart three broad options, and briefly observe the implications of each model for institutional and individual interests.

The three regulatory responses proffered draw on Wicclair's terminology in relation to conscientious objection by individuals,[73] and are framed as:

- 'conscience absolutism' – permitting institutional objections without limit;
- 'compromise or reasonable accommodation' – permitting institutional objections but imposing limits on them; and
- 'non-toleration' – institutional objections are not permitted.

But before considering these three options, we raise two threshold issues. The first is whether a regulatory response should comprise of legislation or policy. We propose that legislation is optimal (which would allow for accompanying policy), and regulatory responses in Part IV(B) and (C) below are framed accordingly. Policy alone is a weaker form of regulation with less coercive force.

<https://www.cbc.ca/news/canada/edmonton/camrose-man-died-in-pain-after-covenant-health-hindered-access-to-assisted-dying-services-son-says-1.4927739>.

70 'Should Catholic Hospitals Have to Provide Access to Medically Assisted Dying?', *CBC Radio* (online, 11 January 2018) <https://www.cbc.ca/radio/thecurrent/the-current-for-january-11-2018-1.4481312/should-catholic-hospitals-have-to-provide-access-to-medically-assisted-dying-1.4482372>.

71 Flynn and Wilson (n 22) 228–9.

72 See Carpenter and Vivas (n 25); Flynn and Wilson (n 22); Gilbert (n 20); Shadd and Shadd (n 6); Sumner (n 6).

73 Mark R Wicclair, 'Preventing Conscientious Objection in Medicine from Running Amok: A Defense of Reasonable Accommodation' (2019) 40(6) *Theoretical Medicine and Bioethics* 539.

While a policy approach is often appropriate to regulate aspects of healthcare, we consider this is not the case where the proposed policy response conflicts with deeply-held views of the target of regulation (here, institutions). The stronger normative and coercive force of law is more likely to be needed here, particularly if an individual citizen is seeking to rely on it to compel an institution (often large and well-resourced) to comply with regulation.[74] Further, a legislative approach ensures any changes occur only with the transparency and public accountability of parliamentary consideration.

The second threshold point we make is that, regardless of which regulatory response is adopted, it should require organisations to disclose their objections publicly.[75]

A 'Conscience Absolutism'

The first regulatory option is for legislation to enshrine the ability of an institution to object. The model gives all weight to an institution's position on VAD and no weight at all to the patient's interests, and enables institutions that effectively have a monopoly on the provision of specialist services to bar individuals from accessing legally-available health services.[76]

Such an approach would bestow greater powers on institutions to object than individuals, upon whom law and ethics in medicine traditionally impose at least some compromise or accommodation duties – eg, providing information or effective referral.[77] Allowing absolutism for institutions could effectively deprive eligible people of access to VAD, even more so than objections by individual health professionals. While changing doctors is not straightforward, it generally remains possible, whereas for a person unable to move from an institution, absolutism is a veto on that person's ability to access VAD.[78] Even if a person was able to move, they may require the cooperation or assistance of the institution to facilitate the transfer, which absolutism would allow them to withhold.

74 We note it would be possible, however, to design a policy response which may nevertheless be effective in ensuring compliance by institutions – eg, if linked to accreditation or funding requirements.

75 A provision requiring such disclosure was included in the Voluntary Euthanasia Bill 2016 (SA) clause 21(3)(a). We do not propose this disclosure being a ground for refusing access to VAD. Rather, we consider the utility of such a provision is to help avoid situations, where possible, of a person finding out subsequent to their admission or residence that the facility objects to access to VAD.

76 See, eg, Schuklenk (n 8).

77 It is worth noting that while the *Voluntary Assisted Dying Act 2019* (WA) section 20(5) requires conscientiously objecting health professionals to provide certain information to their patients, the *Victorian VAD Act 2017* (Vic) s 7 imposes no accommodation duties on doctors who conscientiously object.

78 Sumner (n 6) 972.

B 'Compromise or Reasonable Accommodation' of Institutional Objection

This section outlines how legislation could present a 'compromise or reasonable accommodation' model for institutional objection to VAD. Such an approach recognises that institutional objections to VAD will occur and allows them, but aims to regulate them to ensure as little impact on the person seeking VAD as possible, while still permitting some degree of institutional objection. This need not imply legislative endorsement of these objections; the focus is instead on creating processes to facilitate a person's access to VAD where objections occur. Two of the authors included a clause in their model VAD Bill which aimed to address this by requiring the objecting institution to arrange a transfer if requested.[79] However, in light of the impacts of institutional objections on patients in practice, as described earlier in the article, more may be needed to better support access to VAD when institutions object.

While there are various compromise models that could be designed, in our view, all compromise models should, at a minimum, require institutions to provide information about VAD and facilitate effective referral to a VAD provider. This obligation does not require an objecting institution to endorse VAD, or to be involved with its assessment or administration. Although some organisations may consider that providing information or directly referring to a VAD provider makes them complicit in the activity to which they object,[80] a workable alternative is to connect individuals with a central coordination service (such as the VAD Navigators in Victoria).[81] Therefore, our discussion below focuses on the two other aspects of VAD provision that institutions may object to: conducting VAD assessments and administration.

A final general point is that this compromise or reasonable accommodation category is very broad: legislation could be drawn to require either very little compromise or a great deal of compromise from objecting institutions. The below approach is one put forward for consideration which weighs the balance between individual and institution in favour of the person seeking access to VAD. As explained below, we have struck the balance in favour of the patient when the institutional objection will unduly compromise the patient's interests. This is because the patient, who is close to death and intolerably suffering, is in a vulnerable position.

1 Nature of Provision: No New Rights for Institutions; Creates Process Only

Under this model, legislation should provide that 'nothing in this section creates a right for an institution to refuse to provide access to VAD'. This addresses concerns raised in the Tasmanian debates[82] that legislatively regulating this issue

79 White and Willmott (n 9) 36. See also Voluntary Euthanasia Bill 2016 (SA) cl 21(3)(b). Such a clause was also reflected in amendments proposed in Tasmania to its *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas): see Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 2 (Bastian Seidel).

80 Congregation for the Doctrine of the Faith (n 28) 8, 14.

81 This is also the position that has been adopted in Alberta and Quebec, Canada: Gilbert (n 20) 9.

82 See, eg, Tasmania, *Parliamentary Debates*, Legislative Council, 30 October 2020, 10 (Meg Webb).

might be seen as implicit recognition of institutional objections and conscience rights.[83] Further, the provision should be framed as establishing a process to ensure a person's access to VAD is not unreasonably denied. For example, it could state: 'An institution wishing to refuse a person's request to access VAD within a facility must follow the process outlined in this section'.

2 Would the Patient's Interests Be Unduly Compromised by Requiring Access to VAD Outside the Facility?

One way to accommodate both an institution's objection and a person's desire to access VAD is for VAD assessments and administration to occur outside the facility. This could occur by transferring a person's care or residence to another, non-objecting, institution. However, it is also possible for VAD to occur without a formal transfer. For instance, a person in a residential aged care facility may remain living there but, if well enough to do so, may leave the facility for VAD assessments and then again attend elsewhere to take the VAD medication at a time of their choosing. Determining when this should be required would depend both on establishing criteria to assess the impact on the patient's interests, and identifying who would decide whether these criteria were met.

To address the undesirable consequences for persons seeking VAD outlined above, this criteria could include that it is not appropriate for an institution to refuse access to VAD where:

- that would cause harm to the person (eg, this could be pain or a deterioration of their condition from the required transfer);
- that would prejudice a person's access to VAD (eg, the transfer logistics to another institution mean a person is likely to lose capacity or die first; or pain medication required to manage the transfer means they are likely to lose capacity);
- that would cause undue delay (and thereby extended intolerable suffering) in accessing VAD; or
- access to VAD is not reasonably possible at another institution (eg, another institution will not accept a transfer or the institution is the only facility in the district that could manage the patient in their condition).

Given the criteria (which are medical in nature or at least involve navigating the health system), we consider it appropriate that whether they are met is decided by a doctor. We would propose a doctor who is chosen by or acceptable to the patient. A doctor employed by an objecting institution may not be free to adopt a position contrary to the institution, although we note that a patient might choose to nominate a doctor working in an objecting institution if they considered that doctor was independent.

83 This provision would not, of course, create a right or duty to provide VAD.

This may raise issues if the objecting institution considers that granting permission for this doctor to meet with the person is facilitating access to VAD and so is inconsistent with the institutional objection. However, failing to allow this access to the facility by the doctor could preclude a person's access to VAD altogether, so this is required to appropriately balance institutional and individual interests.

3 Obligations Where Access to VAD Will Occur Outside the Objecting Institution

Where the criteria above mean that access to VAD will occur outside the objecting institution, the institution must offer and take reasonable steps to facilitate this access. For instance, this may require supporting a transfer of the care or residence of the person to a place at which VAD can be assessed or provided by a doctor who does not have a conscientious objection to VAD.

Further, a person must not experience financial detriment because of such a transfer, which could in some instances have financial implications for a person so serious as to create an unconscionable or insurmountable barrier. This detriment could range from the cost of transport between institutions through to costs due to complex financial arrangements associated with entry into and exit from a residential aged care facility. Because the need for a transfer arises from the institution's objection, the legislation should provide that no financial detriment will occur as a result.

4 Obligations Where Access to VAD Will Occur Inside the Objecting Institution

Where the criteria above mean that access to VAD will occur inside the objecting institution, the legislation should provide that access must be permitted by the institution. This is based on a person's claim to access VAD outweighing an institution's objection, when both outcomes cannot be achieved. Not taking this approach would effectively mean that a person who is unable to be reasonably transferred or leave the institution for periods to access VAD would be prevented from accessing VAD by an institution that is objecting.

The legislation should state that an objecting institution will be required to permit a person to access VAD within the institution and will take reasonable steps to allow this where transfer is not possible or unduly harms the person's interests. This may include permitting existing staff (who are willing) to be involved in conducting VAD assessments or administering the VAD medication to this person, or allowing other doctors to visit the person onsite and provide the assistance required. The institution would also not be allowed to impede a person self-administering VAD medication onsite.

C 'Non-Toleration' of Institutional Objection

Under this model, legislation would prohibit an institution from preventing access to VAD on the basis of an objection. The provision could be framed broadly

and prohibit an institution from impeding access of a person seeking VAD.[84] For clarity, it may be desirable for the legislation to specify that the institution could not prohibit entry to its facility of any health professional for the purpose of discussing VAD with a patient, assessing eligibility for VAD, or providing VAD. The institution also could not prohibit a patient from self-administering a VAD substance.

Under this approach, VAD would be available to all eligible individuals who wish to access it, not just for those for whom transfer would be problematic (as canvassed above). This model gives the strongest recognition of the three approaches to the right of an individual to access VAD despite an institution's objection.

V CONCLUSION

This article aims to highlight an important, but largely neglected, aspect of the VAD debate in Australia: objections by institutions when a person seeks lawful access to VAD. Patients and residents being cared for or residing in such institutions may effectively be denied access to VAD or have to overcome significant barriers to access it. There is evidence of institutional objection in Australia, and experience in Canada demonstrates the impact these objections can have on individuals who wish to access VAD and are experiencing intolerable suffering.

This article proposes three possible legislative models to regulate institutional objection. One is conscientious absolutism: legislation that enshrines the ability of an institution to object and imposes no limitation on that right. This model will have adverse outcomes for some individuals, particularly those who are unable to transfer from that facility, as they are effectively deprived of choice, unable to move, and without access to VAD. This prioritises the institutional position at the expense of the individual. At the other end of the spectrum, non-toleration, where an institution is prohibited from exercising an objection in any circumstances, the individual is prioritised even if the institution may be in a position and willing to transfer their care.

The middle ground, the 'compromise or reasonable accommodation' model, is a legislative option worthy of consideration. It does not grant absolute priority to either the institution or the individual seeking VAD, but seeks to accommodate both. The specific compromise model proposed in this article, however, does prioritise the individual if both positions cannot be reasonably accommodated.

Parliaments and law reform bodies considering VAD reform must consider the issue of institutional objection, and select a policy position on how to balance the

84 A stricter version would be to require institutions to employ staff capable of and willing to be involved in the provision of VAD.

desire of an institution to determine what practices are permitted within their facilities and the interests of an individual seeking access to VAD, a lawful medical service. As argued above, this should not be left to policy alone and is an issue that should be explicitly addressed in VAD legislation.

DOES THE *VOLUNTARY ASSISTED DYING ACT 2017* (VIC) REFLECT ITS STATED POLICY GOALS?

BEN P WHITE,* KATRINE DEL VILLAR,** ELIANA CLOSE*** AND LINDY WILLMOTT****

With the commencement of the Voluntary Assisted Dying Act 2017 (Vic) in June 2019, Victoria became the first Australian State to permit voluntary assisted dying. This article considers the extent to which this novel Act reflects its stated policy goals. The first part of the article identifies the purported policy goals of the Act. This analysis draws on the explanatory material accompanying the law, in particular the expert Ministerial Advisory Panel Report which shaped the law. The article then critically evaluates the extent to which key aspects of the Act reflect those identified policy goals. Overall, the article concludes that the Voluntary Assisted Dying Act 2017 (Vic) is not consistent with its policy goals in some important respects.

I INTRODUCTION

When the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act*') commenced in June 2019, Victoria became the first Australian jurisdiction in over 20 years to have an operative voluntary assisted dying ('VAD') system. It joins just a small number of jurisdictions in a handful of countries internationally that permit VAD.[1] One reason such

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1 Currently, nine states in the United States of America, the federal government in Canada, and one Canadian province have passed laws regulating VAD: *Death with Dignity Act*, Or Rev Stat §§ 127.800–127.995 (1994) (Oregon); *Death with Dignity Act*, Wash Rev Code §§ 70.245.010–70.245.903 (2008) (Washington); *Patient Choice and Control at End of Life Act*, Vt Stat Ann §§ 5281–93 (2013) (Vermont); *End of Life Option Act*, Cal Health and Safety Code §§ 443–443.22 (2015) (California); *Death with Dignity Act of 2016*, DC Code §§ 7–661 (2017) (District of Columbia); *End-of-Life Options Act*, Colo Rev Stat §§ 25-48-101–25-48-123 (2017)

laws are rare is that reform in this area is very difficult. VAD is seen by many as politically risky[2] and so in Australia there has been a long history of unsuccessful attempts to reform the law.[3]

The political challenges involved in VAD reform are evident in the *VAD Act* and the process leading to its enactment in three ways. The first is the staged and very consultative process adopted to facilitate reform. This began with a parliamentary committee of inquiry, which received extensive evidence[4] and numerous submissions from a large number of individuals and organisations.[5] In its report, the parliamentary committee recommended the enactment of legislation permitting VAD in certain circumstances.[6] The Victorian Government then adopted this recommendation and appointed a multidisciplinary Ministerial Advisory Panel ('the Panel'), whose role was to advise on the form of the legislation, taking into consideration a range of policy, clinical and legal issues.[7] The Panel also followed a consultative process, receiving

(Colorado); *Our Care, Our Choice Act 2018*, Hawaii Rev Stat §§ 327-1–327-25 (2018) (Hawaii); *Medical Aid in Dying for the Terminally Ill Act*, NJ Stat Ann §§ 26:16-1–26:16-20 (2019) (New Jersey); *An Act to Enact the Maine Death with Dignity Act,* 22 Me Rev Stat Ann § 2140 (2019) (Maine), note this Act commenced in September 2019; *Criminal Code of Canada,* RSC 1985, c C-46, ss 241.1-241.4 (Canada); *An Act Respecting End-of-Life Care,* RSQ 2014, c S-32.0001 (Quebec). It is also legal in Montana by virtue of the court ruling in *Baxter v Montana* 224 P 3d 1211 (Mont, 2009), but no legislation has been passed in that State. Parts of Europe have legalised VAD through legislation: *Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001] (The Netherlands); *Loi Relative à L'euthanasie* [Act on Euthanasia 2002] (Belgium) and *Legislation Reglementant Les Soins Palliatifs Ainsi Que L'euthanasie Et L'assistance Au Suicide 2009* [Legislation Regulating Palliative Care and Euthanasia and Assisted Suicide 2009] (Luxembourg). Assisting a person's suicide is also lawful under certain circumstances in Switzerland (discussed in Samia A Hurst and Alex Mauron, 'Assisted Suicide in Switzerland: Clarifying Liberties and Claims' (2017) 31(3) *Bioethics* 199, 199) and Germany (see recent decision of the second Senate of the Federal Constitutional Court, Zum Urteil des Zweiten Senats vom 26 February 2020, Bundesverfassungsgericht), but there is no legislation regulating its provision in these countries. Finally, a court decision in Colombia permitted VAD in 1997: Constitutional Court of the Republic of Colombia, Sentence C-239/97, Ref Expedient D-1490, 20 May 1997), which was followed by Government regulations to facilitate the practice in 2015: *Protocolo Para La Aplicación Del Procedimiento De Eutanasia En Colombia*: Government of Colombia, *Protocol for the Application of the Procedure of Euthanasia in Colombia* (Report, 2015) <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/Protocolo-aplicacion-procedimiento-eutanasia-colombia.pdf>. For more information on these jurisdictions, see Lindy Willmott and Ben White, 'Assisted Dying in Australia: A Values-Based Model for Reform' in Ian Freckelton and Kerry Anne Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 479, 484–8.

2 Margaret Otlowski, 'Another Voluntary Euthanasia Bill Bites the Dust', *The Conversation* (online, 19 November 2013) <https://theconversation.com/another-voluntary-euthanasia-bill-bites-the-dust-19442>; Ben White and Lindy Willmott, 'Victoria May Soon Have Assisted Dying Laws for Terminally Ill Patients', *The Conversation* (online, 21 July 2017) <https://theconversation.com/victoria-may-soon-have-assisted-dying-laws-for-terminally-ill-patients-81401>; Giles Scofield, writing in the American context, goes so far as to say that 'promoting assisted suicide is politically suicidal': Giles Scofield, 'Privacy (or Liberty) and Assisted Suicide' (1991) 6(5) *Journal of Pain and Symptom Management* 280, 286.

3 For a detailed discussion of the history of attempts at law reform in Australia, see Lindy Willmott et al, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1. See also updated data in Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42 *Australian Health Review* 616.

4 The Committee conducted an extensive program of site visits and public hearings around Victoria over an eight-month period between July 2015 and February 2016. It held 17 days of public hearings and heard from 154 witnesses: Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, 9 June 2016) xix ('*Parliamentary Report*').

5 The Committee received 1037 submissions; 925 from individuals in a private capacity and 112 from organisations: ibid.

6 Ibid xxxv.

7 See Margaret M O'Connor et al, 'Documenting the Process of Developing the Victorian Voluntary Assisted Dying Legislation' (2018) 42(6) *Australian Health Review* 621, 623.

written submissions,[8] and conducting 14 consultation forums across Victoria[9] to receive views as to practical ways to 'implement a compassionate, safe and practical framework' for VAD.[10] The Panel's detailed report (the '*Report*') recommended the system and processes which were ultimately largely enacted in the *VAD Act*.

A second way in which the political challenges of VAD law reform are reflected is in the design of the *VAD Act*. It is narrow in scope in terms of eligibility, with access to VAD only for competent adult residents of Victoria with an incurable disease, illness or medical condition that is advanced, progressive and will cause death within six months (or twelve months for neurodegenerative conditions).[11] That condition must also be causing suffering that cannot be relieved in a manner that the person considers tolerable.[12] Generally, the *VAD Act* only permits a person to take the lethal medication themselves (often called physician-assisted suicide).[13] An exception allowing voluntary euthanasia (a medical practitioner administering the medication) arises only if a person cannot physically take or digest that medication themselves.[14]

The *VAD Act* also contains a large number of safeguards. When first introduced into Parliament, its 68 safeguards[15] led the Victorian Government to describe the Act as the 'safest, and most conservative model in the world'.[16] These safeguards include: the need for repeated requests by a person for VAD; ensuring requests are voluntary and made without coercion; assessment and confirmation that a person meets the eligibility criteria; medication management; and prescribing a designated process to access VAD. The *VAD Act* also contains mandatory reporting to an independent statutory authority throughout the process, and numerous offence provisions intended to ensure strict compliance with the legislation. The design of the Act, with its narrow scope and extensive safeguards, was intentionally crafted to attract the political support needed for it to pass both houses of the Victorian Parliament.

The third impact of the political challenges of VAD reform is inconsistency between the policy objectives of the Act and some of its provisions. Politics often requires compromise[17] and when this occurs in an ad hoc way, the overall scheme and objectives

8 One hundred and seventy-six written submissions were received, although some only expressed a view in support of or opposing assisted dying, and did not address the substantive content of the law: Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) 36 ('*Report*').

9 Five of these forums were held in regional Victoria. Approximately 300 people attended the forums. The Panel noted 'each forum provided stakeholders with an opportunity to discuss, with members of the Panel, the key areas of the eligibility criteria, the voluntary assisted dying request process, and the oversight and safeguards required to implement a compassionate, safe and practical framework': ibid 37.

10 Ibid. The quality of the law reform process leading to the *VAD Act* has been commended by some commentators: Matthew Lesh, *Evidence Based Policy Research Project: 20 Case Studies* (Institute of Public Affairs, October 2018) 60–1.

11 *Voluntary Assisted Dying Act 2017* (Vic) s 9 ('*VAD Act*'). The eligibility criteria are discussed further below.

12 Ibid s 9(1)(d)(iv).

13 Ibid ss 45, 47.

14 Ibid s 48(3)(a).

15 For a complete list of these safeguards, see *Report* (n 8) 221–8. Some of these safeguards relate to the eligibility criteria described above.

16 Daniel Andrews, 'Voluntary Assisted Dying Model Established Ahead of Vote in Parliament' (Media Release, 25 July 2017).

17 Baldwin, Cave and Lodge describe the conflicting interest groups and pressure that legislators are subject to: Robert Baldwin, Martin Cave and Martin Lodge, *Understanding Regulation: Theory, Strategy, and Practice* (Oxford University Press, 2nd ed, 2012) 42–6.

of an Act can be distorted. The final legislation that ultimately passes through Parliament may no longer completely align with the overall intended policy goals. An example of this, considered later in the article, is amendments to the *VAD Act* that occurred in Victoria's Upper House, the Legislative Council, during its review of the Voluntary Assisted Dying Bill 2017 (Vic) ('VAD Bill').

This article focuses on the third potential consequence of these political challenges. It aims to address the question: does the *VAD Act* reflect its stated policy goals? It is important to distinguish this inquiry from the question of whether or not VAD legislation, and this particular *VAD Act*, are 'good' or appropriate reforms. There are a range of views on whether VAD should be permitted[18] and, if so, whether the Victorian VAD system is a good one.[19] These arguments for and against VAD are outside the scope of this article. Instead, it considers a proposition that all would endorse: that legislation should reflect and advance the policy objectives that it was designed to address. This goes to the effectiveness of that legislation in guiding behaviour as intended. Whether or not it is effective in doing this, in turn, has implications for societal acceptance of that legislation or what some call its 'regulatory legitimacy'.[20]

To undertake this exercise, this article is comprised of two substantive parts. It first determines the purported policy goals of the *VAD Act*. This is done through analysing the explanatory material accompanying the *VAD Act*, in particular the Report and the second reading debate. Secondly, it evaluates whether the key aspects of the *VAD Act* reflect those identified policy goals. Overall, the article concludes that the *VAD Act* is not consistent with its policy goals in some important respects.

Before undertaking this analysis, issues of terminology and some limitations of this analysis will be addressed. In relation to terminology, VAD is the term used in the *VAD Act* and is a global concept describing the two main practices in this area: voluntary euthanasia and physician-assisted suicide. As noted above, the former involves the medical practitioner administering a lethal medication and in the *VAD Act* is referred to as 'practitioner administration'. By contrast, the latter involves the medical practitioner providing a person with the medication which they then take themselves and is labelled 'self-administration' by the *VAD Act*. It is also acknowledged that this analysis is in

18 Those who oppose VAD reform include Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (McGill-Queen's University Press, 2nd ed, 2014); Ian Hayes, 'Ethical Challenges about Voluntary Assisted Dying' (2018) 39(3) *Australasian Science* 49; Jeremy Prichard, 'Euthanasia: A Reply to Bartels and Otlowski' (2012) 19(3) *Journal of Law and Medicine* 610; Brian H Le and Jennifer Philip, 'Voluntary Assisted Dying: Time to Consider the Details' (2018) 209(6) *Medical Journal of Australia* 279. Those who support VAD reform include Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17(4) *Journal of Law and Medicine* 532*;* Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, 1997); Nicholas Cowdery, 'A Dignified Ending' (2017) 33 *LSJ* 28; Nicholas Cowdery, 'Will We Legalise Euthanasia?' (2017) 34 *LSJ* 26; Willmott and White (n 1).

19 For some early and contrasting discussions of the *VAD Act*, see, eg, Danuta Mendelson, 'Voluntary Assisted Dying Legislation in Victoria: What Can We Learn from the Netherlands Experience?' (2017) 25(1) *Journal of Law and Medicine* 30; Ben P White, Lindy Willmott and Eliana Close, 'Victoria's Voluntary Assisted Dying Law: Clinical Implementation as the Next Challenge' (2019) 210(5) *Medical Journal of Australia* 207; Bernadette Richards and John Coggon, 'Assisted Dying in Australia and Limiting Court Involvement in Withdrawal of Nutrition and Hydration' (2018) 15(1) *Bioethical Inquiry* 15.

20 Regulatory legitimacy is a contested concept, but Yeung reduces it to two broad aspects: whether a regime achieves its stated goals effectively, and whether it conforms with principles of good governance: see Karen Yeung, 'Regulating Assisted Dying' (2012) 23(2) *King's Law Journal* 163, 164–5. This approach draws on Yeung's earlier work: Karen Yeung, *Securing Compliance: A Principled Approach* (Hart Publishing, 2004) 30–6. This article focuses on the first of these objectives: whether the regulation achieves its stated policy goals in an effective manner.

relation to the legislation itself rather than how it might be implemented in practice. Although the *VAD Act* is supported by a suite of resources such as clinical guidance documents, models of care guidelines, medication protocols and training for medical practitioners,[21] this article is being written as the *VAD Act* commences so is focused on the legislation itself rather than the way it is implemented. The effectiveness of implementation will be important research to undertake in the future, but for present purposes, this analysis focuses on the legislation.

II WHAT ARE THE *VAD ACT*'S POLICY GOALS?

Section 1 of the *VAD Act* sets out its main purposes, which are (in summary):

a) to regulate access to VAD;
b) to establish the VAD Review Board; and
c) to make consequential amendments to other legislation.

These purposes are very broad and provide little insight into how the Act is intended to function. Instead, it is the more concrete policy goals of the Government that determine the nature of the VAD system the Act creates. In this section, those policy goals are discerned from two main (and related) sources. The first source is the Report. As described above, the *VAD Act* was developed through a staged, public process,[22] and its policy goals were explicitly set out in a manner which is unusual when developing legislation. The Panel identified nine 'guiding principles' which 'helped guide … its deliberations'.[23] These principles reflect the intended policy goals and assisted the Panel to design the legislative framework. The Panel also recommended that these principles be included in the Act to 'help guide interpretation'.[24] This was done and so the second source for discerning the policy goals of the *VAD Act* is the list of principles stated in the legislation. The Report's nine guiding principles became 10 in the Act and section 5 requires a person exercising a power or performing a function or duty under the Act to have regard to those principles. As discussed below, the *VAD Act's* principles largely reflect those set out in the Report.

Before turning to these principles, and analysing how they assist in discerning the key policy goals underpinning the *VAD Act*, an observation is made about a phrase that was frequently used in the Report which provides important context for considering the principles and policy goals in this section. A stated overarching goal in the development of the *VAD Act* was to design a legislative framework that is 'safe and compassionate'.

21 Department of Health and Human Services, State Government of Victoria, *Voluntary Assisted Dying* (Web Page, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>.

22 See also the description of the process by the members of the Panel itself: O'Connor et al (n 7) 621–6. The Panel's contribution to policy formulation is described in Stephen Duckett, 'The Long and Winding Road to Assisted Dying in Australia' (2019) *Australian Journal of Social Issues* 1, and see also Lesh (n 10) 60–1. For criticism of this process, in particular of the *Parliamentary Report* (n 4) (although it is not the focus of this article), see John Keown, '"Voluntary Assisted Dying" in Australia: The Victorian Parliamentary Committee's Tenuous Case for Legalization' (2018) 33(1) *Issues in Law and Medicine* 55.

23 *Report* (n 8) 43–6.

24 Ibid 46. These guiding principles were also referred to in the second reading speech of Health Minister Jill Hennessy: Victoria, *Parliamentary Debates,* Legislative Assembly, 21 September 2017, 2944 (Jill Hennessy).

This phrase, derived from the Panel's terms of reference,[25] was used repeatedly throughout the Report.[26] 'Compassion', as used in the Report, refers to understanding, sympathy, care and concern for individuals at the end of their lives[27] who are suffering and wish to reduce that suffering.[28] The term 'safe' was most commonly employed to refer to community safety, for example in relation to the careful handling of the VAD medication,[29] or in relation to the system as a whole, encompassing a range of safeguards and oversight mechanisms.[30] Interestingly, it was only infrequently used to refer to the safety of the individual potentially receiving assistance to die, for example in ensuring there was no abuse or coercion,[31] and that a request for VAD was voluntary and properly informed.[32]

The catchphrase 'safe and compassionate' may be seen as a shorthand way to reflect some of the principles underlying the *VAD Act*: namely, compassionate respect for the autonomous choices of suffering individuals at the end of their lives, and the need to ensure the safety of the community. The need to balance these considerations is outlined in the statement of the Panel's Chair, Professor Brian Owler, in presenting the Report:

> The framework focuses on the eligible person who expresses their enduring wish to end their own suffering through access to voluntary assisted dying. It respects their personal autonomy and choice. That autonomy must of course be balanced against the safety of the community. We seek to provide a compassionate outcome for those people who are at the end of their life, while also addressing the concerns of the community.[33]

A Ten Principles

As noted above, although section 1 of the *VAD Act* contains express statements about its wider purposes, it is the 10 principles in section 5[34] that provide concrete insight into the policy goals underpinning the system. These principles are:

- valuing every human life equally;[35]
- respecting autonomy;[36]
- supporting informed decision making;[37]

25 The terms of reference tasked the Panel with proposing a 'compassionate and safe legislative framework for voluntary assisted dying': *Report* (n 8) 5.

26 This phrase was used 13 times throughout: *Report* (n 8) 1, 2, 10, 11, 12 (two mentions), 21, 36, 47, 48, 188, 200 and 211. There are also four references to the inverse phrase 'compassionate and safe': *Report* (n 8) 5 (two mentions), 33 and 36. This phrase was also used four times in the second reading speech: Victoria, *Parliamentary Debates* (n 24) 2943, 2947, 2950, 2955 (Jill Hennessy). The notion of balancing compassion for the preferences of those who are suffering at the end of life with safeguards for the community was also discussed twice, using the terms 'compassion' and 'safeguards' without using the composite phrase 'safe and compassionate': Victoria, *Parliamentary Debates* (n 24) 2944, 2949 (Jill Hennessy).

27 See *Report* (n 8) 1, 13; Victoria, *Parliamentary Debates* (n 24) 2949 (Jill Hennessy).

28 See *Report* (n 8) 77, 79; 154; Victoria, *Parliamentary Debates* (n 24) 2944 (Jill Hennessy). There is also a single instance where 'compassion' is used to denote sensitivity to the needs of the family in undertaking monitoring to ensure compliance with the legislative requirements after a person's death by means of VAD: *Report* (n 8) 149.

29 Panel Recommendations 31–33 (concerning safe handling of medication): *Report* (n 8) 1, 6, 17, 26, 45, 129, 131, 135–6, 156–7, 170–1, 213.

30 For example, ibid 11, 12, 20, 21, 47, 148, 154.

31 For example, ibid 10, 18.

32 Ibid 15, 45.

33 Ibid 1.

34 See also Victoria, *Parliamentary Debates* (n 24) 2943–4 (Jill Hennessy).

35 *VAD Act* s 5(1)(a).

36 Ibid s 5(1)(b).

37 Ibid s 5(1)(c), including providing information about medical treatment options and palliative care.

- providing quality care that minimises suffering and maximises quality of life;[38]
- supporting therapeutic relationships;[39]
- encouraging open discussions about dying, death and people's preferences;[40]
- supporting conversations with health practitioners and family about treatment and care preferences;[41]
- promoting genuine choices;[42]
- protecting individuals from abuse;[43] and
- respecting diversity of beliefs and values, including among health practitioners.[44]

These principles directly correspond to the nine guiding principles outlined by the Panel to underpin its recommendations.[45]

In addition to identifying these guiding principles, the Panel noted that the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter') also informed its deliberations. Indeed, members of the Panel noted that the guiding principles were drawn from the Charter.[46] Seven human rights were specifically listed as being significant, including the right to equality, the right to privacy (which includes the right to personal autonomy and dignity) and the right to life.[47] The Minister's second reading speech on the introduction of the VAD Bill also contains a detailed statement of compatibility with these Charter rights.[48] She noted that the Panel 'used the [C]harter as a framework' for considering how best to respect the rights of all Victorians, and for formulating the VAD model, including the guiding principles.[49]

B Six Core Policy Goals

For the purposes of our analysis, the principles listed above can be grouped into six broader policy goals (or some may call them values).[50] Our distillation of how the 10 principles support the six policy goals that underpin the VAD legislation is represented in Table 1 (recognising of course that there are necessarily overlaps across categories).

38 Ibid s 5(1)(d).
39 Ibid s 5(1)(e).
40 Ibid s 5(1)(f).
41 Ibid s 5(1)(g).
42 Ibid s 5(1)(h).
43 Ibid s 5(1)(i).
44 Ibid s 5(1)(j).
45 These principles are elaborated on in more detail: *Report* (n 8) 43–6. There are 10 principles in the legislation, rather than nine, because the legislative drafters chose to split the eighth principle in two. The Report stated: 'providing people with genuine choice must be balanced with the need to safeguard people who might be subject to abuse': *Report* (n 8) 11. By contrast, the *VAD Act* separates this into two distinct concepts – 'individuals are entitled to genuine choices regarding their treatment and care' and 'there is a need to protect individuals who may be subject to abuse' – and does not expressly refer to balancing: *VAD Act* ss 5(1)(h), (i).
46 O'Connor et al (n 7) 625.
47 The seven human rights listed were the rights to equality; life; protection from torture and cruel, inhuman or degrading treatment; privacy and reputation; freedom of thought, conscience, religion and belief; protection of the best interests of the child; and liberty and security of person: *Report* (n 8) 43 and Appendix 2.
48 Victoria, *Parliamentary Debates* (n 24) 2943–9 (Jill Hennessy).
49 Ibid 2943 (Jill Hennessy).
50 For a more detailed discussion of the values underpinning the law that are relevant in the context of VAD, see Willmott and White (n 1) 479–510.

Table 1: Six Policy Goals Derived from 10 Principles

Six policy goals	Relevant principles
1. To respect all human life	• Valuing every human life equally
2. To respect personal autonomy	• Respecting autonomy • Supporting informed decision making • Promoting genuine choices • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
3. To safeguard the vulnerable and the community	• Protecting individuals from abuse
4. To provide high-quality care	• Providing quality care that minimises suffering and maximises quality of life • Supporting therapeutic relationships • Encouraging open discussions about dying, death and people's preferences • Supporting conversations with health practitioners and family about treatment and care preferences
5. To respect individual conscience	• Respecting diversity of beliefs and values, including among health practitioners
6. To alleviate human suffering (compassion)	• Providing quality care that minimises suffering and maximises quality of life
Goals 2 and 3 are bolded because, as argued below, while all goals are important, these two appeared to be the dominant ones when making decisions about the scope and nature of the legislation.	

The Minister herself summarised the principles as recognising three values: 'the value of every human life, respect for autonomy and a person's preferences, choices and values, and the provision of high-quality care'.[51] The second of these values – respect for personal autonomy – encompasses the principles of supporting informed decision-making, and promoting genuine choices. The principles of open discussions and supporting conversations will also be relevant to the provision of adequate information about treatment and care options to enable genuine and autonomous choices to be made. The Minister's third value – the provision of high-quality care – incorporates the principles of supporting therapeutic relationships with health practitioners, encouraging open discussions about dying and death, and supporting conversations with family, friends and carers about treatment and care preferences. In addition to the three goals mentioned by the Minister, three other important policy goals are discerned from those principles that underpin the legislation, namely: compassion to alleviate human suffering, safeguarding the vulnerable and the community, and

51 Victoria, *Parliamentary Debates* (n 24) 2951 (Jill Hennessy).

respecting individual conscience. Each of these policy goals will be discussed briefly in turn.

1 Respect All Human Life

The equal value of every human life is the first principle in the Act[52] and was also recognised as the first guiding principle by the Panel.[53] Twice in the second reading speech, the Minister stated that the right to life is the primary or supreme value in these debates.[54] However, it was also clear, for example from the Minister's statement of compatibility tabled in accordance with the Charter, that despite the significance of the right to life, it is not absolute and can be subject to justifiable limitations.[55]

2 Respect Personal Autonomy

The Panel repeatedly referred to the need for 'genuine choice' at the end of life. This included the provision of information about treatment options, and the provision of a range of choices about treatment and care, including the ability to choose the timing and manner of one's impending death.[56] This shows the importance placed on respecting a person's individual autonomy and freedom to 'choose to end their life according to their own preferences'.[57] Similarly, the deliberate choice of the term 'voluntary assisted dying', instead of the term 'dying with dignity' used in some American jurisdictions, reflected the emphasis on individual choice from a range of available end-of-life options.[58]

However, the Panel was at pains to point out that the aim of the *VAD Act* is not to give effect to *all* personal autonomy. Rather, autonomy is to be respected in a narrower set of circumstances: to provide alternative end-of-life care for people with terminal conditions who are suffering. The Panel noted respecting autonomy does not mean allowing people 'to do whatever they want' or to 'choose whether to live or die'.[59] Instead, the autonomy protected is choice over the 'timing and manner' of a death that is otherwise inevitable.[60]

3 Safeguard the Vulnerable and the Community

Another core concern expressed throughout the Report is the need to safeguard vulnerable individuals in the community from abuse or coercion. This principle, recognised in the Report and as a legislative principle,[61] was highly significant in the design of the system as the Report mentions the importance of safeguarding the vulnerable over 30 times.[62] Four potentially vulnerable groups that were discussed in

52 *VAD Act* s 5(1)(a).
53 *Report* (n 8) 43.
54 Victoria, *Parliamentary Debates* (n 24) 2943–4 (Jill Hennessy).
55 Ibid 2944 (Jill Hennessy).
56 There were 17 references to 'genuine choice' in the report: *Report* (n 8) 6, 10, 11, 22, 34 (twice), 38, 43, 44 (twice), 45 (twice), 46, 86 (twice), 99 and 117.
57 Victoria, *Parliamentary Debates* (n 24) 2945 (Jill Hennessy).
58 *Report* (n 8) 7.
59 Ibid 44.
60 Ibid.
61 Ibid 11, 22, 46; *VAD Act* s 5(1)(i).
62 *Report* (n 8) 5, 17 (twice), 18, 24, 51, 58, 63, 80, 82, 84, 87, 88 (3 times), 89, 91, 106, 127, 148, 180, 210 (3 times), 211 (3 times), 212 (3 times), 213, 215.

detail were the elderly,[63] children,[64] people with disabilities,[65] and people with mental illness.[66] The critical importance of this policy goal is also reflected in the emphasis on designing a 'safe and compassionate' VAD system as required by the Panel's terms of reference. Of note though, this policy goal of a safe system was framed to include the protection not only of potentially vulnerable groups but also the wider community.

4 Provide High-Quality Care

The Victorian model situates VAD within the healthcare system as one of a number of medical choices available to a person in the context of end-of-life care.[67] This creates the imperative, as with all healthcare, for any assessment for, or provision of, VAD to be of high quality. This is reflected in the Panel's recognition of the 'critical role of health practitioners' in VAD and the importance of continuity of care within an ongoing therapeutic relationship.[68] This was also noted by the Minister in her second reading speech.[69] In particular, the Report repeatedly recognises that open discussions within an existing therapeutic relationship would be the best way to ensure that any decisions about VAD were appropriate in the context of the person's needs and preferences.[70]

5 Respect Individual Conscience

Respecting medical practitioners' freedom of conscience was part of the terms of reference given to the Panel when advising about the form of *VAD Act*.[71] Respect for 'culture, beliefs, values and personal characteristics' was one of the Report's guiding principles[72] and was likewise included as a legislative principle in the *VAD Act*.[73] The right to freedom of thought, conscience, religion and belief was also noted as one of the core Charter rights engaged in the legislation.[74]

The Panel explains what conscientious objection to VAD means for medical practitioners, referring to this issue on several occasions in its Report.[75] The *VAD Act* respects the right of medical practitioners to choose on conscientious grounds not to participate in the provision of VAD, while continuing to provide holistic care to relieve the suffering and meet the needs of persons in their care.[76] But the Panel emphasised that this must not impede individuals who wish to access VAD from doing so.[77]

6 Alleviate Human Suffering (Compassion)

Compassion was a significant driver at the macro policy level for the *VAD Act*, as reflected in earlier discussions about the need for a 'safe and compassionate'

63 This was discussed in depth in ibid 88–90, and mentioned again at 180.
64 Ibid 53–54.
65 Ibid 84, 91.
66 Ibid 82.
67 Victoria, *Parliamentary Debates* (n 24) 2949–50 (Jill Hennessy).
68 *Report* (n 8) 45.
69 Victoria, *Parliamentary Debates* (n 24) 2952–3 (Jill Hennessy).
70 *Report* (n 8) 186 (Panel Recommendation 58). See also *Report* (n 8) 20, 92, 99, 101, 190.
71 Ibid 5.
72 Ibid 11, 22.
73 *VAD Act* s 5(1)(j).
74 See *Report* (n 8) 211; Victoria, *Parliamentary Debates* (n 24) 2947 (Jill Hennessy).
75 *Report* (n 8) 2, 15, 21, 40, 107, 109–11, 143, 190, 206, 214.
76 Ibid 40.
77 See, eg, ibid 15.

framework. This policy goal aims to alleviate the suffering of individuals at the end of their lives.[78] However, as the Panel shifted to operationalise its recommendations, compassion appeared to assume a less significant role. For example, it receives only limited recognition in the Report and legislative principles and indeed it was sometimes subsumed within two other policy goals. The first was respecting autonomy, with some references framed in terms of compassionate respect for autonomous choices to receive assistance to die.[79] The other was high-quality care, with both the Report and legislative principles referring to 'quality care to minimise the person's suffering'.[80] This may indicate that compassion played an important role in deciding whether or not to enact a VAD law, but then had less influence on the shape of that law; a notable exception is the eligibility requirement relating to suffering discussed below.

C Two Dominant Policy Goals: Respecting Autonomy and Safeguarding the Vulnerable and Community

As the discussion in relation to the policy goal of compassion shows, there are different ways in which policy goals can shape law. Some may establish important macro-level policy settings but do very little beyond that, whereas other goals may be integral in shaping the contours of the law and the detail of what is permitted and what is not. Sometimes policy goals will do both.

Although all six of the identified policy goals were important in framing the *VAD Act*, two goals were particularly dominant in determining the content of that law: respecting autonomy and safeguarding the vulnerable and community. This is evident from the number of references throughout the Report and the second reading speech to the need to balance freedom of choice with safeguards for vulnerable individuals and the wider community, as well as the frequent repetition of the key phrase: a 'safe and compassionate' system for VAD.

The eighth guiding principle in the Report explicitly states: 'providing people with genuine choice must be balanced with the need to safeguard people who might be subject to abuse'.[81] The need to balance these (potentially) competing policy objectives is also recognised in frequent statements such as: '[p]romoting individual autonomy and providing appropriate safeguards are critical, and neither aim is paramount. Instead, they must be balanced'.[82] Although all policy goals were important, this suggests that striking an appropriate balance between these two competing goals was a particular focus in the development of the *VAD Act*.

Minister Hennessy's second reading speech presenting the VAD Bill reinforces this conclusion. Although all 10 principles were listed at the outset of the speech,[83] it was her concluding paragraph that best captured the purpose of the legislation:

> This bill establishes a *safe* and compassionate framework to give Victorians who are suffering the ability to choose the timing and manner of their death. The bill provides a rigorous process with *safeguards* embedded at every step to ensure that only those who

78 See ibid 1, 13 and Victoria, *Parliamentary Debates* (n 24) 2949 (Jill Hennessy).

79 *Report* (n 8) 13 and Victoria, *Parliamentary Debates* (n 24) 2949–50 (Jill Hennessy). Reference was also made to a compassionate framework allowing individual choice, and not requiring a person to demonstrate unbearable suffering to be eligible for VAD: *Report* (n 8) 77–8.

80 *VAD Act* s 5(1)(d) and *Report* (n 8) 11.

81 *Report* (n 8) 22.

82 Ibid 210. See also Ibid 11, 15, 43, 87, 210, 211; Victoria, *Parliamentary Debates* (n 24) 2943 (Jill Hennessy).

83 Victoria, *Parliamentary Debates* (n 24) 2943 (Jill Hennessy).

> meet the eligibility criteria and who are making an *informed, voluntary and enduring decision* will be able to access voluntary assisted dying. The clear and considered details reflected in this bill will provide the Victorian community with the confidence that voluntary assisted dying can be *safely* provided to give Victorians *genuine choice* at the end of their lives.[84]

For this reason, the policy goals of respecting autonomy and safeguarding the vulnerable and the community are often discussed in more detail than the other policy goals in the analysis that follows.

III DOES THE *VAD ACT* REFLECT THESE POLICY GOALS?

The following analysis of whether the *VAD Act* reflects its stated policy goals is arranged according to the main components of the Act: method of VAD permitted; eligibility criteria; the process of requesting VAD, being assessed and then accessing VAD; conscientious objection by health practitioners; and oversight, reporting and compliance. The length and complexity of the *VAD Act* means that the discussion below can be only an overview of its key provisions. Further, and again for reasons of scope, this analysis pays particular attention to aspects of the VAD Act that do *not* comply with the identified policy goals. As legislation is generally expected to implement its stated objectives, it is this divergence that is of most interest in this article. A final point to note in relation to this analysis is that, as mentioned above in relation to respecting autonomy and safeguarding the vulnerable and the community, there will sometimes be tension between different policy goals.[85] Advancing one goal may require reduced recognition of another. The process of this balancing exercise will be outlined as necessary in the analysis below.

A Method of VAD Permitted

1 Overview of Law

The default method of VAD permitted under the *VAD Act* is self-administration; in other words, a medical practitioner prescribing medication which the person takes themselves.[86] It is only if a person is 'physically incapable of the self-administration or digestion' of the medication[87] that they can ask a medical practitioner to administer it (practitioner administration). This limited exception to permit practitioner administration was included to avoid discrimination on the basis of disability where a person's condition would preclude self-administration.[88] The *VAD Act* contains additional safeguards when the person receives practitioner administration: an independent witness of the person's request to administer the VAD medication must certify the person's apparent capacity and voluntariness, and the enduring nature of the request to die.[89]

84 Ibid 2955 (Jill Hennessy) (emphasis added).
85 Yeung also recognises this: Yeung, *Securing Compliance: A Principled Approach* (n 20) 31.
86 A co-ordinating medical practitioner applies for a 'self-administration permit', which enables the medical practitioner to prescribe and supply a lethal substance in a sufficient dose, and authorises the person concerned to possess that substance and administer it to themselves: *VAD Act* ss 45, 47.
87 Ibid s 48(3)(a).
88 *Report* (n 8) 141; Victoria, *Parliamentary Debates* (n 24) 2953 (Jill Hennessy).
89 *VAD Act* ss 46, 65(2).

2 Conformity with Policy Goals

The key policy goals of relevance here are: safeguarding the vulnerable, respect for autonomy and providing high-quality care. For the Panel, the most important goal appeared to be safeguarding the vulnerable, for example from coercion. Its report noted that '[w]hen a person self-administers a lethal dose of medication it is a final indication that their decision is voluntary'.[90] A person physically taking the medication themselves could also be seen as advancing the policy goal of autonomy in that it ensures the choice for VAD is truly the person's.

However, the Panel must have reached the view that practitioner administration of VAD medication is also safe with appropriate additional safeguards. This is reflected in their report and subsequently in the proposed legislation, as per the safeguards noted above. These safeguards are designed to ensure capacity and voluntariness of a person's request so that vulnerable people are not coerced into making requests for VAD. This raises the question though: if it is accepted that practitioner administration is safe, can safeguarding the vulnerable be a defensible basis for restricting VAD primarily to self-administration? Indeed, it could be argued that practitioner administration, which requires additional checks on capacity and voluntariness at the time VAD is provided, may better protect the vulnerable than permitting a person to self-administer unsupervised, which may occur at a later date when capacity has been lost. In a similar vein, later self-administration may also provide less protection against coercion.

In terms of respecting autonomy, the limitations placed on access to practitioner administration of VAD do not accord with this policy goal. The Report refers repeatedly to the importance of choosing the 'timing and *manner'* (emphasis added) of a person's death, yet only one of the two possible lawful methods of VAD is open to the majority of eligible people. The policy goal of respecting autonomy would be better achieved if a person was able to choose to self-administer the VAD medication or have assistance from a medical practitioner for practitioner administration.[91] This choice between self-administration and practitioner administration is available in a number of the other jurisdictions which permit VAD,[92] and where both options are available, available data show practitioner administration is overwhelmingly used.[93] Some people may find self-

90 *Report* (n 8) 141.

91 See Willmott and White (n 1) 479, 490–492, 500–501.

92 *Criminal Code of Canada* s 241.1 (definition of 'medical assistance in dying'); *Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001] art 2.1(f) (The Netherlands). Other countries which allow a choice between euthanasia and assisted dying are Belgium, Luxembourg and Colombia: Emanuel Ezekiel et al, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe' (2016) 316(1) *Journal of the American Medical Association* 79, 79. While the law in Belgium does not address physician-assisted suicide directly, the Federal Control and Evaluation Committee for Euthanasia in Belgium considers it to be a form of euthanasia: at 82.

93 For example, in the Netherlands in 2017, of 6,585 cases reported to Euthanasia Review Committees, 6,303 were of euthanasia, 250 were of assisted suicide, and 29 cases involved a combination of both: Regional Euthanasia Review Committees, *Annual Report 2017* (Report, May 2017) 10. In Canada, drawing on the last two federal government reports covering the period from 1 January 2017 to 31 October 2018, of the 4,575 medically assisted deaths reported, only 2 were self-administered (note: this does not include data from some provinces as outlined in the report): Health Canada, *Fourth Interim Report on Medical Assistance in Dying Canada* (Report, April 2019) 5. Belgium does not differentiate in its reporting between euthanasia and assisted suicide, but data shows that for the period 2016–17, of 4337 deaths, 23 were by oral ingestion of barbiturates, 10 by other methods, and the remaining 4,304 (99%) were by intravenous injection: Commission Fédérale de Contrôle et D'évaluation de L'euthanasie*, Huitième Rapport aux Chambres Législatives Années 2016 – 2017*, (Report, 17 July 2018) 6.

administration to be an unacceptable option, or an unduly burdensome option, even if it is physically possible for them. Others may prefer practitioner administration because it may be safer (see below). It is not simply the ability to choose an option which leads to death, but the choice of a particular option for causing death which is preferred by some individuals.

The third key policy goal is to provide high-quality care and it could be argued that this goal is better served when people also have access to practitioner administered VAD rather than only self-administration. Although there is limited evidence, a Dutch study found that, while both means of providing VAD can experience complications and technical problems, the rate of these is higher with self-administration when compared with practitioner administration.[94] This suggests practitioner administration may be safer, and the legislative prohibition on practitioner administration for those able to self-administer precludes these people from accessing a potentially safer option.[95]

3 Conclusion

Limiting practitioner administration of VAD to those who are physically unable to administer or ingest the medication themselves is not consistent with the policy goals of the *VAD Act*. In particular, respecting autonomy and providing high-quality care would favour allowing eligible persons to choose whether to receive VAD by self-administration or from their medical practitioner. This allows a person both greater choice as to the manner of their death and access to the safer of the two options. Arguments about safeguarding the vulnerable lack traction in this setting, given that practitioner administration is permitted by the *VAD Act* with appropriate safeguards, therefore recognising practitioner administration as a safe VAD option.

94 The study reported on three types of problems: technical problems (eg, difficulty administering the medication); complications (eg, spasm, nausea, and vomiting); and problems with completion (eg, longer time than expected to death). In all categories, physician assisted suicide cases had higher rates of clinical problems compared to euthanasia. Technical problems arose in approximately 10% of cases of physician-assisted suicide (versus approximately 4% of euthanasia cases); complications arose in approximately 9% of physician assisted suicide cases (versus approximately 4% of euthanasia cases) and problems with completion arose in 14% of physician assisted suicide cases (versus 5% of euthanasia cases). The study found approximately 2% of physician assisted suicide patients awoke from a coma, and approximately 12% took longer than anticipated to die or never lost consciousness, compared to less than 1% and 4% respectively of euthanasia cases: Johanna Groenewoud et al, 'Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands' (2000) 342(8) *New England Journal of Medicine* 551, 555. More robust data from other jurisdictions which permit both euthanasia and physician assisted suicide are needed to support this conclusion: see Christopher Harty et al, 'Oral Medical Assistance in Dying (MAiD): Informing Practice to Enhance Utilization in Canada' (2019) 66(9) *Canadian Journal of Anesthesia* 1106. Data on complications from the US States of Oregon and Washington are available, but as these States permit only physician-assisted suicide, comparison with the rate of complications in euthanasia cases is not possible: Ezekiel et al (n 92) 86. Nevertheless, complication rates for physician assisted suicide appear to vary. The most recent statistics from Oregon found that just 2.8% of cases had reported complications (although in 52.6% of cases whether or not there were complications was unknown): Oregon Health Authority, *Oregon Death with Dignity Act 2018 Data Summary* (Report, 25 April 2019) 12. Riley also provides recent evidence of complications experienced with lethal injections of medication: Sean Riley, 'Navigating the New Era of Assisted Suicide and Execution Drugs' (2017) 4(2) *Journal of Law and the Biosciences* 424.

95 In the Netherlands, it is recommended to have a physician present during an assisted suicide, to be able to administer a lethal injection if the assisted suicide fails. This occurred in 21 out of 114 cases of assisted suicide in the study in question: Groenewoud et al (n 94) 554–6.

B Eligibility Criteria

1 Overview of Law

Section 9(1) of the *VAD Act* states that '[f]or a person to be eligible for access to voluntary assisted dying':

(a) the person must be aged 18 years or more; and
(b) the person must–
  (i) be an Australian citizen or permanent resident; and
  (ii) be ordinarily resident in Victoria; and
  (iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months; and
(c) the person must have decision-making capacity in relation to voluntary assisted dying; and
(d) the person must be diagnosed with a disease, illness or medical condition that–
  (i) is incurable; and
  (ii) is advanced, progressive and will cause death; and
  (iii) is expected to cause death within weeks or months, not exceeding 6 months [or 12 months if the disease, illness or medical condition is neurodegenerative];[96] and
  (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

Disability and mental illness alone are not grounds to access VAD,[97] however, the Panel noted that having a disability or a mental illness does not preclude a person from accessing VAD if all the eligibility criteria are met.[98]

2 Conformity with Policy Goals

Before considering the four domains of the *VAD Act's* eligibility criteria – age, capacity, residence and nature of disease, illness or medical condition – it is noted that globally these requirements reflect a balancing of several of the identified policy goals. The threshold choice to allow VAD reflects the policy goals of respecting autonomy and the compassionate alleviation of human suffering (in relation to the latter, recognising that suffering is one of the eligibility requirements). But limiting VAD to those whose deaths are expected to occur within six months (or 12 months in the case of neurodegenerative conditions) reflects the policy goal of respecting all human life, by ensuring that only people who are close to death are eligible to request VAD. Excluding people from accessing VAD on the basis of disability or mental illness alone may be seen as safeguarding the vulnerable. The capacity and age requirements advance the policy goal of safeguarding vulnerable people by ensuring that only competent adults are able to request assistance to die, but a requirement to have capacity to access VAD also promotes autonomy. Finally, the decision to restrict access to Victorian residents was designed to ensure that VAD occurs in the context of an ongoing, caring therapeutic relationship,[99] which is part of the policy goal of providing high-quality care.

96 The words in square brackets have been inserted based on *VAD Act* s 9(4).
97 *VAD Act* ss 9(2)–(3).
98 Panel Recommendation 5: see *Report* (n 8) 80–2 (in respect of mental illness); Panel Recommendation 6: at 83–5 (in respect of disability).
99 Ibid 56; Victoria, *Parliamentary Debates* (n 24) 2948 (Jill Hennessy).

(a) Illness, Disease or Medical Condition

Of the four domains, it is the criterion of the illness, disease or medical condition of the person seeking access to VAD that is the most complex in terms of analysing its compliance with the policy goals.

(i) Will Cause Death

The requirement to have a condition that 'will cause death' reflects a tension between both respecting autonomy and alleviating human suffering on the one hand and respecting all human life on the other. Some other jurisdictions have chosen to preference autonomous choice and the alleviation of suffering by allowing wider access to VAD by individuals who do not have a terminal illness. For example, one of the criteria in Belgium is that a person has a 'medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated'.[100] Nevertheless, on balance, the requirement in the *VAD Act* that the person have a medical condition that will cause death is a defensible balancing of its stated policy goals. As the Panel stated, the purpose of the *VAD Act* was not to foster *all* autonomous choices in relation to the end of life, but only choices concerning the timing and manner of deaths that were already inevitable and impending.[101]

(ii) Six Months until Death

The position in relation to time limits is less able to be justified in light of the policy goals. First, the policy goals individually and when balanced collectively do not necessarily indicate a particular time from death as being an appropriate point at which to grant access to VAD. The selection of a six-month period is arbitrary.[102] This is illustrated by the fact that a 12-month period was initially included in the Report[103] and the VAD Bill that was originally passed by the Victorian Legislative Assembly.[104] While this was the initial preferred policy position, as will be discussed shortly below, this time limit was halved in the Bill presented to the Legislative Council after political negotiations, ultimately resulting in the six-month limit in the *VAD Act*.

One justification for this time limit could be that balancing the policy goals of respect for autonomy and respect for human life led the Panel and Parliament to restrict access to VAD to those who are in the process of dying.[105] But selecting a time period – of six months or some other duration – to restrict access to VAD to a cohort who are in the process of dying has problems. Prognostication about time until death is notoriously difficult.[106] Different diseases have different trajectories, and some are more

100 *Loi Relative à L'euthanasie* [Act on Euthanasia 2002] s 3§1.

101 See *Report* (n 8) 44.

102 Willmott and White (n 1) 503–4.

103 Panel Recommendation 2: *Report* (n 8) 22. See also *Report* (n 8) 13, 68, 70.

104 The Voluntary Assisted Dying Bill 2017 (Vic) ('VAD Bill'), as introduced and passed by the Victorian Legislative Assembly, stated that a person was eligible to receive VAD if they were suffering from an incurable and progressive condition that was 'expected to cause death within … 12 months': at cl 9.

105 This is similar to the restrictions contained within the US laws in force at that time: *Death with Dignity Act 1997*, Or Rev Stat §§ 127.800–127.995 (1994) (Oregon); *Death with Dignity Act 2009*, Wash Rev Code §§ 70.245.010–70.245.903 (2008) (Washington); *Patient Choice at End of Life Act 2013*, Vt Stat Ann §§ 5281–93 (2013) (Vermont); *End of Life Option Act 2016*, Cal Health and Safety Code §§ 443–443.22 (2015) (California); *End of Life Options Act 2016*, §§ 25-48-101–25-48-123 (2017) (Colorado). See *Report* (n 8) 221.

106 Joanne Lynn et al, 'Defining the "Terminally Ill": Insights from SUPPORT' (1996) 35(1) *Duquesne Law Review* 311, 324; Eric Chevlen, 'The Limits of Prognostication' (1996) 35(1) *Duquesne Law Review* 337; James Downar

predictable than others.[107] Studies, as well as anecdotal reports,[108] also demonstrate that a significant percentage of people predicted to die within six months are still alive after two to three years.[109] Lynn and colleagues have concluded that, because prognoses are unavoidably ambiguous:

> Deciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide. Allowing physicians (or anyone else) to decide who is terminally ill without standards or guidance will result in uneven application with unjustified variations across diseases, across physicians, and across regions.[110]

Accordingly, this criterion does not sufficiently respect the value of life, as prognostic uncertainty may inappropriately grant access to VAD to people who have more (perhaps much more) than six months of life remaining.[111] This criterion may also fail to respect autonomy and alleviation of human suffering through the inappropriate exclusion of people who are suffering and close to death, if this proximity to death is not recognised by medical practitioners.[112]

Although problematic for the reasons outlined above, perhaps the best justification for adopting a six-month time period is that it could be seen as a practical compromise representing an imperfect proxy for being close to death. This reflects a pragmatic choice to preference certainty in the legislation (although the uncertainty of this eligibility criterion is noted above) even if doing so means it can only approximately reflect the policy goals of the *VAD Act*.

(iii) Twelve Months until Death for Neurological Conditions

As noted above, when the Legislative Assembly passed the VAD Bill, the eligibility criterion required that death was expected to occur within 12 months. This was reduced to six months when the VAD Bill was presented to the Legislative Council, and this ultimately became law. An exception was made, however, for persons with neurodegenerative conditions, who remained eligible for VAD if their death was expected within 12 months. If a time limit in itself is questionable, having different time

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et al, 'The "Surprise Question" for Predicting Death in Seriously Ill Patients: A Systematic Review and Meta-analysis' (2017) 189(13) *Canadian Medical Association Journal* E484. Glare and colleagues observe that predictions estimating that a certain percentage of patients will survive for a certain time have a 50–75% accuracy rate, whereas predictions estimating the time the patient will survive are only 25% accurate: Paul Glare et al, 'Predicting Survival in Patients with Advanced Disease' (2008) 44(8) *European Journal of Cancer* 1146, 1147. In the Victorian debate on the VAD Bill, Ms Crozier also noted evidence from Washington and Oregon of a considerable proportion of people diagnosed as eligible for VAD being expected to live less than 6 months, whose deaths occur 1–2 years or longer after this diagnosis: Victoria, *Parliamentary Debates,* Legislative Council, 21 November 2017, 6221 (Georgina Crozier).

107 Lynn et al (n 106) 326–7; Downar et al (n 106).

108 Mr Ondarchie referred to his own father's death, which was predicted to occur within three months, but did not in fact occur for another 21 months: Victoria, *Parliamentary Debates,* Legislative Council, 14 November 2017, 5837 (Craig Ondarchie).

109 Lynn and colleagues have demonstrated that 20–40% of those predicted to have a 50% chance to die within the next six months are still alive after two to three years. Even among those predicted to have only a 20% chance of surviving six months, up to 10% survive for two to three years: Lynn et al (n 106) 321–2.

110 Ibid 334.

111 Statistics from Washington and Oregon quoted in the Victorian debate bear this out: Victoria, *Parliamentary Debates* (n 106) 6221 (Georgina Crozier).

112 Colleen Cartwright, 'The Six-Month Amendment Could Defeat the Purpose of Victoria's Assisted Dying Bill' *The Conversation* (online, 23 November 2017) <https://theconversation.com/the-six-month-amendment-could-defeat-the-purpose-of-victorias-assisted-dying-bill-87941>.

limits for different conditions requires a compelling justification. For reasons outlined below, it is argued that this justification is absent.

The stated reason for this differential treatment was a concern that people with neurodegenerative conditions might either lose capacity to apply for, or to self-administer, VAD medication if the eligibility period was restricted to six months.[113] This cannot be justified by reference to the policy objectives of the *VAD Act*. In relation to capacity, allowing only people with neurodegenerative conditions this additional time to access VAD before they lose capacity to request it gives greater protection to the autonomous choices only of a narrow class of individuals.[114] No such provision is made in relation to people with other illnesses which may affect a person's decision-making capacity.[115] Further, the concern to ensure access to self-administration is misplaced, given the law permits practitioner administration where a person is no longer physically capable of taking or ingesting the VAD medication.

(b) Adult with Decision-Making Capacity

The policy goals of respecting autonomy and safeguarding the vulnerable align with the eligibility criteria that a person must be an adult and must have decision-making capacity to access VAD.[116] In relation to the requirement to be an adult, although it may be argued that this devalues the autonomy of competent minors or that 18 years of age is an arbitrary line to draw, the Panel and the Victorian Government formed the view that children do not have sufficient maturity or capacity for abstract reasoning to make difficult decisions concerning death and dying. This accordingly renders them vulnerable, which justified the need to protect them, by imposing a prohibition on minors accessing VAD.[117] This view is not inconsistent with the legal position in Australia which recognises that there are limits on the ability of minors to request the withdrawal of life-saving medical treatment.[118] It also reflects the consensus in the majority of overseas jurisdictions that access to assisted dying be limited to adults.[119] Only Belgium, the Netherlands and Colombia permit requests for VAD to be made by children under the age of 18, and this occurs in practice only in very rare cases.[120]

113 Victoria, *Parliamentary Debates,* Legislative Council, 16 November 2017, 6098 (Gavin Jennings); Victoria, *Parliamentary Debates,* Legislative Council, 21 November 2017, 6216 (Gavin Jennings). No evidence was cited showing that people with neurodegenerative conditions tend to lose capacity earlier than people with other kinds of terminal illness.

114 For example, recent data from Canada found that from 1 January to 31 October 2018, neurodegenerative conditions accounted for just 11% of all cases of medical assistance in dying, while 16% were due to circulatory and respiratory conditions, and another 9% from other causes or unknown. The majority (64%) were cancer-related: Health Canada (n 93) 6.

115 Cartwright observes that '[p]atients suffering from conditions such as congestive cardiac failure, chronic obstructive pulmonary disease and chronic renal (kidney) failure can be given such strong medication at the end of life, which may render them incapable of clear decision-making': Cartwright (n 112).

116 Willmott and White (n 1) 501.

117 *Report* (n 8) 54, 215; Victoria, *Parliamentary Debates* (n 24) 2947–8 (Jill Hennessy).

118 *X v Sydney Children's Hospitals Network* (2013) 85 NSWLR 294. See also *Royal Alexandra Hospital for Children Trading as Children's Hospital at Westmead v J* (2005) 33 Fam LR 448; *Minister for Health v AS* (2004) 33 Fam LR 223.

119 See *Report* (n 8) 53.

120 In the Netherlands between 2002 and 2014, only five cases of euthanasia involving minors were reported: Judith Rietjens, Lenzo Robijn and Agnes van der Heide, 'Euthanasia for Minors in Belgium' (2014) 312(12) *Journal of the American Medical Association* 1258; Ezekiel et al (n 92) 84. In Belgium, euthanasia of minors became lawful in 2014, with the first three cases involving children (aged 9, 11 and 17) reported between 2016 and 2017: Commission Fédérale de Contrôle et D'évaluation de L'euthanasie (n 93) 11–12. On 9 March 2018,

In relation to requiring decision-making capacity at the time of accessing VAD, not permitting advance requests was argued to advance the policy goals of respecting autonomy and safeguarding the vulnerable. For example, the Panel considered that the person making a final choice for VAD at the point it is provided ensures the voluntary nature of the decision and avoids 'manipulation and abuse'.[121] There are contrary views, however, and many argue, for example, that recognition of advance requests is needed to give appropriate respect to a person's autonomy.[122] Nevertheless, requiring capacity at the time of accessing VAD may be regarded as a defensible position in light of the *VAD Act's* stated policy goals. Not recognising advance requests in the *VAD Act* is also consistent with the majority of overseas jurisdictions. Only Belgium, the Netherlands and Luxembourg permit advance requests for VAD and they are only acted on infrequently in those jurisdictions.[123]

(c) Residency Requirements

From the Report, the *VAD Act's* requirements in relation to residency appear to be based primarily on it being 'Victorian legislation that is intended to apply to Victorian residents'.[124] Perhaps the only policy goal that could be said to be relevant is that of providing high-quality care. The Panel observed that while European jurisdictions do not expressly impose residency requirements, they are 'considered to be enforced' through requiring an ongoing therapeutic relationship.[125] The Panel also noted the

Colombia passed a resolution permitting euthanasia of children aged seven or over: Ministerio de Salud y Protección Social [Department of Health and Social Protection], *Resolución Número 825 de 2018* [Resolution 825 of 2018], 9 March 2018. This resolution was issued in compliance with judgment T-544 of 2017, in which the Constitutional Court required the Department to issue a 'procedure to give effect to the right to die with dignity for children and adolescents': *Judgment T-544 of 2017* (Unreported, Constitutional Court of Colombia, Magistrate Ortiz Delgado, 25 August 2017). See Nubia Leonor Posada-González and Nora Helena Riani Llano, 'Eutanasia: Conceptos de la Fundación Colombiana de Ética y Bioética FUCEB, Dirigidos a la Corte Constitucional (Sentencia T-721-17) y al Ministerio de Salud y Protección Social (Borrador de Resolución Sobre Sentencia T-544-2017 de Eutanasia Infantil)' (2018) 22(1) *Persona y Bioética* 148.

121 *Report* (n 8) 61–3.

122 See, eg, Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom* (Alfred A Knopf, 1993); Paul T Menzel and Bonnie Steinbock, 'Advance Directives, Dementia, and Physician-Assisted Death' (2013) 41(2) *Journal of Law, Medicine & Ethics* 484; Thaddeus Mason Pope, 'Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles', *The ASCO Post* (online, 25 December 2017) <https://www.ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/>. See also the discussion of 'key concepts' in this area: Council of Canadian Academies, *The State of Knowledge on Advance Requests for Medical Assistance in Dying* (Report, 2018) 48–58.

123 Emily Tomlinson and Joshua Stott, 'Assisted Dying in Dementia: A Systematic Review of the International Literature on the Attitudes of Health Professionals, Patients, Carers and the Public, and the Factors Associated with These' (2015) 30(1) *International Journal of Geriatric Psychiatry* 10, 11; Sigrid Dierickx et al, 'Euthanasia for People with Psychiatric Disorders or Dementia in Belgium: Analysis of Officially Reported Cases' (2017) 17(1) *BMC Psychiatry* 203. For some discussion of the complexity of the issue, see Johannes van Delden, 'The Unfeasibility of Requests for Euthanasia in Advance Directives' (2004) 30 *Journal of Medical Ethics* 447; Paul Mevis et al, 'Advance Directives Requesting Euthanasia in the Netherlands: Do They Enable Euthanasia for Patients Who Lack Mental Capacity?' (2016) 4(2) *Journal of Medical Law and Ethics* 127; David Gibbes Miller, Rebecca Dresser and Scott Y H Kim, 'Advance Euthanasia Directives: A Controversial Case and its Ethical Implications' (2019) 45(2) *Journal of Medical Ethics* 84; Menzel and Steinbock (n 122).

124 *Report* (n 8) 56. Note that the requirement to be a resident 12 months prior to the first request was not recommended by the Panel but was introduced in the Legislative Council amendments.

125 Ibid.

undesirability of 'death tourism'[126] or 'suicide tourism'[127] in jurisdictions such as Switzerland where VAD is available to non-residents, which a residency requirement would prevent.

That said, while a residence requirement might exclude some cases where a person has only limited contact with a medical practitioner who provides VAD, it does little to promote high-quality care and may in fact impede it in some cases where a non-resident's primary medical practitioner is based in Victoria.[128] In summary, the identified policy goals provide only limited support for imposing residence requirements and some other broader justification may be needed to support them.

3 Conclusion

Some of the *VAD Act's* eligibility criteria align with its stated policy goals. The need to be an adult with decision-making capacity can be said to reflect the goals of respecting autonomy and safeguarding the vulnerable. Likewise, requiring a person to have an illness that will cause death defensibly balances the goals of respecting autonomy, alleviating suffering and respecting all human life. However, the imposition of the general time limit of six months until death is harder to justify by reference to these policy goals, and having a different expected time until death for different conditions cannot be justified at all. Residency requirements are also questionable from the perspective of the stated policy goals.

C VAD Request and Assessment Process, and Access to VAD

1 Overview of Law

The process for requesting, being assessed for and then accessing VAD is very complex so the following discussion can only provide a brief overview of the main steps involved.

(a) A First Request and Two Independent Assessments

The *VAD Act* specifies a very detailed request and assessment process which is triggered by a first request made by a person to a medical practitioner. The request for VAD must be made by the person themselves and it must be clear and unambiguous.[129]

126 Rohith Srinivas, 'Exploring the Potential for American Death Tourism' (2009) 13(1) *Michigan State University Journal of Medicine and Law* 91; Alexander R Safyan, 'A Call for International Regulation of the Thriving Industry of Death Tourism' (2011) 33(2) *Loyola of Los Angeles International and Comparative Law Review* 287; Mary Spooner, 'Swiss Irked by Arrival of "Death Tourists"' (2003) 168(5) *Canadian Medical Association Journal* 600.

127 The name likely stems from a documentary concerning the death in Switzerland of Chicago man Craig Ewert: 'The Suicide Tourist', *Frontline* (CTV, 14 November 2007). See Saskia Gauthier et al, 'Suicide Tourism: A Pilot Study on the Swiss Phenomenon' (2015) 41 *Journal of Medical Ethics* 611; Charles Foster, 'Suicide Tourism May Change Attitudes to Assisted Suicide, but Not through the Courts' (2015) 41 *Journal of Medical Ethics* 620.

128 The Panel briefly acknowledged the 'potential for cross-border issues to arise' but then affirmed its position: *Report* (n 8) 57. There is an established (rebuttable) presumption of interpretation that State laws apply only to regulate conduct within the territory of the legislating State: *Jumbunna Coal Mine NL v Victorian Coal Miners' Association* (1908) 6 CLR 309, 363 (O'Connor J). See also *Interpretation of Legislation Act 1984* (Vic) s 48. However, laws that apply only to residents of one State may infringe upon the guarantee in s 117 of the *Constitution*, unless a relevant exception applies: Amelia Simpson, 'The (Limited) Significance of the Individual in Section 117 State Residence Discrimination' (2008) 32(2) *Melbourne University Law Review* 639.

129 The patient 'may make the request verbally or by gestures or other means of communication available to the person': *VAD Act* s 11(3).

When a medical practitioner receives a first request from the person, if that practitioner is available and willing to be involved, they become the 'co-ordinating medical practitioner'.[130] They then conduct the first eligibility assessment[131] and, if the person is eligible, the co-ordinating medical practitioner will refer the person to another medical practitioner.[132] If that second medical practitioner accepts the referral, they become the 'consulting medical practitioner', and will conduct the second eligibility assessment (called the 'consulting assessment').[133]

Two important safeguards are relevant here. The first is that the *VAD Act* specifically prohibits all registered health practitioners[134] from initiating a discussion about VAD (directly or indirectly) or suggesting VAD to a person, in the course of providing care.[135] The second safeguard is that the medical practitioners who wish to be involved with VAD must have particular qualifications and experience.[136] Both must be either a medical specialist or a vocationally registered general practitioner,[137] and one must have practised for at least five years after completing their fellowship with a specialist medical college or vocational registration.[138] One of the medical practitioners must also have expertise and experience in the disease, illness or medical condition expected to cause the person's death.[139]

(b) Providing Information and Ensuring Voluntary and Enduring Requests

If the co-ordinating medical practitioner or the consulting medical practitioner assesses a person as being eligible for VAD, they must provide certain information to the person. This includes information about diagnosis, prognosis and possible treatment options, as well as that the person may decide at any time not to seek VAD.[140] The medical practitioners must be satisfied that this information is understood and also that the person is acting voluntarily and their request for access to VAD is enduring.[141]

130 Ibid s 15.
131 Ibid s 16.
132 Ibid s 22.
133 Ibid ss 23–5.
134 '[R]egistered health practitioner' is defined as a person registered under the *Health Practitioner Regulation National Law*, which includes the professions of dentist, chiropractor, doctor, medical radiation practitioner, nurse, midwife, occupational therapist, optometrist, osteopath, paramedic, pharmacist, physiotherapist, podiatrist and psychologist, as well as Chinese medicine practitioner and Aboriginal and Torres Strait islander health practitioner: *Health Practitioner Regulation National Law Regulation 2018* (Cth) reg 4.
135 *VAD Act* s 8.
136 Ibid s 10.
137 Vocationally registered general practitioners are those who are Fellows of the Royal Australian College of General Practitioners or of the Australian College of Rural and Remote Medicine, or on the Vocational Register with Medicare. For information, see Quality Practice Accreditation, 'Vocationally registered GP's' (Information Sheet) <https://files.gpa.net.au/resources/QPA_Vocationally_registered_GPs.pdf>.
138 *VAD Act* s 10(2).
139 Ibid s 10(3).
140 Ibid ss 19, 28. In full, this includes information about: their diagnosis and prognosis; the treatment options available and their likely outcomes; the palliative care options available and their likely outcomes; the potential risks of taking the VAD medication for the purpose of causing death; that the expected outcome of taking the VAD medication is death; that they may decide at any time not to continue the process; and that they are encouraged to tell their usual registered medical practitioners (eg their GP and/or specialists, if they are not the co-ordinating medical practitioner) of their VAD request.
141 Ibid ss 20, 29.

(c) Two Further Requests and a Waiting Period

A person who has been assessed as eligible to access VAD by the co-ordinating and consulting medical practitioners must then make two further requests for VAD. One is a written declaration, witnessed by two people,[142] that VAD is sought voluntarily and that the nature and effect of seeking VAD is understood.[143] The second is the 'final request' which can be made verbally.[144] This final request must be made at least nine days after the first request and at least one day after the consulting assessment,[145] although the nine day period can be shortened if the person is likely to die first.[146]

The last step in this stage is for the person to appoint a 'contact person', whose duties include returning unused VAD medication to the pharmacy and being a contact point for the VAD Review Board ('the Board') (the Board is discussed further below).[147]

(d) Accessing VAD

After undertaking a 'final review' to ensure the VAD process has been complied with,[148] the co-ordinating medical practitioner may then apply to the Department of Health and Human Services ('the Department') for a VAD permit for either self-administration by the person or practitioner administration.[149] The Department will decide whether or not to issue the permit for the person to receive VAD within three business days.[150]

For self-administration, on prescribing the VAD medication, the co-ordinating medical practitioner must inform the person about how to take the medication, how it must be stored (in a locked box),[151] there being no obligation to proceed with VAD, and duties (including on the contact person) to return unused VAD medication to the pharmacy.[152] The dispensing pharmacist also must inform the person of this same information when dispensing the VAD medication[153] and include some of this information on the labelling statement.[154] Once dispensed, the person may take the VAD medication at a time of their choosing.

Where VAD is provided through practitioner administration, the co-ordinating medical practitioner is responsible for the VAD medication,[155] so the above information requirements do not apply. The person must make a further (fourth) request for VAD (an 'administration request'), in the presence of an independent witness,[156] immediately

142 Ibid s 35.
143 Ibid s 34.
144 Ibid s 37. This request may also be made by gestures or other means of communication available to the patient.
145 Ibid s 38(1).
146 Ibid s 38(2).
147 Ibid s 39.
148 Ibid s 41.
149 Ibid s 43.
150 *Voluntary Assisted Dying Regulations 2018* (Vic) reg 7.
151 There is also a statutory duty imposed on the patient to store the VAD medication in a locked box: *VAD Act* s 61.
152 Ibid s 57.
153 Ibid s 58.
154 The labelling statement must warn of the purpose of the dose, state the dangers of self-administration, state that the VAD medication is required to be stored in a locked box of certain specifications, and state that any unused or remaining medication must be returned to the dispensing pharmacy: Ibid s 59.
155 Ibid s 46(c).
156 Ibid s 64(4). The witness must be aged 18 or over, and be independent of the co-ordinating medical practitioner: at s 65(1). The witness must also be present when the VAD medication is administered and certify this: at s 65(2).

before the co-ordinating medical practitioner administers the VAD medication.[157] The co-ordinating medical practitioner must be satisfied that the person has capacity, is acting voluntarily and without coercion and the request for VAD is enduring.[158]

2 Conformity with Policy Goals

Many parts of the *VAD Act* outlining the VAD request and assessment process, and how access to VAD is provided, advance the legislation's stated policy goals. One example is the requirement to provide information to a person seeking VAD at key points in the process. This clearly aligns with policy goals such as respecting autonomy and promoting high-quality care by ensuring any decision to seek VAD is fully informed. Another is the waiting period of nine days between first and final requests. The policy intent of ensuring the person's request is 'enduring and well-considered'[159] reflects the policy goals of respecting human life, safeguarding the vulnerable, and respecting autonomy.

As noted above, alignment between legislation and its policy goals is unremarkable and indeed is to be expected. Accordingly, and particularly given it is not feasible to comprehensively review all of the detailed processes outlined in the *VAD Act*, this analysis focuses on three key areas where the law's stated policy goals may not be advanced: the prohibition on initiating VAD discussions, pre-authorisation permits and overall complexity of the system.

(a) Prohibition on Health Practitioners Initiating Conversations about VAD

Most problematic in the request and assessment process is the prohibition on initiating conversations about VAD. Section 8(1) of the *VAD Act* states:[160]

> A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person–
>
> (a) initiate discussion with that person that is in substance about voluntary assisted dying; or
>
> (b) in substance, suggest voluntary assisted dying to that person.

The policy intent of this provision was 'to ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person's own voluntary decision'.[161] This prohibition attempts to further the two central goals of the *VAD Act*: safeguarding the vulnerable and promoting autonomy. The Report prefaced this recommendation with a discussion of elder abuse and abuse of persons with a disability,[162] and considered that the prohibition on raising VAD was justified because '[h]ealth practitioners have considerable influence over the decisions and treatment options their patients may consider'.[163] The Panel also recognised the importance of providing people with

157 Ibid s 64. The final request may be made verbally or by gestures or other means of communication: at s 64(3).
158 Ibid ss 64(1), (5).
159 *Report* (n 8) 125.
160 Breach of section 8 can lead to sanctions for unprofessional conduct or professional misconduct: *VAD Act* s 8(3).
161 *Report* (n 8) 91.
162 Ibid 90–1.
163 Ibid 92–3. See also the Explanatory Memorandum of the VAD Bill, which stated more explicitly that purpose of this prohibition was to 'protect individuals who may be open to suggestion or coercion by registered health practitioners': Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 2.

appropriate information about VAD and other end-of-life options,[164] which has implications for the policy goal of providing high-quality care.

Despite the stated policy intent, this prohibition on initiating discussions about VAD conflicts with the policy goal of respecting autonomy. This is illustrated by the fact that a person asking for all possible end-of-life options to inform their treatment decisions cannot be told about VAD unless they know to ask about it first and do so. It is also highlighted by contrasting this prohibition with some of the relevant legislative principles in the *VAD Act* that underpin the policy goal of respecting autonomy: supporting informed decision making;[165] encouraging open discussions about dying, death and people's preferences;[166] supporting conversations with health practitioners and family about treatment and care preferences;[167] and promoting genuine choices.[168]

Further, the prohibition is problematic because precluding the open dialogue needed at the end of life between health practitioners and persons may compromise the policy goal of providing high-quality care. There are no other lawful medical services that health practitioners are similarly prevented from raising, and this prohibition does not exist in any overseas jurisdictions that have legalised VAD.[169] A final concern is the uncertainty about the scope of the provision:[170] what conversations would it prohibit and what would be permitted?[171] Given medical practitioners' lack of knowledge in other areas of end-of-life law,[172] this could have a chilling effect on open discussions about end-of-life care if health practitioners are uncertain about the permissible boundaries of discussions.

In summary, although this prohibition may align with the policy goal of safeguarding the vulnerable (and some may dispute the premise that medical practitioners would be influential in a person's decision to make a request), the significant conflict with respecting autonomy and the risk to high-quality care means it is not consistent with the *VAD Act's* policy goals overall.

164 The Report noted 'although a health practitioner should never initiate a discussion about voluntary assisted dying, when asked for information it is important that they are able to provide it, or at least explain where such information may be found': *Report* (n 8) 93.

165 *VAD Act* s 5(1)(c).

166 Ibid s 5(1)(f).

167 Ibid s 5(1)(g).

168 Ibid s 5(1)(h).

169 Carolyn Johnston and James Cameron, 'Discussing Voluntary Assisted Dying' (2018) 26(2) *Journal of Law and Medicine* 454. We note, however, that as this article was being written, Western Australia passed its *Voluntary Assisted Dying Act 2019* (WA). That Act includes a similar prohibition on 'health care worker[s]' but is more limited in scope because it does not apply to medical practitioners or nurse practitioners if they also provide certain information to the patient about treatment options and palliative care: s 10.

170 Johnston and Cameron (n 169) 454.

171 For some of the complexities about permissible discussions in light of this prohibition, see Lindy Willmott et al, 'Restricting Conversations about Voluntary Assisted Dying with Patients: Implications for Clinical Practice' (2020) 10(1) *BMJ Supportive and Palliative Care* 1. See also Bryanna Moore, Courtney Hempton and Evie Kendal, 'Victoria's Voluntary Assisted Dying Act: Navigating the Section 8 Gag Clause' (2020) 212(2) *Medical Journal of Australia* 67.

172 Ben White et al, 'Doctors' Knowledge of the Law on Withholding and Withdrawing Life-sustaining Medical Treatment' (2014) 201(4) *Medical Journal of Australia* 229; Ben White et al, 'The Knowledge and Practice of Doctors in Relation to the Law That Governs Withholding and Withdrawing Life-Sustaining Treatment from Adults Who Lack Capacity' (2016) 24(2) *Journal of Law and Medicine* 356.

(b) Pre-Authorisation of VAD by Government Permit[173]

The requirement to obtain a permit from the Department *prior* to providing VAD to a person is unusual, as most other VAD systems rely on *post hoc* reporting mechanisms.[174] The stated policy intent in the Report for the permit requirement was 'to establish clear monitoring and accountability for the safe prescription of the lethal dose of medication for voluntary assisted dying'.[175] This reflects the policy goal of safeguarding the vulnerable and the community, but it also appears to address the policy goal of respecting all human life by scrutinising proposed VAD before it is provided. In support of the permit requirement, the Panel cited stakeholder concerns that 'review after the fact may produce evidence of wrongdoing, but … voluntary assisted dying is irreversible'.[176]

Pre-authorisation permits also have implications for other policy goals. The delay of up to three business days is a constraint on a person's autonomy. This time also extends the period during which an eligible person is enduring suffering, so sits awkwardly with the policy goal of alleviating that suffering. This may represent an appropriate compromise between competing policy goals if the permit system is effective in ensuring only eligible persons can have access to VAD. However, this is unlikely to be so. Although the nature of the scrutiny proposed by the Department is unclear, the focus of the permit issuing process appears to be ensuring that all of the relevant prescribed forms have been completed appropriately and submitted. Such a procedurally-focused review is unlikely to be an effective safeguard to ensure compliance in practice with the substantive criteria of the legislation, making the cost to the policy goals of respecting autonomy and alleviating suffering unjustifiable.

(c) Overall Complexity

The final issue to note in relation to the request and assessment process and gaining access to VAD is the complexity of the scheme as a whole. As outlined earlier, the *VAD Act* was proclaimed to be the 'safest, and most conservative model in the world',[177] with much made of its extensive safeguards. Many of those safeguards are in the request and assessment process and they are specified in great detail in the *VAD Act*. This highly prescriptive detail in the legislation itself is unusual[178] and as a result, the *VAD Act* is significantly longer than other VAD legislation internationally.

173 There are other models that propose pre-authorisation of VAD, such as requiring prior court approval. Such approaches raise different considerations from those below; for example, court approval is more effective in safeguarding the vulnerable given the substantive review but comes with greater cost and delay. For a wider discussion of pre-authorisation in this context, see Yeung, 'Regulating Assisted Dying' (n 20).

174 An exception is Colombia, which requires prior approval by independent committee: Ezekiel et al (n 92) 81.

175 *Report* (n 8) 134.

176 Ibid 133. Concerns about a retrospective review system have also been recently expressed in relation to a case of euthanasia of a patient with dementia in the Netherlands: Miller, Dresser and Kim (n 123) 88. See also more general concerns about the limits of the retrospective system of oversight in David Gibbes Miller and Scott Y H Kim, 'Euthanasia and Physician-Assisted Suicide Not Meeting Due Care Criteria in the Netherlands: A Qualitative Review of Review Committee Judgements' (2017) 7(10) *BMJ Open* 1. For example, they note that the Dutch review process, which is retrospective, in practice focuses on procedural criteria and professionalism of medical practitioners, rather than whether the substantive eligibility criteria are met.

177 Andrews (n 16).

178 More commonly, such prescriptive detail is placed in the Act's regulations or clinical or administrative guidelines.

As briefly described above, the VAD system requires at least three formal requests (four in the case of practitioner administration), two independent assessments of the person, and repeated checks of informed consent, the enduring nature of the decision, voluntariness and coercion. Appropriate witnesses[179] (and sometimes interpreters) must be organised and the co-ordinating medical practitioner must also obtain a permit before prescribing VAD medication or administering it.[180] An appropriate contact person must be found and properly appointed, and in the case of self-administration, the person must then obtain the medication and store it in a locked box.[181]

The goal of this process is to be rigorous in ensuring those who are not eligible do not gain access to VAD.[182] This advances the policy goal of safeguarding the vulnerable and the community, and it also promotes the goal of respect for human life by permitting VAD only in accordance with a strict process.[183] It is also designed to promote autonomy and high-quality care, with the Panel noting that the purpose behind the three request process is twofold: to ensure the request for VAD is 'voluntary, considered and enduring' and to provide 'multiple opportunities for a person and their assessing medical practitioners to discuss the person's request'.[184] The VAD system, at least on its face, meets these key goals.

However, when these procedural steps are viewed as a whole, there are concerns that persons will find accessing VAD very difficult.[185] A process that is described as rigorous could be experienced as onerous, and the process outlined above is also complex. This may complicate, or even frustrate, the policy goals of respecting autonomy and alleviating suffering by precluding, or at least delaying, eligible persons' access to VAD. These persons – who by definition must be suffering and generally be expected to die within six months – may find the process overwhelming and too difficult to navigate and consequently choose not to proceed. Those who do start the process might die (or lose capacity) before they make their way through it, or give up part way through. This complexity may be particularly difficult for persons from diverse cultural and linguistic backgrounds, especially if interpreters are required, as they must be accredited professionals and not a family member.[186] Even if a person is able to navigate the process, the hurdles involved and the stress in navigating them could intensify the person's suffering.

179 *VAD Act* ss 34–6, 65.

180 Ibid ss 47, 48.

181 Ibid s 61.

182 *Report* (n 8) 112.

183 The Panel justified the stages in the request and assessment process with reference to preventing 'doctor shopping', stating that

> even if a person finds one medical practitioner willing to break the law by providing an assessment that a person meets the eligibility criteria even though they do not, this medical practitioner would also need to find another medical practitioner willing to collude with them. Even if they are able to do this, the Department and the Voluntary Assisted Dying Review Board would be able to identify irregularities or wrong doing before a permit for prescription is given.

Ibid 122.

184 Ibid 113.

185 The Panel itself acknowledged this risk. It recognised 'that the person who has requested access to voluntary assisted dying is suffering … so the process should not create undue burden or anxiety or be a tick-box process … [and] should be undertaken in the spirit of person-centred care': Ibid 112. See also White, Willmott and Close (n 19).

186 *VAD Act* s 115. Similar considerations apply to those with communication difficulties who require a speech pathologist to assist in interpreting.

The nature of the VAD process and what it requires may also mean that few medical practitioners will agree to be involved. For example, the duties of a co-ordinating medical practitioner, who oversees the process as a whole, are significant both from a clinical and administrative perspective. (The substantial reporting duties on medical practitioners involved in VAD and the implications for their participation are also discussed further below at Part III(E).) A lack of medical practitioners willing to participate would further compromise the policy goals of autonomy and alleviation of suffering as well as the provision of high-quality care.

In conclusion, while the policy goals of safeguarding the vulnerable and the community, and respecting all human life are advanced by the rigorous VAD process, its many stages and complexity may pose a risk to access and undermine the policy goals of respecting autonomy and alleviating suffering. Although these issues can be identified on the face of the legislation, how and whether these competing policy goals are achieved will depend on how the legislation is implemented. It is possible that good design of the VAD system may mean that its complexity can be 'internally facing' and may not impede access for eligible persons nor create burdens for the medical practitioners involved.[187] Firm conclusions on this will have to wait until after the law has commenced and its operation has been evaluated.

3 Conclusion

In general, the main parts of the process for requesting VAD, having eligibility assessed, and then receiving access to it, align with the *VAD Act's* stated policy goals. The primary policy advanced is safeguarding the vulnerable, but there is also recognition of respecting human life, respecting autonomy and promoting high-quality care. However, policy goals do not appear to be met, and may be impeded, by prohibiting health practitioners from discussing VAD with persons and through the requirement to obtain pre-authorisation for VAD via a government permit. Further, when the process is viewed in its entirety, its complexity may limit the *VAD Act's* fulfilment of the key policy goals of respecting autonomy and alleviating suffering. While individual components or safeguards may be justifiable, a global assessment of them reveals a different picture. This has implications for the overall design of VAD systems which will be revisited in the article's conclusion.

D Conscientious Objection

1 Overview of Law

The *VAD Act* allows medical practitioners and other health practitioners to conscientiously object to participate in VAD. Section 7 protects the right of health practitioners to refuse to:

- provide information about VAD;
- participate in the request and assessment process;
- apply for a VAD permit;
- supply, prescribe or administer a VAD substance;
- be present at the time of administration of a VAD substance; or

187 White, Willmott and Close (n 19) 207.

- dispense a prescription for a VAD substance.

Other provisions also anticipate conscientious objection. One is the requirement to accept or refuse the role of co-ordinating or consulting medical practitioner within 7 days.[188]

2 Conformity with Policy Goals

The right of medical practitioners and other health practitioners to refuse to provide information about or participate in VAD[189] clearly advances the policy goal of respect for individual conscience.[190] Notably, however, there is no duty to refer a person to another medical practitioner who is willing to be involved in VAD. The Panel considered, but rejected, such an approach,[191] instead relying on existing obligations of medical practitioners under their code of conduct not to impede persons' access to lawful care or treatment.[192] The absence of a specific legislative duty to refer stands in stark contrast to the very detailed and prescriptive process outlined for other matters in the *VAD Act*.

While promoting respect for conscience, the lack of a legislative duty to refer may impede access to a lawful end-of-life option.[193] If this happens in relation to VAD, this would compromise the realisation of other important policy goals: respect for autonomous choices, alleviation of suffering and the provision of high-quality care.

E Oversight, Reporting and Compliance

1 Overview of Law

The *VAD Act* contains a number of mechanisms for monitoring VAD and ensuring compliance with the legislative regime.

188 *VAD Act* ss 13(1)(b), 23(1)(b).

189 The Report contained two recommendations specifically with the policy intent of respecting individual conscience. They are: Panel Recommendation 18 – that medical practitioners have a right to conscientiously object, and Panel Recommendation 39 – that where the co-ordinating and consulting medical practitioner both conscientiously object to administering a lethal injection, they may transfer care to a different medical practitioner who is willing to administer the medication: *Report* (n 8) 24, 27.

190 For further discussion of the value of conscience in the Australian legal system, see Willmott and White (n 1). In Victoria, this is reflected in the right to freedom of thought, conscience, religion and belief contained in the *Charter of Human Rights and Responsibilities 2006* (Vic) s 14. See also the *Report* (n 8) 214.

191 *Report* (n 8) 109–11.This duty exists under Victorian law governing termination of pregnancy: *Abortion Law Reform Act 2008* (Vic) s 8.

192 *Report* (n 8) 15, 110. See Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Guideline, March 2014) para 2.4.6 <http://www.medicalboard.gov.au/ Codes-Guidelines-Policies.aspx>.

193 Although a legislative duty to refer may provide stronger normative force than simply relying on existing ethical duties, it still may not be effective. For example, there is evidence that the legislative duty to refer when a medical practitioner has a conscientious objection to a termination of pregnancy is being ignored or evaded by some Victorian medical practitioners: Louise Anne Keogh et al, 'Conscientious Objection to Abortion, the Law and Its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20 *BMC Medical Ethics* 11:1–15.

(a) Board Oversight of the System

The Board is a new independent statutory body[194] that has overall oversight of the VAD system. Its primary function is to monitor activity under the *VAD Act* to ensure compliance.[195] This includes reviewing each case where VAD has been requested, to ascertain compliance with legal requirements. The Board must also evaluate overall patterns and trends of access to VAD, such as discerning possible instances of 'doctor shopping':[196] that is, overuse of one or more medical practitioners who repeatedly find a person to be eligible for VAD despite other medical practitioners finding them to be ineligible.

The Board will be supported in its oversight function by the mandatory reporting obligations imposed on medical practitioners, dispensing pharmacists and others by the *VAD Act*, as outlined in Table 2. In addition to reporting to the Board, all deaths of people who were the subject of a VAD permit are notifiable to the Coroner,[197] although these deaths are not investigated as possible suicides.

194 The Board is established by the *VAD Act* s 92. This model of a separate body, independent of the health department, follows the European models in place in Belgium, the Netherlands and Luxembourg, rather than in the US States, where monitoring is done within existing health departments: *Report* (n 8) 159.

195 *VAD Act* ss 93(1)(a), (b).

196 *Report* (n 8) 168.

197 A medical practitioner attending a person who has died must notify if the person was the subject of a VAD permit, and state their knowledge or belief whether or not the person died as a result of VAD, or VAD was not administered: *VAD Act* s 67(2). These deaths are also notifiable to the Registrar of Births, Deaths and Marriages: at s 67(1). However, VAD is not required to be recorded as the cause of death on the death certificate: *Report* (n 8) 150–3.

Table 2: Reporting to the Board

Matter reported	Person reporting	Form or other document	Legislative provision
That a person was assessed as eligible or ineligible for VAD after a first assessment	Coordinating medical practitioner	First assessment report form (Form 1)	*VAD Act* s 21
That a person was assessed as eligible or ineligible for VAD after a consulting assessment	Consulting medical practitioner	Consulting assessment report form (Form 2)	*VAD Act* s 30
That the request and assessment process has been completed	Coordinating medical practitioner	Final Review Form (Form 5). Note that attached to this Form are copies of Forms 1, 2, 3 (Written declaration) and 4 (Contact person appointment form).	*VAD Act* s 41
That a self-administration permit or practitioner administration permit has been issued (or has been amended)	Secretary of Department of Health and Human Services	VAD permit (or its amendment)	*VAD Act* s 49 (and s 51 for amendment)
That VAD medication was dispensed	Dispensing pharmacist	VAD substance dispensing form (Form 6)	*VAD Act* s 60
That any returned VAD medication was disposed of	Dispensing pharmacist	VAD substance disposal form (Form 7)	*VAD Act* s 63
That VAD was administered to a person by a medical practitioner	Coordinating medical practitioner	Coordinating medical practitioner administration form (Form 8)	*VAD Act* s 66
That an application for review has been lodged with VCAT That VCAT has made an order or determination	Principal Registrar of VCAT	Notice of application to VCAT Copy of VCAT's order or determination	*VAD Act* s 69(c)

(b) Victorian Civil and Administrative Tribunal Review of Eligibility Decisions

The Victorian Civil and Administrative Tribunal ('VCAT') has a more limited role in relation to VAD. It has jurisdiction only to review assessments by a co-ordinating or consulting medical practitioner about residency and decision-making capacity, as these are questions of fact.[198] VCAT does not review clinical issues such as disease-related eligibility criteria.

198 *VAD Act* s 68 and Part 6.

(c) Health Practitioners' Duties to Report

Registered health practitioners (including medical practitioners, nurses, allied health practitioners and pharmacists)[199] are required to report colleagues to the Australian Health Practitioner Regulation Agency (AHPRA) if they believe another registered health practitioner has initiated a discussion about VAD or suggested it to a person, or has offered to provide VAD to a person not eligible under the Act.[200] This reporting obligation also applies to health practitioners' employers, such as hospitals or institutional care providers.[201]

(d) Offences

The *VAD Act* adds several new offences, which are designed to promote compliance with the Act and deter people from intentionally acting outside the law.[202] These offences relate to:

- coercing a person to access VAD;[203]
- administering VAD medication to a person who has been issued a self-administration permit;[204]
- acting contrary to a practitioner administration permit;[205]
- a contact person failing to return unused or remaining VAD medication after the person's death;[206]
- falsifying forms and statements;[207] and
- failing to report to the Board.[208]

(e) Protection from Criminal and Civil Liability

The *VAD Act* specifically protects medical practitioners who provide VAD in accordance with the Act from any criminal or civil liability, or liability for professional misconduct or contravention of a professional code of conduct.[209] It also protects those (including health practitioners, family or carers) who assist or facilitate a request for VAD.[210] These legal protections provide certainty and confidence for those who help a person to access VAD in accordance with the Act.

199 See *Health Practitioner Regulation National Law Regulation 2018* (Cth) for definition of registered health practitioner.

200 *VAD Act* s 75.

201 Ibid s 76.

202 The offence provisions are broadly modelled on offences in force in some US States: *Report* (n 8) 179.

203 This includes both inducing a person to request access to VAD, and inducing a person to self-administer VAD medication: *VAD Act* ss 85, 86. The maximum penalty in both cases is 5 years imprisonment.

204 *VAD Act* s 84. The maximum penalty is life imprisonment.

205 Ibid s 83. The maximum penalty is life imprisonment.

206 Ibid s 89. The maximum penalty is 12 months imprisonment or 120 penalty units or both.

207 Ibid ss 87, 88. The maximum penalty for both offences is 5 years imprisonment for a natural person, or 2400 penalty units for a body corporate. The value of a penalty unit changes annually, and is set by the Treasurer: *Monetary Units Act 2004* (Vic) s 5(3). From 1 July 2018 to 30 June 2019, one penalty unit was $161.19, so the maximum penalty was $386,856.

208 *VAD Act* s 90. The maximum penalty for this offence is 60 penalty units, which at the time of writing was $9,671.40.

209 Ibid s 80. This includes protecting a health practitioner or paramedic who does not administer life-saving treatment to a person who is dying after the administration of VAD medication: at s 81.

210 Ibid s 79.

2 Conformity with Policy Goals

Collectively, these provisions of the *VAD Act* are designed to ensure that the VAD system operates as intended: that VAD is provided within the law and that unlawful behaviour does not occur. In this way, these provisions generally advance the overall key policy goals of protecting human life and safeguarding the vulnerable and the community, while ensuring that human suffering can be alleviated through people exercising their autonomy within the law. It could be further argued, though, that some of these provisions give greater emphasis to particular policy goals. For example, the Board's oversight of all cases of VAD and the reporting that underpins this[211] are especially aimed at safeguarding the vulnerable. Offence provisions also safeguard the vulnerable and the community, and, arguably, those that prohibit the causing of death outside the Act are also aligned with the policy goal of respecting all human life.

Accordingly, when looking at these provisions in general, each can be justified as aligned with policy goals of the Act. One concern, though, is that when these provisions are considered cumulatively, they become burdensome such that the balance between permitting eligible persons access to VAD on the grounds of autonomy and compassion and safeguarding the vulnerable is tilted so as to hinder reasonable access to VAD. The prime example is the volume of reporting, particularly that required of the co-ordinating medical practitioner. This may mean that health practitioners decline to be involved in VAD due to these burdens, especially when added to the significant duties noted above in relation to the request, assessment and access processes. While the manner in which these reporting duties will be implemented is not yet clear, it is at least noted on the face of the legislation that this reporting burden may deter involvement and hinder access to VAD, thus potentially compromising the policy goals of respect for autonomy and alleviation of suffering.

IV CONCLUSION

Stepping beyond entrenched arguments for and against VAD, this article evaluated instead whether the *VAD Act* reflects its own stated policy goals. It first analysed the Report that provided the foundation for the Act, along with its legislative principles, to discern six key policy goals that underpin the legislation:

- To respect all human life;
- To respect personal autonomy;
- To safeguard the vulnerable and the community;
- To provide high-quality care;
- To respect individual conscience; and
- To alleviate human suffering (compassion).

The article then analysed the major parts of the *VAD Act* to determine whether they reflected those identified policy goals. A failure to align with goals was the focus of this analysis, as legislation that achieves intended objectives is to be anticipated. The overall conclusion was that there are important respects in which the Act fails to reflect its own

211 Researchers agree that reporting all cases of VAD is important to safeguard the quality of the process: Tinne Smets et al, 'Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases' (2010) 341(7777) *British Medical Journal* 819, 825.

policy goals. Key examples of this are: having self-administration as the default means of providing VAD and allowing practitioner administration only in very limited circumstances; requiring time limits to death and those time limits varying depending on the nature of a person's illness; prohibiting medical practitioners from raising VAD with persons; and creating a system that when considered globally is very complex and arguably burdensome for persons seeking access to VAD and medical practitioners.

While being critical in relation to these findings of policy misalignment, it is important to consider how and why they occurred. It was suggested earlier that the design of the Act was a reflection of the political strategy necessary for it to pass the Victorian Parliament. Indeed, the original Bill, which was already very narrow and with many safeguards, was not conservative enough initially to pass Victoria's upper house, the Legislative Council. It is suggested that decisions about the design of the law, including by the Panel, were shaped by an awareness of what might be needed to secure necessary political support. This is not to suggest that the Panel's deliberations were purely political, and without careful regard to its nine guiding principles underpinning the six policy goals set out above. However, it is argued that the Panel, and the Victorian Government in drafting the VAD Bill, also had regard to more pragmatic considerations such as what sort of law would be capable of attracting the necessary political support. This understandable intrusion of politics into decision-making about policy is one reason the *VAD Act* does not adequately reflect its stated policy goals in some key respects.

This policy misalignment was also exacerbated by the need for more overt political compromise. As noted above, alterations to the VAD Bill were required for the Legislative Council to pass the *VAD Act*. Arguably, such late changes to Bills are not principle-based decisions but rather pragmatic concessions needed to garner sufficient support to pass a law. As such, instead of being new ways to advance the legislation's stated policy goals, these 'add-ons' can often actually be in conflict with those goals. An example of this, as mentioned earlier, is the changes to the period of time expected until the person's death. The original VAD Bill that was passed by the Victorian Legislative Assembly provided for a 12-month period. This period was then halved to six months, except for a subset of medical conditions that had a neurological basis, for which cases the 12-month period was retained.[212] The imposition of a time limit, and particularly different time limits for different conditions, was critiqued earlier in this article as inconsistent with stated policy goals. This is an obvious example of where overt but necessary political compromise caused policy misalignment.

The analysis in this article has focused on the legislation itself rather than implementation. It is acknowledged, however, that it is possible for effective implementation to address some of the ways in which the legislation fails to best reflect its policy goals.[213] One example is the complexity of, and the burdens imposed by, the VAD request and assessment processes, and the corresponding duties of reporting. It is possible that well-designed systems could facilitate access to VAD for eligible persons and avoid undue burdens for medical practitioners, while still effectively safeguarding the vulnerable. While those responsible for the law's implementation should be mindful of opportunities to better advance policy goals, this will not always be possible. Some

212 See Part III(B)(2)(ii) 'Six Months until Death'.

213 White, Willmott and Close (n 19).

gaps between policy goals and the *VAD Act* are structurally embedded in the legislation and cannot be alleviated. An example is eligibility limits relating to expected times until death and the prohibition on raising VAD with persons.

A final observation is to note is that this analysis has implications for wider VAD reform in Australia as other states actively consider law reform in this area. As this article was being written, Western Australia passed its *Voluntary Assisted Dying Act 2019* (WA), following reports by a Parliamentary Committee[214] and then a Ministerial Expert Panel.[215] Both Queensland and South Australia have established Parliamentary Committees whose terms of reference include VAD, with the Queensland Committee recommending VAD reform.[216] A draft Tasmanian Bill has been released for consultation by the Hon Michael Gaffney[217] and a Bill is also expected to be introduced into the New South Wales parliament within the foreseeable future.[218] The default position for other states is likely to be adopting the Victorian model, or at least to use it as a starting point for their proposed law.[219] This was the case with the Western Australian Act which is very similar to the Victorian law. However, this analysis has concluded that the *VAD Act* does not advance its stated policy goals in important respects. This suggests critical review is needed by other states considering reform. A more principled approach is suggested,[220] with each aspect of proposed laws being tested against those principles or policy goals to ensure policy coherence of the law.

This needs to be done individually in relation to each aspect of the law but it must also be done globally in relation to the law as a whole and how it will operate. The claim of the Victorian VAD system to be the most conservative in the world has implications for access for VAD. The many safeguards and processes that form part of that claim, when considered in total, are likely to present challenges for persons seeking access to VAD and medical practitioners. These concerns were specifically identified in this article both in relation to reporting and also the processes for requesting, being assessed and then accessing VAD. It is only when the Act as a whole is considered that the complexity in the VAD system becomes clear.

When thinking about the politics of reform, it can be tempting to only consider each safeguard or process individually. Each may have merit and advance a particular policy goal. It may also be difficult politically to argue that a specific safeguard is not needed, particularly if it appears to achieve at least some useful purpose. However, when the safeguards are aggregated, the VAD system as a whole can become very complex and

214 Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (First Report, 23 August 2018).

215 Government of Western Australia, Department of Health, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, July 2019).

216 Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland*, Voluntary Assisted Dying* (Report No 34, 31 March 2020) 105 (Recommendation 1); Joint Committee on End of Life Choices, Parliament of South Australia, *Terms of Reference* (April 2019).

217 End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) <http://www.parliament.tas.gov.au/LC/gaffney/EOL.pdf>.

218 Carla Mascarenhas, 'Port Macquarie State Election Candidates Debate Assisted Dying for the Terminally Ill', *Port Macquarie News* (online, 26 February 2019) <https://www.portnews.com.au/story/5925502/state-election-candidates-debate-assisted-dying-for-the-terminally-ill/>.

219 White and Willmott, 'Victoria May Soon Have Assisted Dying Laws for Terminally Ill Patients' (n 2). Note, however, that this is not the case in Queensland: see Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland (n 216) 105 (Recommendation 1), which proposed instead that the starting point for reform be the draft Bill outlined in Ben White and Lindy Willmott, 'A Model Voluntary Assisted Dying Bill' (2019) 7(2) *Griffith Journal of Law and Human Dignity* 1.

220 Willmott and White (n 1) 484–8. Such a model is presented in Bill form in White and Willmott (n 219).

unwieldly, and slowly take the legislation away from its policy goals. This 'policy drift by a thousand cuts' – the incremental loss of policy focus through accumulation of individual safeguards without reference to the whole – is a key issue for other states to consider when evaluating their proposed VAD reforms. It is suggested that each part of the law be evaluated both on its own, and also for its impact on the functioning of the overall system. This is needed to enable VAD laws to meet their policy goals, in particular, the two key goals at the core of the design of the *VAD Act*: safeguarding the vulnerable while respecting the autonomy of eligible persons who wish to access to VAD.

VOLUNTARY ASSISTED DYING AND THE LEGALITY OF USING A TELEPHONE OR INTERNET SERVICE: THE IMPACT OF COMMONWEALTH 'CARRIAGE SERVICE' OFFENCES

KATRINE DEL VILLAR, ELIANA CLOSE, RACHEL HEWS, LINDY WILLMOTT, BEN P WHITE [1]

ABSTRACT

Following parliamentary inquiries in both states, Victoria and Western Australia recently passed legislation to permit voluntary assisted dying (VAD), under strict conditions, with other states expected to follow. Although laws on VAD are a state responsibility, a significant hurdle to their implementation has been prohibitions in the Commonwealth Criminal Code on using a carriage service (including the telephone or internet) to counsel, promote or provide instruction on suicide. These provisions, enacted when VAD was unlawful in every Australian jurisdiction, have led state governments to instruct health practitioners to avoid discussing or facilitating VAD via telehealth. This article examines whether these concerns are founded and evaluates the extent of Commonwealth criminal liability that health practitioners might face for engaging in various conduct under the State assisted dying laws. The article argues that although the legal position is untested VAD would likely meet the definition of 'suicide' under Australian law and hence fall under the Commonwealth Criminal Code. The article then evaluates the extent of potential criminal liability for using a

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carriage service in each step of the VAD process. It concludes that there are areas with real legal risk, especially for activities that directly facilitate VAD, requiring urgent reform of the Commonwealth law.

I INTRODUCTION

Following the lead of a number of other jurisdictions worldwide, Australia appears to be on the cusp of widespread law reform to permit voluntary assisted dying ('VAD'), for terminally ill individuals who are experiencing unbearable suffering.[2] VAD (also known as voluntary euthanasia or assisted suicide,[3]) was legalised in Victoria in 2017, with the passage of the *Voluntary Assisted Dying Act 2017* (Vic) ('the *VAD Act* (Vic)'), which commenced operation on 19 June 2019. Shortly after, in December 2019, Western Australia enacted the *Voluntary Assisted Dying Act 2019* (WA) ('the *VAD Act* (WA)'), which will come into force in mid-2021. Legislation is expected to pass in Tasmania in March 2021.[4] Reform efforts continue in Queensland and South Australia, which may lead to the tabling of assisted dying legislation in the near future.[5]

[2] Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) 42 *Australian Health Review* 616.

[3] 'Voluntary euthanasia' refers to a medical practitioner administering a lethal medication to a terminally ill person at the person's request. 'Assisted suicide' occurs when a medical practitioner prescribes a lethal medication at the person's request, but the person takes the medication themselves, generally by ingesting it orally, but in some cases by activating a machine which gives a lethal injection. The term 'voluntary assisted dying' can encompass both voluntary euthanasia and assisted suicide, although in some jurisdictions (such as Switzerland and States of the USA) only assisted suicide is lawful.

[4] The End-Of-Life Choices (Voluntary Assisted Dying) Bill 2020 (Tas) was introduced by Tasmanian MLC Mike Gaffney in August 2020, and passed the Tasmanian Legislative Council on 10 November 2020. Debate on the bill commenced in the House of Assembly on 3 December 2020. It is expected to pass in March 2021 after review by a panel from the University of Tasmania: Emily Baker and Alexandra Humphries, 'Tasmania's Premier Peter Gutwein Voices Support for Voluntary Assisted Dying to Become Law', *ABC News* (online, 3 December 2020) < https://www.abc.net.au/news/2020-12-03/tas-premier-voices-support-for-voluntary-assisted-dying-reform/12947092>.

[5] A Queensland parliamentary committee has recommended introducing legislation to legalise VAD: Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Parliament, *Voluntary Assisted Dying* (Report No 34, 31 March 2020). The Queensland Law Reform Commission has been tasked with drafting a Bill for the Government's consideration: Queensland Law Reform Commission, *Queensland's Laws Relating to Voluntary Assisted Dying* (Terms of Reference, 2020) <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0004/651379/vad-tor.pdf>. Legislation is anticipated in February 2021: Jessica Rendall and Anna Hartley, 'Queensland Leaders Annastacia Palaszczuk and Deb Frecklington Formally Launch Their 2020 Election Campaigns', *ABC News* (online, 18 October 2020) <https://www.abc.net.au/news/2020-10-18/qld-state-election-2020-palaszcuk-frecklington-campaign-launch/12770290>. In South Australia, a joint parliamentary committee of inquiry has recently tabled its report: Australia, Parliament of South, *Report of the Joint Committee on End of Life Choices* (Report, 13 October 2020). On 2 December 2020, the Voluntary Assisted Dying Bill 2020 (SA), modelled on the Victorian law, was simultaneously introduced into both houses of South Australian Parliament.

A significant challenge to implementing VAD laws, however, is presented by provisions of a Commonwealth law, the *Criminal Code Act 1995* (Cth) ('the *Commonwealth Criminal Code'*), which were enacted when assisted dying was unlawful in every jurisdiction.[6] Shortly after the *VAD Act* (Vic) commenced, the Victorian government became aware that doctors and others involved in providing VAD who communicated with patients through a 'carriage service' risked contravening the *Commonwealth Criminal Code*.[7] In 2005, the federal government had introduced three new criminal offences into the *Commonwealth Criminal Code* prohibiting the use of a carriage service 'for suicide related material'.[8] 'Carriage service' is defined as 'a service for carrying communications by means of guided and/or unguided electromagnetic energy'.[9] Telephones, television, the internet, radio, and fax all satisfy this definition. The federal government's stated purpose in enacting these offences was to target pro-suicide websites, internet chat rooms, and online cyberbullying, which were proliferating and readily accessible, and might incite vulnerable people to commit suicide.[10] In particular, websites were providing detailed instructions on how to build your own suicide device in Australia, circumventing customs regulations prohibiting the importation of suicide

[6] VAD was briefly legal in the Northern Territory under the *Rights of the Terminally Ill Act 1995* (NT), until that law was overturned by the Commonwealth government's *Euthanasia Laws Act 1997* (Cth). Twenty years elapsed before the *VAD Act* (Vic) was enacted.

[7] Jacob Kagi, 'Doctors may Face Prosecution for Discussing Euthanasia with Patients over Phone, Computer', *ABC News* (online, 23 Aug 2019) <https://www.abc.net.au/news/2019-08-23/doctors-fear-prosecution-over-wa-voluntary-euthanasia-laws/11440394>; 'Risk to Vic Doctors Discussing Euthanasia', *The Canberra Times* (online, 27 June 2019) <https://www.canberratimes.com.au/story/6243599/risk-to-vic-doctors-discussing-euthanasia/?cs=14264>.

[8] The offences were inserted by the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* (Cth). Australia was the first country in the world to criminalise such conduct: Jane Pirkis et al, 'Legal Bans on Pro-Suicide Web Sites: An Early Retrospective from Australia' (2009) 39(2) *Suicide and Life-Threatening Behavior* 190. Although constitutionally, criminal law (including assisted suicide) is a state responsibility, the Commonwealth government retains power to legislate for federal criminal offences (including those that relate to 'carriage services'). The power to legislate with respect to telecommunications services is contained in the Commonwealth *Constitution* s 51(v). This is why the offences concerning suicide only apply to pro-suicide communication over telephone, chat rooms or internet services, and do not include printed material: *Criminal Code Act 1995* (Cth) ss 474.29A, 474.29B ('*Commonwealth Criminal Code'*).

[9] The *Commonwealth Criminal Code* (n 8) s 473.1 defines 'carriage service' to have the same meaning as in the *Telecommunications Act 1997* (Cth) s 7.

[10] Commonwealth, *Parliamentary Debates*, House of Representatives, 10 March 2005, 4 (Philip Ruddock, Attorney-General); Pirkis et al (n 8) 191.

devices.[11] However, these laws were also reportedly[12] in part a response to a campaign led by right-to-die activist Dr Philip Nitschke, who drew considerable media attention in Australia by promoting methods for terminally-ill individuals to end their lives.[13] Voluntary euthanasia groups and their supporters opposed the introduction of these offences at the time, arguing it would affect both their potential and existing activities if it was illegal for them to 'share information over the phone, host websites ... or even to provide help and advice to people who request it by phone or the internet'.[14]

Now that VAD is lawful in Victoria (and will soon be operational in Western Australia), these Commonwealth offences have raised concerns that doctors and other health professionals could be criminally liable under the *Commonwealth Criminal Code* for actions which are lawful under state legislation, when they provide information about VAD or conduct VAD consultations and assessments using a carriage service (such as a telephone or the internet).[15] Indeed, the then Victorian Health Minister, Jenny Mikakos, instructed all doctors and other practitioners involved in the provision of VAD services to conduct all

[11] Evidence to Senate Legal and Constitutional Legislation Committee, Parliament of Australia, Canberra, 14 April 2005, 46 (Kimberley Williams, Attorney-General's Department) ('Evidence to Senate Legal and Constitutional Legislation Committee').

[12] See, eg, Kemal Atlay, 'Will Doctors be Committing Crimes When Discussing Euthanasia over the Phone?', *Australian Doctor* (online, 23 August 2019) <https://www.ausdoc.com.au/news/will-doctors-be-committing-crimes-when-discussing-euthanasia-over-phone>.

[13] Over the last 40 years, in response to thwarted law reform efforts, a number of 'right-to-die' advocacy groups have published guidance to terminally ill individuals about how to end their lives. The first reported publication was *How to Die with Dignity*, published by the Scottish Voluntary Euthanasia Society in 1980, followed closely by the English Voluntary Euthanasia Society's *Guide to Self-Deliverance*: Clare Dyer, 'Assisted Suicide 1. America 2. Britain' (1991) 303 *British Medical Journal* 431. In 2006, the United States branch of the international organisation, Final Exit, published *The Peaceful Pill Handbook*, written by Australians Philip Nitschke and Fiona Stewart: Philip Nitschke and Fiona Stewart, *The Peaceful Pill Handbook* (Exit International Ltd, 2006). Increasingly, these materials are now available online, and the websites of Exit International, Final Exit Network, and the Scottish Voluntary Euthanasia Society sell how-to guides such as the *Peaceful Pill eHandbook* (first released in 2008), *Final Exit*, *Departing Drugs* and *Five Last Acts*.

[14] Department of Parliamentary Services (Cth), *Bills Digest* (Digest No 13 of 2004–2005, 2 August 2004) 14 ('*Bills Digest* No 13 of 2004–2005'), quoting Democrats (Media Release 04/302, 19 April 2004).

[15] Kagi (n 7); 'Risk to Vic Doctors Discussing Euthanasia' (n 7). Concerns were also expressed that family members supporting a loved one through the process of VAD via telephone or email may potentially be subject to criminal prosecution under the *Commonwealth Criminal Code* (n 8), but this is beyond the scope of the present paper: Melissa Cunningham, 'Doctors, Family Warned They Could be Breaking Law Discussing Euthanasia on Phone, Internet', *The Age* (online, 26 June 2019).

discussions, consultations and assessments face-to-face, so as to avoid potentially breaching the Commonwealth law.[16] This issue was also of considerable concern in the subsequent parliamentary debates on the Voluntary Assisted Dying Bill 2019 (WA). Because of Western Australia's geography, provisions allowing for consultations and assessments to occur via telephone or telehealth are specifically included in the *VAD Act* (WA).[17] Several Liberal members of Parliament sought reassurance from the government that health practitioners would not risk prosecution under the *Commonwealth Criminal Code* for providing VAD-related services via telehealth, but no such assurance has been provided.[18] The risk of prosecution for using a carriage service to provide VAD services assumed increased significance with COVID-19 related lock-down and social distancing measures,[19] which encourage telehealth or telephone consultations with GPs and medical specialists where feasible.[20]

The purpose of this article is to examine whether these concerns about potential criminal liability under the *Commonwealth Criminal Code* are warranted. This will be achieved by

[16] See also Department of Health and Human Services, Victorian Government, *Voluntary Assisted Dying: Guidance for Health Practitioners* (Policy Document, July 2019) 4, 74 ('*VAD Guidance for Health Practitioners'*).
[17] *Voluntary Assisted Dying Act 2019* (WA) ss 158, 159 ('*VAD Act* (WA)'). Geography has also been identified as a reason for using telehealth to provide VAD services in the United States: Konstantin Tretyakov, 'Medical Aid in Dying by Telehealth' (2020) 30(1) *Health Matrix* 325, 329. It is possible in Canada to provide VAD services via telehealth, which is of particular importance for rural and remote communities: Catharine J Schiller, 'Medical Assistance in Dying in Canada: Focus on Rural Communities' (2017) 13 *Journal of Nursing Practice* 628, 631.
[18] Western Australia, *Parliamentary Debates*, Legislative Assembly, 24 September 2019, 7264 (Zac Kirkup), 7265 (Mia Davies); Western Australia, *Parliamentary Debates*, Legislative Council, 22 October 2019, 8008 (Adele Farina); Western Australia, *Parliamentary Debates*, Legislative Council, 24 October 2019, 8281 (Aaron Stonehouse).
[19] Nick Carr, 'Outdated Law Makes Doctors Criminals, Leaves Dying Patients Anxious', *Crikey*, (online, 2 April) <https://www.crikey.com.au/2020/04/02/coronavirus-voluntary-assisted-dying-law/>. In relation to social distancing, see 'Social Distancing for Coronavirus (COVID-19)', *Australian Government, Department of Health* (Web Page, 31 March 2020) <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/how-to-protect-yourself-and-others-from-coronavirus-covid-19/social-distancing-for-coronavirus-covid-19>.
[20] Greg Hunt and Michael Kidd, 'COVID-19: Whole of Population Telehealth for Patients, General Practice, Primary Care and Other Medical Services' (Joint Media Release, Australian Government, Department of Health, 29 March 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/covid-19-whole-of-population-telehealth-for-patients-general-practice-primary-care-and-other-medical-services>.

examining the intersection of the *Commonwealth Criminal Code* with the *VAD Act* (Vic) and the *VAD Act* (WA) to evaluate the degree of potential criminal liability health practitioners may face if they use a carriage service to facilitate VAD. Section II describes the VAD framework in both Victoria and Western Australia, and how the telephone or internet can be used in the process. Section III briefly sets out the relevant offences in the *Commonwealth Criminal Code*. Section IV then considers two threshold issues which affect whether the *Commonwealth Criminal Code* applies to the VAD regimes: whether VAD is suicide and the constitutional issue of whether there is any inconsistency between the federal *Commonwealth Criminal Code* and the state VAD laws. After concluding that the *Code* likely applies to conduct under the VAD regimes, section V discusses the interpretation of the relevant *Commonwealth Criminal Code* provisions. Section VI then provides a detailed analysis of the degree to which activities undertaken pursuant to the VAD laws, including providing information or conducting an assessment over the phone or internet, may breach the *Commonwealth Criminal Code* provisions. Finally, section VII makes recommendations for reform, and argues the *Commonwealth Criminal Code* should be urgently amended to provide that 'suicide' does not include VAD carried out lawfully pursuant to a State law.

II VAD LEGAL FRAMEWORK

Both the *VAD Act* (Vic) and the *VAD Act* (WA) provide a detailed process to enable adults with decision-making capacity resident in Victoria or Western Australia to receive medical assistance to die.[21] To be eligible, individuals must have a disease, illness or medical condition that is advanced, progressive and is expected to cause death within 6 months (12 months if the condition is neurodegenerative), and be experiencing intolerable suffering

[21] For a more detailed analysis of the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)'), see Ben P White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417. For a comparative analysis that includes the *VAD Act* (Vic) and the *VAD Act* (WA) (n 17), see Ben P White et al, 'Comparative and Critical Analysis of Key Eligibility Criteria to Access to Voluntary Assisted Dying under Five Legal Frameworks' (under review).

caused by that condition.[22] This section of the article sets out the obligations of medical practitioners, pharmacists (acting as part of the Statewide Pharmacy Service)[23] and VAD Care Navigators[24] under the respective VAD laws, as well as how a carriage service could be used in the process (absent any concerns about the *Commonwealth Criminal Code*). Although in both jurisdictions VAD can be administered by a practitioner in certain circumstances,[25] this paper focusses on discussions when self-administration is contemplated (the default model of VAD). This is because practitioner administration does not involve 'suicide', as the person dying does not perform the act causing death. Hence it does not intersect with the *Commonwealth Criminal Code* provisions.

To access VAD, a person must make three requests over a period of at least 9 days, and be assessed as eligible by two independent medical practitioners, one of whom must have relevant expertise in the person's medical condition.[26] The 'coordinating medical practitioner' takes primary responsibility for coordinating the assessment process and access to VAD.[27] In response to the first request, they conduct the first assessment, and if they consider the person is eligible for VAD, they refer the person to a 'consulting medical

[22] *VAD Act* (Vic) (n 21) s 9(1); *VAD Act* (WA) (n 17) s 16. In Victoria, but not in Western Australia, the condition must also be incurable.
[23] Information about the Statewide Pharmacy Service is available here: 'Health Services Information', *Department of Health and Human Services, Victorian Government* (Web Page, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>. The Service was established to provide a single point from which VAD medication could be dispensed and is currently based at the Alfred Hospital.
[24] As part of the implementation of the *VAD Act* (Vic) (n 21), the Victorian government established the Statewide VAD Care Navigation Service. The VAD Care Navigators, who provide information, support and education, are currently part of the Peter MacCallum Cancer Centre in Melbourne. See 'The Statewide Voluntary Assisted Dying Care Navigator Service', *Department of Health and Human Services, Victorian Government* (Web Page, September 2019) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying>.
[25] In Victoria, practitioner administration is possible if a person is 'physically incapable of the self-administration or digestion': *VAD Act* (Vic) (n 21) s 48(3)(a). In Western Australia, practitioner administration is permitted if a doctor considers that self-administration is inappropriate having regard to the method of administration, the patient's physical abilities and the patient's concerns: *VAD Act* (WA) (n 17) s 56(2).
[26] The legislative requirements for medical practitioners to provide a VAD assessment are contained in the *VAD Act* (Vic) (n 21) ss 10, 17, 26; and *VAD Act* (WA) (n 17) ss 17, 25, 36.
[27] *VAD Act* (Vic) (n 21) s 15; *VAD Act* (WA) (n 17) s 23.

practitioner'[28] for a second assessment.[29] As is common in modern medical practice, a convenient way to contact the other medical practitioner to facilitate the referral is over the telephone, email or through another electronic system.

Both the first and second assessments are designed to evaluate whether the person meets the eligibility criteria, and whether their request is voluntary and enduring.[30] Although there are advantages to in-person assessments, evidence from Canada suggests high-quality assessments can take place via telehealth, improving equity of access.[31] This is beneficial if an individual has difficulty locating a VAD provider. There are currently only 65 medical practitioners throughout regional and rural Victoria who are trained and registered to be able to provide VAD assessments. Some people wishing to access VAD have reported difficulty in locating a medical practitioner willing to assist.[32] Telehealth would also be advantageous when the patient is too unwell to travel. Oncologist Cameron McLaren reports commonly conducting home visits to do VAD assessments, as many patients are house-bound or bed-bound and unable to travel.[33] It would also be beneficial where the patient lives in a regional or rural area, hours away from a registered participating VAD provider, or a suitably qualified specialist. For example, although there are 226 qualified neurologists in Victoria, only 9 are currently registered to provide VAD.[34] Given the vast majority of neurologists are located in Melbourne, and the remaining few in regional centres such as Ballarat, Bendigo

[28] *VAD Act* (Vic) (n 21) s 24; *VAD Act* (WA) (n 17) s 34.
[29] *VAD Act* (Vic) (n 21) s 22; *VAD Act* (WA) (n 17) s 30.
[30] *VAD Act* (Vic) (n 21) ss 16, 25; *VAD Act* (WA) (n 17) ss 24, 35.
[31] Stephanie Dion, Ellen Wiebe, Michaela Kelly, 'Quality of Care with Telemedicine for Medical Assistance in Dying Eligibility Assessments: A Mixed-Methods Study' (2019) 7(4) *Canadian Medical Association Journal* E721.
[36] Ibid.
[33] Cameron McLaren, 'An Update on VAD: (Almost) A Year in Review' (Research Report, 16 June 2020), 2.
[34] See McLaren (n 33), 2, and Voluntary Assisted Dying Review Board, *Report of Operations June to December 2019* (Victorian Government, February 2020) ('*VADRB Report*'), 7.

and Shepparton,[35] it is unlikely a patient with advanced motor neurone disease in a rural or remote area would be able to locate a participating consultant neurologist willing to travel to the patient's place of residence for a home visit.

In Western Australia, the *VAD Act* (WA) specifically allows the assessment to occur using audiovisual communication,[36] if in-person communication is not practicable.[37] If the medical practitioner is uncertain about the person's capacity or whether their medical condition meets the eligibility criteria, they must refer the person to an appropriately trained specialist for assessment on either question.[38] A logical method to make this referral would be electronically.

After each eligibility assessment, if the coordinating or consulting medical practitioner finds the person is eligible for VAD, they must provide the person with comprehensive and wide-ranging information, including about their diagnosis and prognosis, treatment options, palliative care options, the risks of taking a VAD medication, and their right to decide at any time not to continue with their request for VAD.[39] In Western Australia, the *VAD Act* (WA) specifically allows this information to be provided electronically (including by telephone, email, and audiovisual communication).[40] The Victorian Act does not explicitly mention electronic methods of communication, but neither does it prohibit them.

[35] The Health Direct directory of practitioners run by the Australian government lists the locations of neurologists in Victoria, and other jurisdictions: https://www.healthdirect.gov.au/australian-health-services/.
[36] This is defined to mean methods of communication which allow people to see and hear each other simultaneously*: VAD Act* (WA) (n 17) s 158(1), and would include video calling apps such as Skype, FaceTime or Zoom.
[37] *VAD Act* (WA) (n 17) s 158(2). In Western Australia, an 'access standard' will also be issued setting out how the State intends to facilitate access to VAD for residents, particularly regional residents: s 156.
[38] *VAD Act* (Vic) (n 21) ss 18, 27; *VAD Act* (WA) (n 17) ss 26, 37.
[39] *VAD Act* (Vic) (n 21) ss 19, 28; *VAD Act* (WA) (n 17) ss 27, 38.
[40] *VAD Act* (WA) (n 17) s 158(3). However, the *VAD Act* (WA) (n 17) also states that this provision is subject to a contrary or inconsistent Commonwealth law: s 158(4).

Once the assessments are complete, if the person is found eligible, they may then make a written declaration, signed in the presence of two witnesses and the coordinating medical practitioner (the second request).[41] If a person has been assessed as eligible by both the coordinating and consulting medical practitioners, and at least 9 days have elapsed since the first assessment, the person can then make a third and final request for VAD to the coordinating medical practitioner.[42] In Western Australia, this final request is expressly permitted to occur via audiovisual communication,[43] while the Victorian Act is silent on this. At this point, in Victoria, the coordinating medical practitioner may apply to the Department of Health and Human Services for a VAD permit, which authorises the medical practitioner to prescribe (and the person to self-administer) the VAD substance.[44] The permit application is completed online through the VAD Portal.[45] In Western Australia, the coordinating practitioner may prescribe a VAD substance without a permit.[46]

The coordinating medical practitioner's final duty to the patient is to prescribe the VAD medication. The medical practitioner sends the prescription directly to the Statewide Pharmacy Service, which later dispenses the medication to the patient on their request.[47] At the point of prescription, the medical practitioner must give the person further information specific to the administration process,[48] and must inform them that there is no obligation to

[41] *VAD Act* (Vic) (n 21) s 34; *VAD Act* (WA) (n 17) s 42.
[42] *VAD Act* (Vic) (n 21) s 38; *VAD Act* (WA) (n 17) ss 47, 48. The person seeking to access VAD must also appoint a contact person: *VAD Act* (Vic) (n 21) s 39; *VAD Act* (WA) (n 17) s 65.
[43] *VAD Act* (WA) (n 17) s 158(2).
[44] *VAD Act* (Vic) (n 21) ss 43, 47. If the person is physically unable to self-administer or digest a VAD medication, a VAD permit may authorise the coordinating medical practitioner to administer the VAD medication for them: s 48. However, the focus of the present paper is on self-administration.
[45] The VAD Portal is located at: Victorian Government, 'Voluntary Assisted Dying Portal', *Victorian Agency for Health Information* (Web Page, 2020) <https://www.bettersafercare.vic.gov.au/about-us/about-scv/councils/voluntary-assisted-dying-review-board/voluntary-assisted-dying-portal> ('VAD Portal').
[46] *VAD Act* (WA) (n 17) ss 58, 59.
[47] 'Voluntary Assisted Dying Statewide Pharmacy Service', *Department of Health, Victorian Government* (Web Page, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-services-information>.
[48] *VAD Act* (Vic) (n 21) s 57; *VAD Act* (WA) (n 17) s 69.

proceed with VAD.[49] The dispensing pharmacist[50] must also provide the person with similar information when dispensing the VAD medication,[51] including stating that the person is not obliged to self-administer the medication even once it has been dispensed.[52] In Western Australia, the provision of this information and advice via any method of communication (including internet-based, telephone and email) is specifically authorised.[53]

There are also requirements at every step of the assessment and request process for medical practitioners and pharmacists to report to the Board appointed for this purpose.[54] In Victoria, this is done online through the VAD Portal.[55] It is not yet clear how these reports will be completed in Western Australia.[56]

In Victoria, the State government has appointed VAD Care Navigators to act as a contact point for people interested in VAD, in addition to health practitioners. They are not mentioned in the *VAD Act* (Vic), but their role includes providing general advice, specific information and support to people who wish to access VAD, such as connecting them with medical practitioners prepared to participate in VAD.

[49] *VAD Act* (Vic) (n 21) ss 57(b), (d); *VAD Act* (WA) (n 17) ss 69(2)(b)–(c).
[50] In Western Australia, this person is called an 'authorised supplier': *VAD Act* (WA) (n 17) s 71.
[51] *VAD Act* (Vic) (n 21) s 58; *VAD Act* (WA) (n 17) s 72.
[52] *VAD Act* (Vic) (n 21) s 58(c); *VAD Act* (WA) (n 17) s 72(2)(a). Some of this information (such as the purpose of the dose, the dangers of self-administration, how the VAD medication is required to be stored, and where any unused or remaining medication must be returned for safe disposal) is included on the labelling statement on the lethal medication, although this does not include a statement that the person is not obliged to proceed with VAD: *VAD Act* (Vic) (n 21) s 59; *VAD Act* (WA) (n 17) s 73.
[53] *VAD Act* (WA) (n 17) s 158(3).
[54] In Victoria, this is the Voluntary Assisted Dying Review Board. Obligations to provide information to the Board are contained in: *VAD Act* (Vic) (n 21) ss 21(2), 30(1)(b)(i), 41(2), 49(4), 60(2), 63(2), 66(2). In Western Australia, this is the Voluntary Assisted Dying Board. Obligations to provide information to the Board are contained in: *VAD Act* (WA) (n 17) ss 22(1), 29(2), 33(1), 40(2), 46, 50(1), 60(1)(b), 61(4), 63(3)(c), 66(4), 74(3), 76(3), 78(3), 157(4).
[55] The VAD Portal is located at: VAD Portal (n 45).
[56] This is one of many details to be fleshed out during the implementation period.

Finally, the *VAD Act* (Vic) and the *VAD Act* (WA) protect medical practitioners, and other health practitioners who assist or facilitate a request for VAD, from any criminal or civil liability or liability for professional misconduct or contravention of a professional code of conduct, provided they act in accordance with the Act.[57]

III COMMONWEALTH CRIMINAL CODE ACT PROHIBITION

The *Commonwealth Criminal Code* provisions which prohibit using the internet or other telecommunications to incite or promote suicide were introduced in 2005.[58] The key provisions are sections 474.29A and 474.29B of the *Commonwealth Criminal Code*, which are part of a broader range of offences relating to the use of a carriage service for unlawful purposes.[59] The offences cover:

- counselling or inciting suicide;
- promoting suicide or giving instructions on particular methods of suicide; and
- possessing or supplying suicide related material intended to counsel suicide or provide instructions.[60]

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[57] *VAD Act* (Vic) (n 21) ss 79–81; *VAD Act* (WA) (n 17) s 113(a), 114.

[58] The provisions were originally introduced as part of an omnibus bill, the Crimes Legislation Amendment (Telecommunications Offences and Other Measures) Bill 2004 (Cth), containing numerous offences concerning inappropriate use of telecommunications services for a range of purposes, including child pornography, abhorrent violent material, and internet grooming of minors for sexual purposes. The suicide related offences were later separated from the general bill, reintroduced as the Criminal Code Amendment (Suicide Related Material Offences) Bill 2004 (Cth). This Bill lapsed when Parliament was prorogued in August 2004, and was reintroduced in substantially identical form as the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 (Cth). The Bill received Royal Assent on July 6, 2005, and entered into force on January 6, 2006. For more detail on the legislative history, see Legal and Constitutional Legislation Committee, Parliament of the Commonwealth of Australia, *Provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005* (Report, 12 May 2005) <//www.aph.gov.au/senate/committeelegconctte/suicide/report/report.pdf>, [1.2]–[1.4] ('*Senate Report*'). See also Jennifer Prinz, 'The Phenomenon of Cybersuicide' (2008) 18(2) *Indiana International and Comparative Law Review* 477, 486–9.

[59] These include threatening or harassing a person; child pornography; grooming or engaging in sexual activity with a child; sharing abhorrent violent material (relating to terrorism, murder, torture, rape or kidnapping); or inciting trespass, property damage or theft on agricultural land: *Commonwealth Criminal Code* (n 8) pt 10.6 div 474.

[60] Ibid ss 474.29A, 474.29B.

The *Commonwealth Criminal Code* generally classifies offences into two main components: physical elements, and fault elements. Sections 474.29A and 474.29B are lengthy and complex, and are summarised in Table 1 using these classifications and the language of the statute.

Table 1: Elements of offences in the *Criminal Code Act 1995* (Cth) concerning use of a carriage service for suicide related material

Provision	**Summary**	**Physical Elements**		**Fault Element**
		The person…[61]	***The material directly or indirectly…***[62]	
474.29A(1) **Maximum penalty:** person = 1000 penalty units ($222,000)[63] corporation = 5,000 penalty units ($1,110,000)[64]	Counsel or incite suicide	• uses a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **counsels or incites** • committing or attempting to commit **suicide**	the person **intends to use the material** (or the material be used by another) to • counsel or incite committing or attempting suicide
474.29A(2) **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Promote or provide instructions on methods of suicide	• use a **carriage service** • to **access**/ cause to be transmitted/ **transmit**/ make available/ publish or otherwise distribute • **material**	• **promotes** OR • **provides instruction** on a particular method of committing **suicide**	the person **intends to use the material** (or the material to be used by another) to • promote/provide instruction on a method of suicide OR • the person **intends** it be used by another person to commit suicide

[61] The physical elements of the *Commonwealth Criminal Code* also have their own fault elements: s 5.1. In relation to conduct, this is intention: *Commonwealth Criminal Code* s 5.2, 5.6(1).

[62] The fault element for these circumstances is recklessness: *Commonwealth Criminal Code* s 5.4(1), 5.6(2). In other words, the prosecution would need to establish that the accused was reckless as to the existence of these circumstances. See Explanatory Memorandum, Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 (Cth), 5.

[63] The maximum penalty for an individual is 1000 penalty units. Currently, a penalty unit is $222: *Crimes Act 1914* (Cth) s 4AA(1), as indexed on 1 July 2020 (s 4AA(3)).

[64] The penalty imposed on a body corporate is five times the maximum penalty for an individual: ibid s 4B(3). Sections 474.29A and 474.29B are the only offences in Part 10.6 of the *Commonwealth Criminal Code* (n 8) which impose on an individual a pecuniary penalty rather than a term of imprisonment for conduct related to a carriage service. (There are also pecuniary penalties imposed on internet service providers or content hosts for failure to refer child abuse material or abhorrent violent content to the police: *Commonwealth Criminal Code* (n 8) ss 474.25, 474.33.)

474.29B **Maximum penalty:** person = 1000 penalty units ($222,000) corporation = 5,000 penalty units ($1,110,000)	Possess or supply suicide related material	• has **possession**/ **control** of/ produces/ **supplies**/ obtains material	• **counsels or incites** committing or attempting to commit suicide; OR • **promotes or provides instruction** on a particular method of committing suicide	the person has possession/engages in supply with the **intention** that the material be used: • by that person; OR • by another person; in committing an offence against section 474.29A (even if committing the offence is impossible).

It is not an offence to use a carriage service to engage in public discussion and debate about euthanasia or suicide, or to advocate law reform in that area, if there is no intention that the discussion be used to counsel or incite suicide, or to promote or provide information about a method of committing suicide.[65]

These offences only apply to conduct and communications which use a 'carriage service'. Accordingly, subject to other arguments (considered below), it may be an offence under s 474.29A or 474.29B of the *Commonwealth Criminal Code* to use telephone, email, or internet-based methods, including telehealth services, text messages or social media,[66] to discuss VAD with another person. The Code offences will apply even to conduct which is lawful under the *VAD Act* (Vic) and the *VAD Act* (WA).[67]

IV IS VAD 'SUICIDE'?

The authors could not locate any prosecutions for offences under either s 474.29A or 474.29B of the *Commonwealth Criminal Code*. The interpretation of the provisions remains to be judicially settled. There are several terms in the *Commonwealth Criminal Code* whose meaning

[65] *Commonwealth Criminal Code* (n 8) ss 474.29A(3), (4). See also *Senate Report* (n 58) [2.3], [3.78]. These provisions were inserted in response to concerns that the restrictions would infringe the constitutional implied freedom of political communication. See Prinz (n 58) 488.

[66] The provisions when first enacted were specifically directed at communications using 'the internet, email and other online applications': *Senate Report* (n 58) [2.3].

[67] The interaction between Commonwealth and State laws is discussed in more detail in Section IV.B below.

has not been considered by the courts, but the most significant is 'suicide'. If VAD does not meet the definition of 'suicide' under the legislation, then the provisions of the *Commonwealth Criminal Code* have no application to anyone acting under the Victorian or Western Australian VAD Acts. On the other hand, if VAD falls within the *Code's* definition of 'suicide', then how activities authorised under VAD laws are conducted needs careful consideration. This section accordingly addresses the core threshold issue of whether VAD is 'suicide' according to the *Commonwealth Criminal Code*.[68]

A *Meaning of 'Suicide' in the* Commonwealth Criminal Code

Although the term 'suicide' is used many times in s 474.29A and 474.29B of the *Commonwealth Criminal Code*, it is not defined. Neither is there a definition of suicide in any other Commonwealth legislation, or in State or Territory legislation criminalising assisting suicide.[69] Therefore, its meaning falls to be determined by accepted principles of statutory construction, which seek to determine the 'ordinary and natural meaning'[70] of the language used, informed by the meaning the legislature intended the words to have, considering their context and purpose.[71] This test is simple to state, but notoriously difficult to apply. Accordingly, what constitutes a suicide under Australian law remains unclear.[72]

[68] Whether VAD meets the definition of suicide under the *Commonwealth Criminal Code* is an issue of statutory interpretation and is distinct from the broader normative debates that have resulted in a move away from the language of suicide to describe assisted dying. For an analysis of these debates see eg, Phoebe Friesen, 'Medically Assisted Dying and Suicide: How Are They Different, and How Are They Similar?' (2020) 50(1) *Hastings Centre Report* 32.

[69] The Northern Territory uses the phrase assists or encourages 'another person to kill … himself or herself' interchangeably with the term 'suicide': *Criminal Code 1983* (NT) s 162. Some States use the section heading 'aiding suicide', then define the offence as aiding 'another to kill himself or herself': see, eg, *Criminal Code 1924* (Tas) s 163; *Criminal Code 1899* (Qld) s 311.

[70] *Amalgamated Society of Engineers v Adelaide Steamship Co Ltd* (1920) 28 CLR 129, 162 (Higgins J).

[71] *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355, 384 (McHugh, Gummow, Kirby and Hayne JJ). See also *Acts Interpretation Act 1901* (Cth) s 15AA (construction that promotes the purpose or object underlying the Act is preferred).

[72] John Barry, 'Suicide and the Law' (1965) 5 *Melbourne University Law Review* 1. See also Stephanie Jowett, Belinda Carpenter, and Gordon Tait, 'Determining A Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 363, discussing the variations between definitions of suicide used in different contexts.

1 *A Legal Definition of the Word 'Suicide'?*

The *Oxford English Dictionary* defines suicide as 'an act of taking one's own life, self-murder'.[73] Recent Australian judicial decisions adopt a similar definition. In *X v The Sydney Children's Hospitals Network*, in the context of a decision to refuse life-saving medical treatment, Basten JA defined the legal concept of suicide as being 'the **intentional taking of one's own life**'.[74] Similarly, in *IL v The Queen*, three members of the High Court defined suicide as self-murder,[75] the 'intentional taking of one's own life',[76] or 'intentional self-killing'.[77] Expressed in these simple terms, an act of VAD pursuant to Victorian or Western Australian law would fall within the definition of suicide. A person who has been granted permission to access VAD performs an intentional act (ingesting lethal medication) which causes their death. Because the act is done with the intention of bringing about the person's death, both elements of suicide are satisfied.

However, the legal definition of 'suicide' is likely to be more complex, as the early common law recognised. In *Stuart v Kirkland-Veenstra*, members of the High Court referred to Bracton as the earliest known legal discussion of suicide.[78] Writing in the 13th century, Bracton distinguished four categories of suicide, differentiating the motive behind the act causing death.[79] The first two – killing oneself after committing a felony, to avoid punishment; and killing oneself 'without any cause, through anger or ill will' – resulted in escheat of lands and forfeiture of goods and chattels. The third category – killing oneself

[73] *Oxford English Dictionary* (online at March 2020) 'suicide, n.2'.
[74] *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294, 308 [59] (Basten J) ('*X v Sydney Children's Hospitals Network*').
[75] *IL v The Queen* (2017) 262 CLR 268, 302 [79] (Bell and Nettle JJ), 314 [111] (Gageler J).
[76] Ibid 302 [79] (Bell and Nettle JJ).
[77] Ibid 314 [111] (Gageler J). Although the context of this case was different – the application of the felony-murder rule in criminal law – the legal definition of suicide adopted was the same.
[78] (2009) 237 CLR 215, 249–250 [94] (Gummow, Hayne and Heydon JJ).
[79] Bracton, *De Legibus et Consuetudinibus Angliae* (Bracton on the Laws and Customs of England, c 1210–1268), discussed in William Mikell, 'Is Suicide Murder?' (1903) 3(6) *Columbia Law Review* 379, 379–80; Danuta Mendelson and Ian Freckelton, 'The Interface of the Civil and Criminal Law of Suicide at Common Law (1194–1845)' (2013) 36(5–6) *International Journal of Law and Psychiatry* 343, 344.

'from weariness of life or unwillingness to endure further bodily pain' – was punishable by forfeiture of goods and chattels, but not land.[80] The final category – killing oneself while insane, or by accident – was adjudged to be guiltless, and resulted in no criminal consequences.[81]

Although Bracton's distinctions were lost by the end of the 13th Century, the English common law retained a requirement that suicide be committed voluntarily and by a person with sound mind. A classic definition was provided in 1736 by Sir Matthew Hale: '*Felo de se* or *suicide* is, where a man of the age of discretion, and *compos mentis* voluntarily kills himself by stabbing, poison, or any other way.'[82]

According to this definition, 'suicide' was restricted to culpable killing of oneself, and did not apply to self-killing under compulsion or with an impaired mental state.[83] There is some authority to suggest that Hale's additional elements – voluntariness and decision-making capacity – may be part of the modern Australian legal definition of suicide.[84] Nevertheless, accessing VAD under Victorian or Western Australian law still falls within this conception of

[80] Bracton's third category of suicide has some resonance with the eligibility criteria for VAD, particularly the criterion of intolerable suffering: *VAD Act* (Vic) (n 21) s 9(1)(d)(iv); *VAD Act* (WA) (n 17) s 16(1)(c)(iii).
[81] Mikell claims Bracton borrowed this categorisation from Roman law, particularly Justinian, but he diverged from Justinian in preferring a punishment for suicide by a person 'weary of life or impatient of pain', whereas Roman law found these types of suicide justifiable: Mikell (n 79) 380.
[82] Hale, *Historia Placitorum Coronae: The History of the Pleas of the Crown* (1736) vol 1, 411. The English common law recognised three distinct categories of homicide: *felo de se*, murder and manslaughter: see Blackstone, *Commentaries on the Laws of England* (Cavendish, 1769) vol 4, 189; Coke, *The Third Part of the Institutes of the Laws of England; Concerning High Treason, and other Pleas of the Crown and Criminal Causes* (E and R Brooke, 1817) 54. For a discussion of this history, see Barry (n 72); Mendelson and Freckelton (n 79); *IL v The Queen* (2017) 262 CLR 268, 274–5 [8]–[11], 278 [18] (Kiefel CJ, Keane and Edelman JJ).
[83] *Clift v Schwabe* (1846) 3 Common Bench Reports 437; 136 ER 175, 189–191. See Mendelson and Freckelton (n 79) 345.
[84] In *Inquest into the Death of Tyler Jordan Cassidy*, the coroners' test for suicide was described as 'a *voluntary* and deliberate course of conduct or act or acts in which he *consciously intended* at the moment of engagement in the acts, that those acts, would end his life': [2011] VicCorC 192 (23 November 2011) [244] (Coates J) (emphasis added). This accords with English case law, which describes suicide as 'voluntarily doing an act for the purpose of destroying one's own life whilst one is conscious of what one is doing': *R v Cardiff Coroner, ex parte Thomas* [1970] 1 WLR 1475, 1478.

suicide, because in order to meet the eligibility criteria, VAD must be requested voluntarily and by a person with capacity.

2 *Excluded Categories of Self-Killing*

The law recognises that certain categories of self-killing do not amount to suicide. Most prominently in Australian law, provided a person has decision-making capacity, they can lawfully refuse life-sustaining treatment, even if it results in their death.[85] This is not legally regarded as suicide.[86] Several recent Australian cases have held that requesting the withholding or withdrawal of medical treatment (including blood transfusions,[87] a ventilator[88] or artificial nutrition and hydration[89]) is not suicide, even if the person's intention in refusing treatment is to bring about their death.[90] By extension, in *H Ltd v J* Kourakis J held that the refusal of food and water is not suicide, but 'merely speeding "the natural and inevitable part of life known as death"'.[91] Accordingly, a hospital or doctor respecting any of these wishes would not be liable for assisting suicide.[92]

In *Seales*, New Zealand's common law recognised a second category of intentional self-killing that would not be classified as suicide: that of altruistic self-killing (such as a soldier who sacrifices himself to save his comrades).[93] This has not yet been considered in Australia.

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[85] See, for example, *Brightwater Care Group v Rossiter* (2009) 40 WAR 84 ('*Brightwater v Rossiter*'); *Re JS JS* [2014] NSWSC 302 ('*Re JS*').
[86] *X v Sydney Children's Hospitals Network* (n 74) 308 [59] (Basten JA), quoted with approval in *Re JS* (n 85), [34] (Darke J).
[87] *X v Sydney Children's Hospitals Network* (n 74).
[88] *Re JS* (n 86).
[89] *Brightwater Care Group v Rossiter* (2009) 40 WAR 84 ('*Brightwater v Rossiter*').
[90] *Re JS* (n 86) [3], [20], [25] (Darke J); *Brightwater v Rossiter* (n 89) 88 [11]: 'Mr Rossiter has clearly and unequivocally indicated … that he wishes to die on many occasions' (Martin CJ).
[91] *H Ltd v J* (2010) 107 SASR 352, 371 [56], 374 [67] (Kourakis J).
[92] Ibid 374 [68]. *Brightwater v Rossiter* (n 89) 97 [58] (Martin CJ); *Re JS* (n 86) [34] (Darke J).
[93] *Seales v Attorney-General* [2015] 3 NZLR 556, [137], [143] ('*Seales*'). It should be noted that these comments are *obiter dicta*.

It could be argued that VAD is another category of '… self-chosen deaths ... regarded as non-suicidal',[94] and VAD deaths under a statutory regime should be recognised as a third category of exception to suicide.[95] Although there is a lively debate about the possible philosophical differences between suicide and assisted dying in the bioethical literature,[96] this has not been judicially considered in Australia. Courts internationally have varied in their approach to this issue. In *Baxter v Montana*, Nelson J commented that terminally ill persons who wish to self-administer a physician-prescribed lethal medication:

> …do not seek to commit 'suicide'. Rather they acknowledge that death within a relatively short time is inescapable because of their illness or disease.[97]

However, in *Seales*, Collins J rejected this analysis, stating such a case would satisfy the elements of suicide.[98] Further, in several Australian cases, courts have ruled that actions taken to assist a loved one to die, intending that death will occur, fall within the legal concept of assisting suicide, even where there may be a rational reason for desiring death, such as the presence of terminal illness or intolerable pain.[99]

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[94] Colin Gavaghan, 'Stopping Suicide after *Seales*' [2016] *New Zealand Criminal Law Review* 4, 6.
[95] This is the position taken by Professor Cameron Stewart who suggested '[b]y definition 'suicide' cannot apply to death under VAD legislation because such deaths are not suicides; they are prescribed forms of voluntary assisted deaths.' Quoted in Atlay (n 12).
[96] See, eg, American Association of Suicidology, 'Statement of the American Association of Suicidology: 'Suicide' is not the Same as 'Physician Aid in Dying' (Statement, 30 October 2017); 'What's the Difference Between Suicide and Medical Assistance in Dying in Canada?', *Centre for Suicide Prevention* (Web Page, 2018) <www.suicideinfo.ca/resource/suicide-physician-assisted-death>; Malcolm Parker, 'Words and Reasons: Psychiatry and Assisted Suicide' (2012) 46(2) *Australian & New Zealand Journal of Psychiatry* 80; Robert D Goldney, 'Neither Euthanasia nor Suicide, but Rather Assisted Death' (2012) 46(3) *Australian & New Zealand Journal of Psychiatry* 185, 186; Héctor Wittwer, 'The Problem of the Possible Rationality of Suicide and the Ethics of Physician-Assisted Suicide' (2013) 36(5–6) *International Journal of Law and Psychiatry* 419; Ellen R Wiebe et al, 'Suicide vs Medical Assistance in Dying (MAiD): A Secondary Qualitative Analysis' (2019) *Death Studies* 1.
[97] *Baxter v Montana*, 2009 MT 449 (Mont, 2009) [71] (Leaphart J). A similar point was made in *Truchon v Procureur Général du Canada* [2019] QCCS 3792, [466] (Baudouin J).
[98] *Seales* (n 93) [144].
[99] In several cases, a person who assisted a loved one to die in such circumstances was convicted of aiding and abetting suicide: *R v Maxwell* [2003] VSC 278; *R v Godfrey* (Supreme Court of Tasmania, Underwood J, 26 May 2004); *R v Pryor* (Supreme Court of Tasmania, Hill AJ, 19 December 2005); *R v Rijn* (Melbourne Magistrates Court, Mag Lethbridge, 23 May 2011) ('*Rijn*'); *R v Justins* [2011] NSWSC 568; *R v Mathers* [2011] NSWSC 339. For a further analysis of these cases, see Katrine Del Villar, Lindy Willmott and Ben

3 *Legislative Purpose*

Reference to the legislative purposes confirms that at the time the *Commonwealth Criminal Code* offences dealing with suicide-related material were enacted acts of self-administered VAD would fall within the meaning of 'suicide'. Although neither the second reading speech[100] nor the Explanatory Memorandum[101] concerning these provisions considered whether the definition of 'suicide' was intended to apply to people seeking VAD, the parliamentary debate and submissions to the Senate's report on the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 (Cth) makes it clear that it was.

In the parliamentary debates, some senators criticised the Bill for precluding elderly and terminally ill people from accessing information that would enable them to die with dignity.[102] They and pro-euthanasia advocacy groups[103] considered that the Bill would criminalise the electronic communication of material counselling or providing options to seriously or terminally ill persons wishing to end their lives,[104] including discussing methods of 'voluntary euthanasia type deaths'.[105]The Attorney-General's Department which sponsored the Bill confirmed this interpretation, saying '[i]f a doctor, in the course of that telephone communication, were to provide information about a method of suicide which encouraged the use of that method it would be caught.'[106] These views were, however,

White, 'Assisted Suicides and 'Mercy Killings': Voluntary Requests, or Vulnerable Adults? A Critique of Criminal Law and Sentencing' (under review).

[100] Commonwealth, *Parliamentary Debates*, House of Representatives, 10 March 2005 (Philip Ruddock, Attorney-General).

[101] Explanatory Memorandum, Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 (Cth).

[102] Commonwealth, *Parliamentary Debates*, Senate, 23 June 2005, 237 (Brian Greig), 241–2 (Lyn Allison), 243 (Bob Brown).

[103] Such as the Voluntary Euthanasia Societies of NSW, Victoria, Queensland, Western Australia, South Australia, Tasmania, and the Australian Civil Liberties Union.

[104] *Senate Report* (n 58) [3.31]–[3.33], [3.40]–[3.44]; Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 22 (Kep Enderby QC, President of the Voluntary Euthanasia Society of NSW).

[105] *Senate Report* (n 58) [3.10], quoting Mr Kep Enderby QC from the Voluntary Euthanasia Society of New South Wales. Right to life groups also considered this was the effect of the Bill. These included the Coalition for the Defense of Human Life, Right to Life Australia, Salt Shakers, Festival of Light, Catholic Women's League Australia, and the Australian Christian Lobby.

[106] Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 37–38 (Geoffrey Gray, Attorney-General's Department); *Senate Report* (n 58) [3.52].

expressed at a time when VAD was not lawful in Australia, and the parliamentary debates did not consider the application of the *Commonwealth Criminal Code* if VAD was legalised.[107]

4 *Western Australia's Exclusion of VAD from 'Suicide'*

The Western Australian government initially claimed that the *Commonwealth Criminal Code* offences did not apply in that State because the *VAD Act* (WA) expressly defines VAD as not being suicide:[108]

> For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.[109]

However, this provision specifically applies only to the interpretation of the word 'suicide' in Western Australian laws and (as members of the Western Australian government later recognised[110]) it can have no effect on the interpretation of 'suicide' in Commonwealth laws such as the *Commonwealth Criminal Code*, as State and Commonwealth laws operate independently.[111]

[107] Stewart et al doubt that the Commonwealth Parliament intended to include lawful VAD schemes as 'suicide', although they did not specifically engage with the views of the Commonwealth Attorney General's Department: Cameron Stewart et al, 'Suicide-Related Materials and Voluntary Assisted Dying' (2020) 27 *Journal of Law and Medicine* 839, 843.

[108] Letter from John Quigley (Attorney-General WA) to Christian Porter (Attorney-General Cth), 26 August 2019 <https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4012693a8e51208c08d499584825846c0058d24b/$file/2693.pdf>. See also Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6315 (Roger Cook).

[109] *VAD Act* (WA) (n 17) s 12.

[110] Western Australia, *Parliamentary Debates*, Legislative Council, 22 November, 9170 (Simon O'Brien and Stephen Dawson), 9174 (Nick Goiran and Stephen Dawson).

[111] Legislative definitions in State laws are not necessarily picked up by Commonwealth laws: *Masson v Parsons* (2019) 368 ALR 583 (concerning different provisions under NSW and Commonwealth laws as to whether a man who provided semen for artificial insemination was the 'father' of the child). Compare Stewart et al, who concluded that if VAD is excluded from the meaning of 'suicide' under State law, it must also be excluded from the definition of 'suicide' in the *Commonwealth Criminal Code*: Stewart et al (n 107), 845.

During parliamentary debate, the Western Australian government stated that this section was not drafted to avoid potential inconsistencies with the *Commonwealth Criminal Code*.[112] It subsequently conceded that it will not rely on this section to protect medical practitioners from liability for offences under the *Commonwealth Criminal Code*,[113] and also appeared to concede that VAD would be considered suicide under the *Code*.[114]

5 *Summary: Meaning of 'Suicide'*

In summary, then, it appears likely that VAD by self-administration would fall within the ordinary English meaning of the word 'suicide', as well as the common law concept of suicide.[115] Whether VAD would also be considered 'suicide' as a matter of statutory interpretation under the *Commonwealth Criminal Code* remains unsettled. It appears clear from the ordinary meaning of the word, and the discussion of legislative purpose at the time the offences were inserted in 2005, that the provisions were originally intended to encompass providing information or assistance to enable a seriously or terminally ill person to 'die with dignity'.[116] However, that intention was formed at a time when VAD was unlawful in all Australian states and territories. Whether the provisions may be interpreted differently now that VAD is lawful under highly regulated and controlled conditions in Victoria and Western Australia remains to be tested. If the issue were raised in court, it is possible to argue that the *Commonwealth Criminal Code* provisions should be restricted to unlawfully assisting a person to die rather than assisting a person to exercise a legal right under State VAD

[112] Western Australia, *Parliamentary Debates,* Legislative Assembly, 5 September 2019, 6576 (Roger Cook).
[113] Western Australia, *Parliamentary Debates,* Legislative Council, 24 October 2019, 8281 (Stephen Dawson).
[114] Western Australia, *Parliamentary Debates,* Legislative Council, 22 November 2019, 9174, 9176, 9177 (Stephen Dawson). See also at 9175, 9177 (Nick Goiran). Perhaps the clearest discussion on this issue occurs when Goiran asks: '… would the death of a person as a result of the administration of a prescribed substance in accordance with this act still be considered a suicide under commonwealth law?' to which Dawson replies: 'Yes, it would, because this applies only to Western Australian law.' It is noted, however, that Dawson later stated, when talking about the Western Australian provision, that 'VAD is not suicide'.
[115] Note that Cameron Stewart et al take a different view: Stewart et al (n 107), 841.
[116] Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 37–38 (Geoffrey Gray, Attorney-General's Department).

legislation. There is also scope to argue that VAD should fall within an excluded category of self-killings which are not considered 'suicide', based on a revival of the distinct motivations for suicide described in Bracton's early categorisation, or relying on analogies with common law cases concerning refusals of treatment or of food or water to bring about death.[117] However, neither of these arguments has been tested before the courts. Until the courts have an opportunity to authoritatively settle the question, it would be wise for medical practitioners to act on the assumption that VAD may be considered 'suicide' within the meaning of the *Commonwealth Criminal Code*. The following sections of this paper adopt this assumption.

B *Potential Section 109 Inconsistency*

Assuming that VAD falls within the *Code* definition of 'suicide', the next question is whether the *Commonwealth Criminal Code* is inconsistent with the *VAD Act* (Vic) or the *VAD Act* (WA). Section 109 of the Commonwealth Constitution provides that where a State law is inconsistent with a Commonwealth law, the latter prevails to the extent of the inconsistency. The operation of s 109 is replicated by section 158(4) of the *VAD Act* (WA),[118] which states that communication via audiovisual or other electronic means of communication is not authorised 'if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.'[119]

The Western Australian government initially took the view that there was no inconsistency between its legislation and the *Commonwealth Criminal Code* provisions.[120] This was based

[117] It should be noted, however, that these cases all involved *omissions* causing death rather than *acts* causing death, so the analogy may not extend to acts of VAD.
[118] These are now *VAD Act* (WA) (n 17) ss 158, 159.
[119] Ibid s 158(4).
[120] Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6572, 6576 (Roger Cook); Western Australia, *Parliamentary Debates*, Legislative Assembly, 19 September 2019, 7162 (Mark McGowan).

on initial legal advice[121] that VAD is not suicide because the legislation states it is not suicide,[122] a view that was later (correctly) retracted during parliamentary debate.[123] The Western Australian government's current position is that there is uncertainty and ambiguity surrounding the interaction of the *Commonwealth Criminal Code* and the *VAD Act* (WA), and that alternatives to telehealth may need to be considered in some circumstances.[124] The Victorian government clearly considers that there is potential for inconsistency between the *VAD Act* (Vic) and the *Commonwealth Criminal Code*, because it has instructed all medical practitioners and people involved with the administration of VAD to conduct all consultations face-to-face rather than via telehealth or telephone.[125] The Victorian government will arrange transport for patients or clinicians where necessary to allow clinicians to discuss VAD in face-to-face meetings only, avoiding any potential liability under the *Commonwealth Criminal Code*.[126] The federal Attorney-General Christian Porter has confirmed that clinicians conducting face-to-face medical consultations will not breach the *Commonwealth Criminal Code*,[127] but has not given the same assurance for consultations conducted via telehealth or other electronic means of communication.

Whether the suicide related material provisions in the *Commonwealth Criminal Code* are inconsistent with the *VAD Act* (Vic) or *VAD Act* (WA) depends on whether there is a 'real

[121] The government of Western Australia received legal advice from the Department of Justice, the State Solicitor-General, the State Solicitor's Office and the State Director of Public Prosecutions: Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 6572, 6576 (Roger Cook).
[122] Quigley (n 108).
[123] Western Australia, *Parliamentary Debates*, Legislative Council, 24 October 2019, 8281 (Stephen Dawson), Western Australia, *Parliamentary Debates*, Legislative Council, 22 November 2019, 9174 (Stephen Dawson).
[124] This was mentioned at several points during debate in the Legislative Council. See, eg, Western Australia, *Parliamentary Debates*, Legislative Council, 16 October 2019, 7735 (Jacqui Boydell); Western Australia, *Parliamentary Debates*, Legislative Council, 23 October 2019, 8166 (Stephen Dawson).
[125] See also *VAD Guidance for Health Practitioners* (n 16) 4, 74.
[126] Kemal Atlay and Paul Smith, 'Australia's First Euthanasia Doctor Tells his Story of Ending the Lives of Patients', *Australian Doctor*, 26 February 2020, 8-9.
[127] 'Risk to Vic Doctors Discussing Euthanasia' (n 7).

conflict' between the two laws.[128] That question is answered by determining whether the State law alters, impairs or detracts from the Commonwealth law in a way that is significant and not trivial.[129] The tests of direct and indirect inconsistency are interrelated and there are overlapping tools for undertaking that analysis.[130]

Indirect inconsistency occurs where the Commonwealth intends to exclusively 'cover the field' or be the only body to regulate a certain area of conduct, thus excluding any State laws on that subject. Here, the *Commonwealth Criminal Code* does not evince an intention to exclusively regulate telecommunications relating to suicide. Indeed, s 475.1(1) of the *Code* contains an 'anti-exclusivity clause',[131] which explicitly states that '[t]his Part is not intended to exclude or limit the operation of any other law of the Commonwealth or any law of a State or Territory.' The intention behind this provision was to allow State laws criminalising the same conduct to continue to apply concurrently with the *Commonwealth Criminal Code* offences.[132]

There are two different types of direct inconsistency. The first is where it is impossible to obey both the State and Commonwealth laws.[133] In this instance, there is no question of

[128] This is the language that the High Court has repeatedly used to expand the word 'inconsistent' in the Commonwealth Constitution s 109. See, eg, *Collins v Charles Marshall Pty Ltd* (1955) 92 CLR 529, 553 (Dixon CJ, McTiernan, Williams, Webb, Fullagar and Kitto JJ); *Jemena Asset Management (3) Pty Ltd v Coinvest Ltd* (2011) 244 CLR 508, 525 [42] (French CJ, Gummow, Heydon, Crennan, Kiefel and Bell JJ) ('*Jemena*'); *Momcilovic v The Queen* (2011) 245 CLR 1, 233 [630] (Crennan and Kiefel JJ) ('*Momcilovic*'); *Work Health Authority v Outback Ballooning Pty Ltd* (2019) 93 ALJR 212, 228–9 [70]–[72] (Gageler J), 236 [105] (Edelman J) ('*Outback Ballooning*).

[129] *Victoria v Commonwealth* (1937) 58 CLR 618, 630 (Dixon J); *Telstra Corporation Ltd v Worthing* (1999) 197 CLR 61, 76 [28]; *Dickson v The Queen* (2010) 241 CLR 491, 502 [13] ('*Dickson*'); *Jemena* (n 128) 524 [52]; *Outback Ballooning* (n 128), 221 [32] (Kiefel CJ, Bell, Keane, Nettle and Gordon JJ), [70]–[72] (Gageler J), 236 [105] (Edelman J).

[130] *Momcilovic* (n 128) 112 [245] (Gummow J), 134 [318] (Hayne J).

[131] *Outback Ballooning* (n 128) [133] (Edelman J), citing a provision in similar terms in the *Corporations Act 2001* (Cth) s 5E(1).

[132] Explanatory Memorandum, Crimes Legislation Amendment (Telecommunications Offences and Other Measures) Bill 2004 (Cth) 53. Accordingly, the *Commonwealth Criminal Code* (n 8) is intended to be 'supplementary to or cumulative upon' State criminal law: *Outback Ballooning* (n 128) [39] (Kiefel CJ, Bell, Keane, Nettle and Gordon JJ), quoting *Ex Parte McLean* (1930) 43 CLR 472, 483 (Dixon J).

[133] For example, where one law commands what the other forbids or one law compels disobedience to the other: *R v Licensing Court of Brisbane; Ex parte Daniell* (1920) 28 CLR 23, 29.

impossibility, because people providing VAD in Victoria or Western Australia can choose to avoid using a telecommunications service to conduct conversations, and thus comply with both laws. This is in fact the solution implemented by the Victorian government.[134]

The second type of direct inconsistency occurs where one law confers a right, privilege or entitlement that the other law purports to take away or diminish.[135] This includes situations where one legislature criminalises certain conduct and hence closes off areas of liberty 'designedly left open' by the other polity.[136] There is a strong argument that there is a rights-based inconsistency between the *Commonwealth Criminal Code* and the relevant State VAD Acts. This is because the Victorian and WA laws expressly authorise intentional self-killing where certain eligibility criteria for VAD are met. They allow medical practitioners and others in some circumstances to conduct conversations or assessments via telephone or telehealth and provide information via email or over the internet. As discussed above, although the position is not settled, this article proceeds on the basis that VAD will be 'suicide' under the Commonwealth law. If these electronic communications can be considered to counsel or incite VAD, or promote or provide instruction concerning VAD, they may breach the Commonwealth's suicide related material offences.[137] Thus, the Victorian and WA VAD Acts confer rights on medical practitioners and others which the *Commonwealth Criminal Code* restricts. As a result, the Victorian and WA VAD Acts will be inoperative to the extent of the inconsistency. This means that any conduct that uses a carriage service to transmit material that encourages suicide (including VAD) would not be

[134] *VAD Guidance for Health Practitioners* (n 16) 4, 74.
[135] *Clyde Engineering Co Ltd v Cowburn* (1926) 37 CLR 466, 478 (Knox CJ and Gavan Duffy J); *Colvin v Bradley Brothers Pty Ltd* (1943) 68 CLR 15.
[136] *Dickson* (n 129) [25], quoting *Wenn v Attorney-General (Vic)* (1948) 77 CLR 84, 120 (Dixon J).
[137] *Commonwealth Criminal Code* (n 8) ss 474.29A, 474.29B.

protected by the *VAD Act* (Vic) or *VAD Act* (WA),[138] but would be an offence under the *Commonwealth Criminal Code*.

V INTERPRETING THE PROVISIONS OF THE *COMMONWEALTH CRIMINAL CODE*

Having determined both that VAD could potentially be regarded as suicide under the *Commonwealth Criminal Code*, and that there is inconsistency between the Commonwealth criminal law provisions and State-based VAD laws, it is necessary to analyse the *Code* provisions to determine what, if any, conduct might give rise to possible criminal responsibility. As mentioned above, the proposed offences cover the use of a carriage service (including internet, email, telephone, and online apps[139]) for suicide-related material. What communication relating to VAD will be caught by these provisions depends on the meaning of key terms in each of the three offences. This section considers the interpretation of these key terms, first addressing the physical elements of each offence (in section V(A)-(C)) and then discussing the fault elements (in section V(D)).

A *Section 474.29A(1) - Transmitting Material that Counsels or Incites Suicide*

Section 474.29A of the *Commonwealth Criminal Code* makes it an offence to **'access, transmit, make available, publish or otherwise distribute'** suicide-related material using a carriage service. 'Access' is defined in terms which would include viewing, printing, downloading, copying or storing material from a computer.[140] The other verbs are not specifically defined, but cover a variety of methods of conveying information to a specific person or unspecified class of people. The noun **'material'** is broadly defined to include 'material in any form, or combination of forms, capable of constituting a communication'.[141]

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[138] The provisions which give health practitioners immunity from liability are *VAD Act* (Vic) (n 21) s 80; *VAD Act* (WA) (n 17) ss 113(a), 114.
[139] Explanatory Memorandum, Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 (Cth) 3.
[140] *Commonwealth Criminal Code* (n 8) s 473.1.
[141] Ibid.

Taken together, the action contemplated by this section can be broadly described as communicating information concerning suicide to other people, which would include: publishing content online for reading or downloading; online advertising of resources or workshops to potential participants; sending advice or information over email; and private verbal communication via the telephone or audiovisual means of communication (such as videocalling apps).

To fall within the realm of conduct proscribed by s 474.29A(1), transmitting this material must have the consequence that it 'directly or indirectly counsels or incites committing or attempting to commit suicide'. During the Senate inquiry into the draft legislation, concerns were expressed that criminalising conduct that '**directly or indirectly**' counsels suicide is very broad, and may not 'provide a sufficiently certain legal standard for courts to measure conduct against.'[142] However, the Department responded that 'directly or indirectly' is a drafting device commonly used in the criminal law, which covers communication either in 'express words' or 'by necessary implication'.[143]

The term **'counsels or incites'** is the most challenging element in this provision to interpret. Although **'counsels'** is undefined, representatives of the Commonwealth Attorney-General's department gave evidence to the Parliamentary committee of inquiry that it has the narrow meaning it bears in criminal offences concerning aiding, abetting and procuring. They stated: 'It is not counselling in the medical sense of providing assistance and information; it is actually

[142] *Bills Digest* No 13 of 2004–2005 (n 8) 22; Department of Parliamentary Services (Cth), *Bills Digest* (Digest No 133 of 2004–2005) 8; Electronic Frontiers Australia Inc, Submission No 28 to Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Inquiry into the provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005* (3 April 2005) 12.
[143] Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 40 (Geoffrey Gray, Attorney-General's Department); Attorney-General's Department, Submission No 32 to Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Inquiry into the provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005* (14 April 2005) 10.

encouraging the person with an intent to bring about a result.'[144] Accordingly, it seems clear that 'counselling' means urging or encouraging a person to commit suicide, and is directed at the actual commission of suicide.[145] It encompasses intentionally using material to encourage a person to commit suicide,[146] but would not cover providing broad general advice which is not intended to be acted upon.

The term **'incite'** is also not defined in the *Commonwealth Criminal Code*. Section 11.4 of the *Code* creates an offence of 'incitement', which is committed by a person 'who urges the commission of an offence'. Although this is not directly applicable to the offence contained in s 474.29A of the *Code*, it is an accepted principle of statutory construction that the meaning of words should be determined by reference to the language of the statute as a whole.[147] Accordingly, 'incite' should be given a meaning such as 'urge', which is similar to the meaning given to the word 'counsel'. The comparable State offence of inciting suicide has been briefly considered in one Victorian case: *R v Rijn*.[148] In that case, the charge preferred was 'inciting' rather than 'aiding and abetting' suicide, because the offender's role was characterised as 'passively encouraging' suicide rather than actively assisting.[149] This confirms that 'incite' bears a very similar meaning to 'counsel' – namely, to urge or encourage a person to kill themselves.

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[144] Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 38 (Geoffrey Gray, Attorney-General's Department). This narrow interpretation was repeated by Senator Chris Ellison in the parliamentary debate: Commonwealth of Australia, *Parliamentary Debates*, Senate, 23 June 2005, 246 (Chris Ellison). See also Supplementary Explanatory Memorandum, Criminal Code Amendment (Suicide Related Material Offences) Bill 2005, which states that "… the term "counsels" is intended to have a narrow meaning. It would cover the encouragement or urging of a person to commit suicide and the giving of advice or assistance directed at the actual commission of suicide."

[145] *R v Morant* [2018] QSC 222, [20] (Davis J), quoting *R v Oberbillig* [1989] 1 Qd R 342, 345.
[146] *Senate Report* (n 58) [3.63].
[147] *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355, [69] (McHugh, Gummow, Kirby and Hayne JJ).
[148] *Rijn* (n 99).
[149] The characterisation of the actions of Rijn is curious, given he provided his wife with the equipment needed to complete her suicide: Ibid.

In summary, therefore, the physical elements of the offence in s 474.29A are established when a person uses a carriage service to access material, provide it to someone else, or distribute or make it available, and that material encourages or urges committing or attempting to commit suicide. The person must also possess the necessary fault element, as will be discussed further below (section V(D)).

B *Section 474.29A(2) - Transmitting Material that Promotes or Provides Instruction on a Particular Method of Suicide*

It is also an offence under the *Commonwealth Criminal Code* to 'access, transmit, make available, publish or otherwise distribute' material which promotes or provides instruction on a particular method of committing suicide.[150] The phrase '**promote or provide instruction**' is not defined in the *Code*, and has not been the subject of judicial comment. The term 'promote' is used elsewhere in the *Code* as part of the definition of 'advocate' and appears there as a synonym of counsel, encourage or urge.[151] Thus it appears to suggest purposive conduct.

A similar phrase – 'promote, incite or instruct in matters of crime or violence' – was considered by the Federal Court in relation to offences under the classification legislation.[152] In *Brown v Classification Review Board*, **'promote'** was defined as 'to further the growth, development, progress or establishment of (anything); to further advance, encourage.'[153] **'Instruct'** was defined as 'to furnish with knowledge, esp. by a systematic method; teach;

[150] *Commonwealth Criminal Code* (n 8) s 474.29A(2).
[151] Ibid ss 80.2C, 80.2D.
[152] The phrase is used in the Schedule to the *Classification (Publications, Films and Computer Games) Act 1995* (Cth); *Classification of Films and Publications Act 1990* (Vic) s 3; *Classification of Publications Ordinance 1990* (ACT) s 19(4).
[153] *Brown v Members of the Classification Review Board of the Office of Film and Literature Classification* (1998) 82 FCR 225, 239 (French J) ('*Brown*'), adopting the *Shorter Oxford English Dictionary's* definition.

train, educate',[154] but with a purposive meaning, going 'beyond the mere provision of information' which describes, depicts or teaches,[155] or convey knowledge in a general way.[156] Sundberg J considered 'instruct in matters of crime' involves two elements: 'first, furnishing readers with information as to how crime can be committed, and secondly, encouraging them to use that information to commit crime.'[157] The test is purposive, but it is also objective: that is, whether the information has the effect of promoting or encouraging people to commit an action is to be assessed objectively, regardless of the actual intention of the person making the information available.[158] There is also no requirement to look at the effect or likely effect of the action.[159]

This phrase is not identical to the phrase used in s 474.29A(2) of the *Commonwealth Criminal Code*. For suicide related material, the words 'promote or provide instruction' are used without the word 'incite', which is included in relation to matters of crime or violence. Applying the maxim *expressio unius est exclusio alterius*, it may be argued that the phrase 'promote or provide instruction' should be interpreted more broadly, as the provision of information or instruction, without any element of incitement to suicide. However, courts have been cautious to apply this maxim of statutory construction, particularly where fundamental rights are involved. In this case, reading the phrase without reference to any purpose of inciting or encouraging suicide would broaden the class of persons potentially exposed to criminal sanctions. Such a construction is to be avoided. It also appears contrary to linguistic and contextual factors. It therefore seems likely that the phrase 'promotes or

[154] Ibid, 239 (French J). See also *NSW Council of Civil Liberties Inc v Classification Review Board (No 2)* (2007) 159 FCR 108, 123 ('*NSW Council of Civil Liberties*').
[155] *Brown* (n 153) 82 FCR 225, 239 (French J).
[156] Ibid 257 (Sundberg J).
[157] Ibid.
[158] Ibid 239, (French J), 242 (Heerey J), 257 (Sundberg J). See also *NSW Council of Civil Liberties Inc* (n 154) 123.
[159] *NSW Council of Civil Liberties* (n 154) 126.

provides instruction' should be interpreted as having a purposive element, having embedded in it some notion of purposeful encouragement.

In summary, the physical element in s 474.29A(2) encompasses accessing or providing information using a carriage service, where the material provided directly or indirectly encourages or teaches a person how to commit suicide using a particular method. However, the offence would not apply to information which merely provided knowledge about suicide or a particular method of suicide. To establish the offence, the person must also possess the necessary fault element (discussed in section V(D)).

C *Section 474.29B - Being in Possession or Supplying Material that is Intended to be Used to Commit One of the Transmission Offences*

Section 474.29B of the *Commonwealth Criminal Code* applies to the possession or supply of suicide related material which is intended to be used for the commission of either of the offences contained in section 474.29A.[160] A person can commit this offence without having a specific person in mind, or without anyone having committed or attempted suicide using this provision.

These offences are very broadly expressed. '**Possession or control**' of suicide related material is defined to include possession of a computer or data storage device, possession of a document in which data is recorded, and control of data held in someone else's computer (even if that computer is not located in Australia).[161] The second composite phrase, '**producing, supplying or obtaining'** material, is defined to include producing, supplying or obtaining data held in a computer or data storage device; or a document in which the data is

[160] Similarly worded provisions apply to preparatory conduct related to child abuse material: *Commonwealth Criminal Code* (n 8) ss 273.6, 471.20, 474.22A, 474.23.
[161] Ibid s 473.2. Similar definitions are provided, in relation to other offences at ss 273.1(2), 470.4(2).

recorded.[162] As with the two offences contained in s 474.29A, the final element of this offence is that the conduct must be accompanied by an intention that the material be used for committing an offence against s 474.29A.

D *Fault Element*

For an offence to be committed under either s 474.29A or 474.29B of the *Commonwealth Criminal Code*, the prosecution must also prove beyond a reasonable doubt that the accused possessed the requisite fault element of intention. The framing of 'intention' varies slightly for each section, but all require the intention to use the relevant material for certain purposes. These are:

- That the person has an intention to use (or intention that another person use) the relevant material to **counsel or incite committing or attempting to commit suicide** (s 474.29A(1));
- That the person has an intention to use (or intention that another person use) the relevant material to **promote a method of suicide, to provide instruction on a method of suicide,** or has an intention that another person use the material **to commit suicide** (section 474.29A(2)); and,
- That the person has possession or control or produces, supplies or obtains the material with the intention to use (or intention that another person use) the relevant material **to commit an offence** against s 474.29A (s 474.29B).

Section 5.2 of the *Commonwealth Criminal Code* defines intention for conduct, a circumstance, and a result:

[162] Ibid s 473.3. Similar definitions are provided, in relation to other offences at ss 273.1(3), 470.4(3).

1) A person has intention with respect to conduct if he or she means to engage in that conduct.
2) A person has intention with respect to a circumstance if he or she believes that it exists or will exist.
3) A person has intention with respect to a result if he or she means to bring it about or is aware that it will occur in the ordinary course of events.

This definition combines the ordinary meaning of intention with a stipulated, technical meaning.[163] For example, s 5.2(3) refers to the ordinary meaning of 'means to bring about [that result]', and adds the technical meaning of where the person 'is aware that [a result] will occur in the ordinary course of events'. The term 'intention' in s 5.2(3) is used more expansively in the *Commonwealth Criminal Code* than at common law, as the definition includes foresight of results which are certain or virtually certain to occur. This section has not been judicially interpreted, but the official commentary on the draft Code produced by the Model Criminal Code Officers' Committee suggests that 'aware it will occur in the ordinary course of events' means the defendant knows the consequences or results of conduct are 'morally or virtually certain to occur'.[164] There must be proof of actual subjective intention to achieve the result.[165]

As will be discussed in section VI, while it can be difficult to establish subjective intention, there is the potential for coordinating practitioners (or others involved in navigating the VAD legislation)—particularly towards the latter stages of the process—to satisfy the fault element

[163] Australian Government, Attorney-General's Department, '5.2 Intention - Commonwealth Criminal Code: Guide for Practitioners' (online) <https://www.ag.gov.au/crime/publications/commonwealth-criminal-code-guide-practitioners-draft/part-22-elements-offence/division-5-fault-elements/52-intention>.
[164] Criminal Law Officers' Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapters 1 and 2: General Principles of Criminal Responsibility* (Report, December 1992), 25.
[165] *Zaburoni v R* (2016) 256 CLR 482*; R v Willmot (No 2)* [1985] 2 Qd R 413, 418. This is similar to the English concept of oblique intention, which was described by Nettle J in *Zaburoni* at 504 [66]: 'where it is proved that an accused foresaw that his or her actions would have an inevitable or certain consequence, it logically follows that the accused intended to bring about that consequence' [emphasis added]. Nettle's J's statement is not the position of the majority, but it is analogous with the position in the Commonwealth Criminal Code. For further discussion see: Jordan Wei Peng Teng and Rebecca Mahony, 'Zaburoni v The Queen' (2016) 37(2) *Adelaide Law Review* 553, 559, 564-567.

in the *Commonwealth Criminal Code*. Section 474.29A(2) is particularly concerning, given that a coordinating practitioner conducting a final VAD assessment or prescribing a VAD substance will necessarily need to provide material and instructions to their patient about how to carry out VAD (the method). In providing this information, they are doing so to instruct their patient on how to complete the VAD process if they choose, or to instruct another person (such as a family member or nurse) on how to provide support to the patient if needed. Arguably this information is provided with the intention to 'promote that method of committing suicide' (ie VAD) and almost certainly to 'provide instruction on that method of committing suicide'.[166] It would be difficult, then, to argue that a coordinating practitioner does not intend the relevant material to be used for that purpose.[167]

For s 474.29A(1) of the *Commonwealth Criminal Code*, to prove intention, the coordinating practitioner must intend to use (or intend that another person use) the material to 'counsel or incite committing or attempting to commit suicide'. Because this is purposive, it may be more difficult to establish than the intention to provide instruction, which is fault element under s 474.29A(2).

E *Summary: Interpreting the Provisions of the* Commonwealth Criminal Code

In summary, sections 474.29A and 474.29B of the *Commonwealth Criminal Code* are broad provisions which capture a wide range of conduct. As noted above, these offences have two main elements, which must be proved beyond a reasonable doubt: a physical element (or elements), and a fault element. In terms of the physical element, many *actions* conducted using a telephone, email, the internet, videocalling facilities or social media applications are potentially caught if they involve possessing, supplying, discussing or sending material related to suicide (including VAD). However, the offences are limited by the fact that the

[166] *Commonwealth Criminal Code* (n 8) ss 474.29A(2)(i),(ii).
[167] This is explored in more detail in section VI.F below.

conduct has a purposive component, such as 'counsel', 'incite' or 'promote'. The offences are further limited by the fault element of 'intention' – for example, to be prosecuted, a person must intend to counsel or encourage a person to commit suicide, intend to provide instruction which explains how and encourages a person to commit suicide, or intend that another person use the material to commit suicide. How these offences may apply at the various stages of the VAD process is discussed directly below.

VI PRACTICAL IMPLICATIONS OF THE COMMONWEALTH OFFENCE

Nationwide, telehealth is now a significant method for providing medical services, particularly for regional and rural patients.[168] Telehealth is of critical importance in a State such as Western Australia, which has a vast geographical area, sparse population density,[169] and limited medical services outside the capital city.[170] While Victoria is not as vast as Western Australia, telehealth is routinely used in this jurisdiction as well.[171] The social distancing measures introduced in response to the COVID-19 pandemic have greatly increased reliance on telehealth for the provision of medical services for all Australians.[172]

[168] Medicare statistics show that in the five years between 1 July 2011 and 30 June 2016, there was an exponential increase in the use of telehealth services, with the largest users being GPs and specialists, from under 2,000 services per quarter to over 40,000 services per quarter: Department of Health, *Telehealth Quarterly Statistics Update* (Report, 24 August 2016) <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-factsheet-stats>.

[169] Western Australia has established over 900 videoconferencing endpoints, to give people access to specialists in Perth via the telehealth system. This system delivered 18,224 telehealth consultations in 2017 alone, saving regional patients 27.3 million km of travel to access medical appointments: Western Australia, *Parliamentary Debates*, Legislative Council, 23 October 2019, 8130 (Jim Chown).

[170] Many regional towns have only one general practitioner, and others have no medical service at all: Western Australia, *Parliamentary Debates*, Legislative Council, 24 October 2019, 8293 (Jim Chown). Because specialist doctors are concentrated in the capital city, and people living in regional or remote areas may be thousands of kilometres away, the Ministerial Expert Panel recommended that nurse practitioners could be involved in the delivery of VAD, and envisaged a key role for telehealth in delivering specialist advice: Government of Western Australia, Department of Health, *Ministerial Expert Panel Report on Voluntary Assisted Dying* (Final Report, June 2019) 6 ('*WA Ministerial Expert Panel Report*').

[171] Alice King and Susan Jury, *Telehealth in Victoria: What, Where, Who and How?* (Presentation, 2017) <https://telehealthvictoria.org.au/wp-content/uploads/2017/10/Telehealth-in-Victoria.pdf>

[172] Hunt and Kidd (n 20).

Because of concerns about committing an offence under the *Commonwealth Criminal Code*, doctors in Victoria have been advised not to conduct eligibility assessments via the telephone or telehealth, but to either travel to the patient or make arrangements for the patient to travel to the doctor.[173] Similarly, VAD Care Navigators in Victoria have been advised not to respond fully to phone inquiries, but to conduct all discussions concerning VAD in person.[174]

Although the *VAD Act* (WA) is yet to commence, similar 'alternative implementation strategies' have been proposed in Western Australia and will be explored prior to the Act commencing in 2021.[175] These might include sending 'mobile crews or teams of medical professionals and support staff such as translators and care navigators into our regional areas to service country people'.[176] Alternatively, it may include packages to assist patients to travel to a doctor in the city if there is not one in a patient's region.[177] Finally, a 'hub-and-spokes' model has been proposed, under which requests are received by a central hub, which would facilitate the provision of information either by hard copy or in person, and arrange travel for the patient or health practitioner to conduct assessments in person.[178]

This section considers whether the obligations of medical practitioners, pharmacists and VAD Care Navigators at each step of the VAD process must be carried out in person, or can be carried out using a telecommunications service without breaching the *Commonwealth*

[173] Statements of the former Health Minister Jenny Mikakos in Cunningham (n 15).
[174] Victorian Government, Department of Health and Human Services, *Voluntary Assisted Dying: Quick Reference Guide for Health Practitioners* (Reference Guide, July 2019) 7 <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care> ('*VAD Quick Reference Guide for Health Practitioners*').
[175]Western Australia, *Parliamentary Debates,* Legislative Council, 23 October 2019, 8166 (Stephen Dawson).
[176] Western Australia, *Parliamentary Debates,* Legislative Council, 16 October 2019, 7735 (Jacqui Boydell); Western Australia, *Parliamentary Debates,* Legislative Council, 24 October 2019, 8278, 8294 (Stephen Dawson). See generally Western Australia, *Parliamentary Debates,* Legislative Council, 24 October 2019, 8293–6, as well as comments made at 8301 (Nick Goiran). See also Western Australia, *Parliamentary Debates,* Legislative Council, 22 November 2019, 9183 (Nick Goiran).
[177] Western Australia, *Parliamentary Debates,* Legislative Council, 16 October 2019, 7735 (Jacqui Boydell).
[178] Western Australia, *Parliamentary Debates,* Legislative Council, 23 October 2019, 8166 (Stephen Dawson).

Criminal Code.[179] It is not possible to comprehensively identify all possible communication that could occur via a carriage service, but the below discussion identifies in chronological order the key points in the VAD process where this is likely to arise. This paper focusses on the use of a carriage service by doctors, VAD Care Navigators or other health practitioners who act in good faith, in accordance with legislative requirements, and take a neutral role – allowing the patient to explore the option of VAD without either encouraging or discouraging a patient from accessing VAD. If a medical practitioner plays a more active role in encouraging patients to access VAD, this would be likely to increase their risk of contravening the *Commonwealth Criminal Code*.[180]

It is important to acknowledge at the outset that these are difficult issues. Some conclusions are tentative only, either because of uncertainty in the interpretation of the law, or because it depends on the circumstances (such as the wording used by, or the subjective intention of, the health practitioner discussing VAD). The analysis concludes with Table 2, which outlines the nine identified actions that are examined under the seven headings below.

A *Providing Contact Information for a VAD Provider via a Carriage Service*

A VAD Care Navigator may be a first point of contact for a person seeking information about VAD,[181] and may provide general information, contact details of a trained VAD provider, and

[179] Although there is also the potential for family or friends to breach the *Commonwealth Criminal Code* (n 8) when providing support via a carriage service to a loved one who is accessing VAD, the focus of the present paper is on the obligations of medical practitioners and other health practitioners.
[180] Active encouragement could also constitute an offence under the VAD Acts if it induced a patient to request VAD, or to self-administer a VAD substance, through dishonesty or undue influence (or coercion in WA): *VAD Act* (Vic) (n 21) ss 85, 86; *VAD Act* (WA) (n 17) ss 100, 101.
[181] In the first year of operation of the *VAD Act* (Vic) (n 21), VAD Care Navigators provided support to 613 people seeking information about VAD: *VADRB Report* (n 34) 5. However, VAD Care Navigators are not the only first point of contact. Some patients will seek VAD assistance from a medical practitioner with whom they have an existing relationship.

individualised support through the process.[182] It could be argued that providing details of a VAD provider via a carriage service constitutes the transmission of material which indirectly promotes a method of committing suicide (ie VAD),[183] or indirectly counsels or incites suicide.[184] It is also arguable that in doing so the VAD Navigator intends to promote this method or counsel or incite the person into VAD because the information is provided to connect the patient to a medical practitioner to explore VAD. Due to such concerns, the Victorian government instructed VAD Care Navigators to conduct all conversations and provide all advice or information concerning VAD in person, rather than by telephone, email or internet.[185] This approach was also noted in the Western Australian Parliamentary debates.[186]

Given the law is unclear, it is appropriate that VAD Care Navigators exercise caution. However, in our view several factors make it highly unlikely that simply providing the contact details of a VAD provider, via a carriage service, would be encouraging or inciting a person to access VAD or promoting a method of suicide:

- the referral is made at an early stage in the VAD process;
- the information provided is of a general nature;
- the person retains a discretion whether to use that information to further investigate VAD;
- the person has not yet been assessed as eligible for VAD; and

[182] See 'The Statewide Voluntary Assisted Dying Care Navigator Service', *Department of Health and Human Services, Victorian Government* (Web Page, September 2019).
[183] *Commonwealth Criminal Code* (n 8) s 474.29A(2).
[184] *Commonwealth Criminal Code* (n 8) s 474.29A(1).
[185] *VAD Quick Reference Guide for Health Practitioners* (n 174) 7.
[186] Western Australia, *Parliamentary Debates,* Legislative Council, 24 October 2019, 8280–1, 8295–6 (Stephen Dawson).

- the person will be informed repeatedly throughout the VAD process that they are under no obligation to proceed.

Although this is highly unlikely to contravene the *Commonwealth Criminal Code*, this conclusion does not apply to all information and support that could be provided by a VAD Care Navigator via a carriage service. Particularly in the mid to later stages of the VAD process, the risks that VAD Care Navigators might breach the *Code* are similar to those discussed for other health practitioners below.

B *Providing Information about VAD via a Carriage Service*

In Victoria, a medical practitioner or other registered health practitioner (including nurse or pharmacist) cannot initiate conversations about VAD,[187] even where a patient asks about all available treatment options.[188] In Western Australia, medical practitioners or nurse practitioners (but not other health care workers) may initiate conversations about VAD provided, at the same time, they inform the person about treatment and palliative care options, and the likely outcomes of that care and treatment.[189] A health practitioner can, however, provide information about VAD after a person has specifically requested such information, but this risks breaching the *Commonwealth Criminal Code* if this information is provided via a carriage service. As discussed below, the more detailed and specific the information provided, the greater the risk of contravening the *Code*.

[187] This is prohibited under the *VAD Act* (Vic) (n 21) s 8, and is considered unprofessional conduct, which is subject to mandatory notification to the Australian Health Practitioner Regulation Agency: *VAD Act* (Vic) (n 21) ss 75, 76.
[188] For critique of this provision, see Lindy Willmott et al, 'Restricting Conversations About Voluntary Assisted Dying: Implications for Clinical Practice' (2020) 10(1) *BMJ Supportive and Palliative Care* 105, 107; Carolyn Johnston and James Cameron, 'Discussing Voluntary Assisted Dying' (2018) 26(2) *Journal of Law and Medicine* 454; Bryanna Moore, Courtney Hempton and Evie Kendal 'Victoria's Voluntary Assisted Dying Act: Navigating the Section 8 Gag Clause' (2020) 212(2) *Medical Journal of Australia* 67.
[189] *VAD Act* (WA) (n 17) s 10.

The lowest level of risk is present in initial discussions with a patient about end-of-life options. Communications only relating to the range of treatment, non-treatment and palliative care options available to a patient (including VAD as a possible option), are highly unlikely to breach the suicide-related material provisions of the *Commonwealth Criminal Code*. Unless a doctor, VAD Care Navigator or health practitioner framed the conversation in a way which clearly encouraged a patient to choose VAD, it is unlikely that a general discussion of VAD as one among a number of options for treatment or care at the end of life would amount to counselling or inciting suicide,[190] or promoting a method of suicide.[191] It is also unlikely that a doctor, VAD Care Navigator or other health practitioner would have the necessary subjective intention to counsel or encourage suicide.[192] Accordingly, it seems that providing general information or discussing end-of-life options and preferences could safely occur using a carriage service without infringing the *Commonwealth Criminal Code*.

In contrast, more risk could be involved if doctors, VAD Care Navigators, or other health practitioners provide information including *specific advice* such as about a method of VAD, the drugs used and the procedure followed by someone wishing to end their life in accordance with the statutory framework. These sorts of discussions could occur at the initial stages of seeking VAD or at other points in time, such as after eligibility assessments when mandated information must be provided. Depending on the context and the information being provided, it is possible that providing the mandated information could contravene s 474.29A(2) of the *Commonwealth Criminal Code* if the material was transmitted through a carriage service. The health practitioner's action in providing specific information about a

[190] Within the meaning of the *Commonwealth Criminal Code* (n 8) s 474.29A(1).
[191] *Commonwealth Criminal Code* (n 8) 474.29A(2).
[192] Professor Ian Freckelton QC agrees, stating that doctors 'may be speaking to the person about what they can or can't do and explaining the possibilities and technicalities, but they ought not to be counselling or inciting the commission of suicide': in Atlay (n 12).

method of VAD would be likely to be considered to have the effect of at least indirectly 'promot[ing] or provid[ing] instruction' on a particular method of suicide if that information is sufficiently detailed.[193] As mentioned above, whether providing information has the effect of promoting suicide is assessed purposively and objectively,[194] and providing information which can be used has been held to encourage its use.[195]

Just as the physical element of 'promoting or providing instruction' is likely made out if the material is sufficiently detailed, the fault element of intention would also appear to be satisfied in these circumstances, provided there is proof of the health practitioner's subjective intention. If the evidence showed a health practitioner only intended to facilitate their patient's access to medical options to which they are legally entitled, or to provide the patient with peace of mind that an option exists in the event that their pain later becomes unbearable, this intention would not be establishedGiven the possibility of criminal sanctions for breach of the *Code*, in our view, it would be prudent for doctors, VAD Care Navigators and other health practitioners to avoid providing patients with information about VAD medication, methods and procedures over the telephone or telehealth.[196]

Finally, any conversation in which a practitioner specifically suggests over a carriage service that VAD is a preferable option for a patient is at a higher risk of breaching the *Commonwealth Criminal Code,* with the risk elevating with the strength of the practitioner's

[193] *Commonwealth Criminal Code* (n 8) s 474.29A(2).
[194] See discussion above in Part V(B) at nn 167-168.
[195] Dawson J stated that 'to impart information which can be used … is necessarily to encourage its use if the recipient of the information is so inclined': *Langer v Commonwealth* (1996) 186 CLR 302, 326, cited in *Brown* (n 153) 241 (Heerey J). Dawson J further stated, 'If there is a line between imparting information with an intention to encourage its application and imparting information with an intention merely to inform it must (save where there is active discouragement) be a thin one': at 326. This was also the way the *Commonwealth Criminal Code* was interpreted when these offences were inserted in 2005: Evidence to Senate Legal and Constitutional Legislation Committee (n 10) 17 (Philip Nitschke), 21 (Brian Greig), 38 (Geoffrey Gray).
[196] A representative of the Attorney-General's Department told the Senate Committee inquiring into the Bill that 'If a doctor, in the course of that telephone communication, were to provide information about a method of suicide which encouraged the use of that method it would be caught': *Senate Report* (n 58) [3.52].

recommendation.[197] When communication suggesting VAD as an option reaches the point of encouraging or urging a patient to choose it, that would amount to counselling or inciting VAD.[198] If this included information about VAD methods, that would also likely meet the criteria for providing instruction or promoting suicide.[199] In both cases, the prosecution would need to prove beyond a reasonable doubt that the medical practitioner also had the subjective intention to counsel or incite the person to access VAD.

C *Assessing Eligibility for VAD via a Carriage Service*

In Victoria, the government contemplated eligibility assessments by medical practitioners (and, if necessary, consultations with other specialists or psychiatrists) would occur in person, and thus would not breach the *Commonwealth Criminal Code* provisions. However, the recent COVID-19 pandemic will likely necessitate that some now occur via telehealth. The Western Australian legislation makes explicit provision for eligibility assessment to occur via telehealth,[200] acknowledging problems of geographical remoteness from relevant qualified medical practitioners which exist in that state.[201] Despite this, during debate in the upper house, the Western Australian government conceded that due to conflict with the *Commonwealth Criminal Code*, eligibility assessments 'may need to be undertaken in person, with either the patient travelling to the practitioner or the practitioner travelling to the patient.'[202]

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[197] As noted above, in Victoria, medical practitioners and others are specifically prohibited from raising the topic of VAD: *VAD Act* (Vic) (n 21) s 8. However, a practitioner may potentially encourage a patient once they have raised the topic.
[198] Thereby breaching the *Commonwealth Criminal Code* (n 8) s 474.29A(1).
[199] In breach of the *Commonwealth Criminal Code* (n 8) s 474.29A(2).
[200] The *VAD Act* (WA) (n 17) s 158(2) specifically provides that a patient may make a request for VAD using audiovisual communication, and a medical practitioner may assess the person's eligibility and provide advice or information via telehealth where it is not practical to communicate in person.
[201] *WA Ministerial Expert Panel Report* (n 170).
[202] Western Australia, *Parliamentary Debates*, Legislative Council, 24 October 2019, 8293 (Stephen Dawson). See also Western Australia, Parliamentary Debates, Legislative Council, 29 October 8400 (Martin Aldridge); Western Australia, Parliamentary Debates, Legislative Council, 4 December 2019, 9846 (Stephen Dawson).

This conclusion may be an overly cautious interpretation of the *Code*. In our view, conducting a medical examination of a person, reviewing the person's clinical notes, evaluating decision-making capacity and verifying the person's residency do not constitute the transmission of 'material' which directly or indirectly counsels or incites suicide. Not only are these processes merely establishing relevant facts concerning the person, they do not involve the sending of material of the nature that attracts the *Commonwealth Criminal Code* prohibition.

However, communicating the outcome of the eligibility assessment is a separate consideration. Using a carriage service to advise the person that he or she meets the eligibility criteria for VAD may fall within the ambit of transmission of 'material'. Although the matter has not been settled, and legal advice provided on this point to the governments of Victoria and Western Australia is not publicly available, it seems unlikely that a medical practitioner who used a carriage service to communicate that a person is assessed as eligible for VAD would be considered to meet the physical element of 'counselling or inciting suicide' in the *Commonwealth Criminal Code*. Several factors contribute to this conclusion:

- eligibility assessment is an early step in the VAD process and one that is focused not on the provision of VAD but on a person's future ability to access it;
- both the coordinating and consulting medical practitioners are legally obliged to give the patient information which emphasises that the patient is under no obligation to proceed with VAD,[203] and that other treatment or palliative care options are available;[204] and

[203] *VAD Act* (Vic) (n 21) ss 19(1)(f), 28(1)(f); *VAD Act* (WA) (n 17) ss 27(1)(i), 38(1).
[204] *VAD Act* (Vic) (n 21) ss 19(1)(b)–(c), 28(1)(b)–(c); *VAD Act* (WA) (n 17) s 27(1)(c), 38(1).

- the legislation in both States expressly provides that a person is under no obligation to continue with the request and assessment process.[205]

Because of these cumulative requirements, it can persuasively be argued that the purpose of eligibility assessment is not to encourage or incite a person to access VAD,[206] but rather to evaluate whether the person meets strict legal criteria relating to age, terminal illness, capacity, voluntariness and residence.[207]

It may also plausibly be argued that a coordinating or consulting practitioner communicating that a person has met the eligibility criteria would not satisfy the fault elements for the offence under s 474.29A(1) of the *Commonwealth Criminal Code*. A medical practitioner could argue that communicating the result of the eligibility assessment was not intended to counsel or incite the person to access VAD, but was merely provided so the person can assess whether VAD is a viable option. If a medical practitioner did not possess the requisite intention, he or she would be able to communicate the results of eligibility assessments over the telephone or telehealth (if that were clinically appropriate), without breaching the *Commonwealth Criminal Code*.

The situation is more complex regarding the offence under s 474.29A(2) of the *Code*. As a VAD assessment is part of the VAD process, it is more likely that the coordinating or consulting practitioner would meet the criteria for providing instruction or promoting a particular method of suicide (that is, VAD).[208] Although a medical practitioner in the course of assessing a person for eligibility for VAD may not intend to promote VAD to that person, their assessment of the person as eligible and discussion of the next step in the VAD process

[205] *VAD Act* (Vic) (n 21) s 12; *VAD Act* (WA) (n 17) s 19.
[206] As required by the *Commonwealth Criminal Code* (n 8) s 474.29A(1).
[207] *VAD Act* (Vic) (n 21) s 16; *VAD Act* (WA) (n 17) s 24.
[208] In breach of the *Commonwealth Criminal Code* (n 8) s 474.29A(2).

may constitute evidence of an intention to provide instruction about a particular methods of suicide (VAD), as eligibility assessment is a required step in the VAD process. Given this possibility that communicating the results of a VAD assessment may contravene the Code, some doctors may out of an abundance of caution prefer not to take the risk of conducting an eligibility assessment via a carriage service.

D *Referral to Other Doctors or Specialists via a Carriage Service*

As described above, the VAD legislation sets out circumstances where referrals must be made to a consulting practitioner for a second eligibility assessment,[209] or to an appropriately trained registered health practitioner when a medical practitioner is uncertain if the patient meets the illness, capacity or (in Western Australia) voluntariness criteria.[210]

It is highly unlikely that an electronic referral from one doctor to another would have the purpose of counselling or inciting a person to access VAD, or meet the stipulated fault element of the relevant *Commonwealth Criminal Code* offence,[211] for a number of reasons:

- the communication itself occurs between two medical practitioners, not directly with the patient;
- the process does not directly or indirectly encourage (counsel or incite) a patient to access VAD; and
- it is unlikely that the doctor would intend the referral to encourage a patient to participate in VAD.

[209] *VAD Act* (Vic) (n 21) s 22; *VAD Act* (WA) (n 17) s 30.
[210] *VAD Act* (Vic) (n 21) ss 18, 27; *VAD Act* (WA) (n 17) ss 26, 37. In Western Australia, for assessments relating to voluntariness or coercion, that referral can be to 'another person [not necessarily a registered health practitioner] who has appropriate skills and training'.
[211] *Commonwealth Criminal Code* (n 8) s 474.29A(1).

The Western Australian government is also confident that providing a referral for VAD electronically would not breach the *Commonwealth Criminal Code*.[212]

E *Requesting a VAD Permit via a Carriage Service (Victoria Only)*

In Victoria, once the eligibility assessment is complete, the coordinating medical practitioner may apply for a VAD permit and this must be done via the online VAD Portal.[213] This is required before the VAD substance can be prescribed. While there are arguments both ways, it is unlikely but remains possible that a permit application could constitute a breach of the *Commonwealth Criminal Code*.

The argument that making a permit application does not breach section 474.29A(1) of the *Commonwealth Criminal Code* is that this step is merely an administrative process, analogous to referral to another doctor. In this sense, it is not an action which has the effect of directly or indirectly encouraging a patient to proceed with VAD. Three factors support this interpretation:

- the material is not transmitted to the person wishing to access VAD, but to an independent third party: a government body;
- following the eligibility assessment, the patient must make a formal request for VAD which is a necessary precondition for the doctor to apply for the VAD permit: the medical practitioner is responding to the patient's request, not encouraging the patient; and
- the legislative provisions state that even after a permit has been issued and the VAD medication has been prescribed and dispensed, a person is still free to choose other

[212] Western Australia, *Parliamentary Debates*, Legislative Assembly, 5 September 2019, 8280 (Stephen Dawson).
[213] *VAD Act* (Vic) (n 21) ss 43, 47, 48.

> options for treatment and care, and is under no obligation to proceed with VAD, therefore this is unlikely to satisfy the physical elements of the offences.[214]

The effect of obtaining a permit, then, is part of providing a range of options, rather than the specific encouragement of VAD.

However, there remains an argument that transmitting an electronic application for a VAD permit amounts to indirectly encouraging a person to avail themselves of VAD under s 474.29A(1) of the *Commonwealth Criminal Code*. A permit application is one of the final steps in the VAD process, occurring after a final request. It occurs at a point in the VAD process when the person is highly likely to access VAD. In this context, the coordinating practitioner applying for a VAD permit may be described as (at least indirectly) encouraging or facilitating the person to take up the option. It also may be argued that applying for a permit amounts to promoting VAD as a method of suicide under s 474.29A(2) of the *Commonwealth Criminal Code*, in the sense that a doctor applying for a permit advances the process by making a representation that the person concerned be granted permission to access VAD. Any prosecution would also need to prove that the coordinating medical practitioner possessed the requisite intention under both offences. Therefore, provided there is sufficient evidence of intention, it remains theoretically possible that applying for a permit could be interpreted to breach the *Code*.

F *Prescribing and Dispensing a VAD Substance via a Carriage Service*

The physical act of dispensing a VAD substance to a patient, contact person, or medical practitioner will take place in person — not via a carriage service — thus alleviating any risk of breaching the *Commonwealth Criminal Code*. However, it is conceivable that the

[214] See *VAD Act* (Vic) (n 21) ss 57(b), (d), 58(c).

information provided when prescribing or dispensing medication, or the prescription itself, may be transmitted electronically.[215] The VAD Acts set out a range of information that must be provided to the patient before prescribing,[216] and when dispensing,[217] a VAD substance.

The transmission of information to a patient regarding administration of the VAD substance via a carriage service probably constitutes promoting or providing instructions on methods of suicide, in contravention of the *Commonwealth Criminal Code*.[218] This is because the information contains very specific details concerning the VAD substance, and instructions on the methods of self-administration, which would directly provide instruction on a particular method of suicide.[219] Depending on how the communication is framed, arguably there would be evidence to satisfy the fault element in s 474.29A(2)(c) that the coordinating medical practitioner or pharmacist intended to provide instruction on that method of committing suicide. As a result, it is probable that when providing this information a doctor (when prescribing) and a pharmacist (when dispensing) may commit an offence under s 474.29A(2) of the *Commonwealth Criminal Code*. In addition, these same acts may also be considered to 'counsel or incite' suicide within the meaning of s 474.29A(1)(b). The fault element for this offence under s 474.29A(1)(c) might be more difficult to prove than merely intending to

[215] The provision of advice or information by a medical or health practitioner by electronic means is specifically contemplated in the *VAD Act* (WA) (n 17) s 158(3).
[216] At the prescription stage, the coordinating medical practitioner must inform the person how to self-administer the VAD substance, how to store it, what to do with an unfilled prescription, and how to dispose of any unused VAD substance: *VAD Act* (Vic) (n 21) s 57; *VAD Act* (WA) (n 17) s 69. In Western Australia, the coordinating practitioner must additionally inform the patient, contact person or agent collecting the medication what combination of poisons constitute the VAD substance, how to prepare the substance, the method by which the substance will be self-administered, the period within which the patient is likely to die after self-administration, and the potential risks of self-administration: *VAD Act* (WA) (n 17) ss 72(1), 69. Both Acts also require the patient to be given notice that they are under no obligation to self-administer the VAD substance: *VAD Act* (Vic) (n 21) s 57; *VAD Act* (WA) (n 17) s 69.
[217] Similar information is required to be provided at the time the medication is dispensed: *VAD Act* (Vic) (n 21) ss 58, 59; *VAD Act* (WA) (n 17) ss 72, 73.
[218] *Commonwealth Criminal Code* (n 8) ss 474.29A(2), 474.29A(1).
[219] *Commonwealth Criminal Code* (n 8) ss 474.29A(2)(b).

provide instruction, but still could be made out in the circumstances provided there is evidence of intent to counsel or incite committing suicide.

Transmitting the prescription itself electronically is also highly likely to breach the *Code*. Although the Victorian legislation contemplates a prescription being issued to the patient,[220] in practice, the coordinating medical practitioner provides it directly to a pharmacist in the Statewide Pharmacy Service.[221] In Western Australia, the coordinating practitioner must give the prescription directly to an authorised supplier.[222] Because the prescription document would contain some instructions on taking the medication (for example doses and in combination with other medications such as anti-nausea drugs), this is likely to be regarded as providing instructions on a method of suicide.[223] It would be difficult to argue that the coordinating practitioner does not also intend that the prescription instructions be used for that purpose. The risk of liability remains even though it is directed to the pharmacist rather than the patient, because the *Commonwealth Criminal Code* provisions include supplying material which is intended to be later used by another to commit suicide.[224]

However, liability for transmitting the prescription is less likely to meet the physical element under the 'counsel or incite' provision,[225] for three reasons:

- the prescription is communicated to the pharmacist, not to the patient;
- it may be considered an administrative process, analogous to an application for a VAD permit; and

[220] *VAD Act* (Vic) (n 21) ss 57(b), (e).
[221] 'Co-ordinating and consulting medical practitioner information', *Department of Health and Human Services, Victorian Government* (Web Page, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/coordinating-consulting-medical-practitioner-information>.
[222] *VAD Act* (WA) (n 17) ss 70(6), 79(2).
[223] This would constitute a breach of the *Commonwealth Criminal Code* (n 8) s 474.29A(2).
[224] Ibid s 474.29B.
[225] Ibid s 474.29A(1).

- the patient must again be notified, at both the prescription and dispensing stages, that there is no obligation to self-administer the substance.[226]

These factors in combination suggest that transmitting a prescription would not have the effect of directly or indirectly encouraging a person to commit suicide, but merely provides an end-of-life option. A contrary (and less compelling) argument, however, is that the electronic transfer of the prescription may be considered to indirectly encourage a person to proceed with VAD,[227] because it is the very step which authorises the dispensing of the VAD substance to the patient.

G *Reporting to the Review Board via a Carriage Service*

Both doctors (the coordinating and consulting medical practitioners) and pharmacists must report to the Board at every step in the assessment and administration process. In Victoria, these forms are submitted online through the VAD Portal. The Western Australian reporting process has not yet been decided. It is highly unlikely that submitting online forms would breach the *Commonwealth Criminal Code*. This is because, with the exception of the application for a VAD permit discussed above, the forms are submitted after the relevant conduct – eligibility assessment, prescribing, dispensing or administering a VAD medication – has occurred. The forms are also submitted to the Board, a government body, rather than communicating directly with the patient. The function of reporting is not to encourage conduct relating to VAD, but to report on conduct which has occurred relating to VAD.

[226] *VAD Act* (Vic) (n 21) ss 57(b), 57(d), 58(c); *VAD Act* (WA) (n 17) ss 69(2)(b), 69(2)(c), 72(2)(a).
[227] This would breach the *Commonwealth Criminal Code* (n 8) s 474.29A(1).

Table 2: When might actions pursuant to the VAD legislation undertaken via carriage service contravene the *Criminal Code Act 1995* (Cth)?

Section of this article	Action	Person(s)	*VAD Act* (Vic) Provision(s)	*VAD Act (*WA) Provision(s)	Likelihood of breaching the *Code*
VI(A)	Provide contact details of a VAD provider	VAD Care Navigator (as first point of contact)	N/A	N/A	Highly unlikely
VI(B)	Discuss VAD generally as one of a range of end-of-life options	Doctor; Other health practitioner; or VAD Care Navigator	N/A	N/A	Highly unlikely
VI(B)	Provide information about VAD as an option or information about specific methods of VAD	Doctor; Other health practitioner; or VAD Care Navigator	ss 19(1), 28(1)	ss 27(1), 38(1), 158(2)	Highly unlikely to possible, depending on the nature of the information and intention of the practitioner
VI(C)	Conduct eligibility assessment	Coordinating and consulting medical practitioners	ss 16, 25	ss 24, 30	Unlikely
VI(D)	Referral to other specialists for VAD consultations	Coordinating and/or consulting medical practitioner	s 22 (referral to consulting medical practitioner) ss 18, 27 (referral to specialist or psychiatrist when unable to determine eligibility)	s 30 (referral to consulting practitioner) ss 26, 37 (referral to specialist or psychiatrist when unable to determine eligibility)	Highly unlikely
VI(E)	Request a VAD Permit	Coordinating medical practitioner	s 43	N/A	Unlikely
VI(F)	Prescription of VAD substance and related processes	Coordinating medical practitioner	s 57	ss 69, 70	Highly likely
VI(F)	Processes relating to dispensing VAD substance	Pharmacist	s 58	s 72	Highly likely
VI(G)	Reporting required forms to Board	Coordinating and consulting medical practitioners, Pharmacist	ss 21, 30, 41, 49, 60, 63, 66	s 22, 33, 46, 50, 60	Highly unlikely

VII CONCLUSION

The foregoing analysis reveals that the interpretation of the *Commonwealth Criminal Code* is not settled, hence its interaction with the provisions of the *VAD Act* (Vic) and *VAD Act* (WA) is unclear. As a result, it is difficult to draw a clear 'line in the sand'[228] and state with confidence which communications concerning VAD in Victoria and Western Australia may be conducted electronically and which must be conducted face to face. A threshold issue which remains unresolved is whether the word 'suicide' in the *Commonwealth Criminal Code* applies where self-administered VAD medication is authorised under State legislation.[229] Assuming that it does, the likelihood of breaching the *Code* provisions relating to using a carriage service to promote or incite suicide will vary according to the conduct involved. The spectrum of risk will depend on the intersection of three domains: whether the communication involves the patient directly; the level of specificity of the information provided; and whether the communication occurs towards the beginning or end of the VAD process. Establishing breach of the *Code* also requires evidence of the health practitioner's subjective intention.

In relation to communication that involves the patient directly, Victoria has taken a conservative approach by requiring that all communications between patient and practitioner, or patient and VAD Care Navigator, must take place in person.[230] To some degree this is prudent, since the risk increases when the patient is directly involved. However, in our view, some communications with patients are highly unlikely to breach the *Commonwealth*

[228] The use of the phrase in this context is adopted from Western Australian Legislative Councillor Martin Aldridge: Western Australia, Parliamentary Debates, Legislative Council, 4 December 2019, 9844 (Martin Aldridge).
[229] See above Part IV(A).
[230] *VAD Guidance for Health Practitioners* (n 16) 4.

Criminal Code: in particular, providing contact details of a VAD provider,[231] and discussing VAD in general terms as one of a range of end-of-life options.[232] Conducting an eligibility assessment in neutral terms without advocating that a patient avail themselves of VAD is also unlikely to breach the *Code*[233] Further, most communications between practitioners (such as sending electronic referrals to the consulting practitioner, or a specialist to determine eligibility[234]), or with the Board (submitting the prescribed reporting forms via the VAD Portal in Victoria[235]) are highly unlikely to constitute an offence against the *Commonwealth Criminal Code*.[236]

The second domain is that the more concrete or specific the information provided, the greater the risk of committing an offence against the *Commonwealth Criminal Code*. So, for example, discussing VAD in general terms as one option among several at the end of life is highly unlikely to constitute an offence.[237] Providing information about specific methods of VAD may possibly constitute an offence,[238] and providing the detailed information required when prescribing or dispensing a VAD substance is highly likely to contravene the *Commonwealth Criminal Code* if done via electronic means of communication.[239]

The final domain concerns the point in the process at which communication occurs. Where a doctor does not encourage a patient to access VAD, but merely provides information and responds to the patient's concerns and requests, it is unlikely that conversations occurring early in the VAD process will infringe the *Commonwealth Criminal Code*.[240] The risk

[231] See above Part VI(A).
[232] See above Part VI(B).
[233] See above Part VI(C).
[234] See above Part VI(D).
[235] See above Part VI(G).
[236] An exception is the issuing of a prescription from the doctor to the pharmacist: See above Part VI(F).
[237] See above Part VI(B).
[238] Ibid.
[239] See above Part VI(F).
[240] The spectrum of risk ranges from highly unlikely to possible, depending on the nature of the information provided and the intention of the doctor: see above Part VI(C).

increases after the eligibility assessments, and conversations with a patient about the final request for administration, prescription and dispensing of the VAD substance are highly likely to need to occur in person to avoid breaching the *Code*.[241] The risk increases towards the end of the VAD process because the level of detail concerning the method of VAD increases. Therefore, it is more likely that transmitting the material would meet the physical elements of the offences — counselling or inciting suicide or promoting a method or providing instruction.

Finally, to establish the offences, there would need to be evidence of subjective intention to satisfy the respective fault elements. This would turn on the facts of each case, but in some circumstances, in particular prescribing or dispensing the VAD substance, it would be difficult to argue the practitioner did not intend to provide instructions for how to access VAD.

If telehealth is prohibited for VAD and in-person communication is needed, numerous practical issues arise. Firstly, there are significant financial and resource costs in funding travel for medical practitioners, VAD Care Navigators and/or patients, to conduct consultations and assessments in person, which may be borne by the State and by individuals. But there are also likely to be issues regarding access to VAD. People in a terminal stage of illness may be too sick to travel, and a specialist who can spare an hour for a consultation in their usual place of business may be less willing to devote additional time (hours or days) to travel to a remote area.[242] Further delays may occur where allied health practitioners or translators are unavailable at the same time as medical practitioners.[243] Delays are concerning

[241] See above Part VI(F).
[242] Tretyakov (n 17), 329. These concerns were also noted by the Voluntary Assisted Dying Review Board in Victoria: *VADRB Report* (n 34) 16 and Cameron McLaren, 'An Update on VAD: (Almost) A Year in Review' (Research Report, 16 June 2020), 2.
[243] In one case, it was reported that arranging all the required appointments for the VAD process took 6 months, and many times the interpreter did not attend or cancelled at the last minute: *VADRB Report* (n 34) 16.

in this context, where the people seeking access to VAD are often critically ill and in significant pain or suffering.[244] Concerns about criminal liability under the *Commonwealth Criminal Code* for performing functions which are lawful under State VAD laws lead to complex logistical arrangements which impair equality of access to VAD for people living in rural and regional areas and cause inefficiency and waste.

Certainty is needed about liability under the *Commonwealth Criminal Code* for using telephone or telehealth to communicate about VAD. Although the Western Australian government sought an undertaking that the Commonwealth would not prosecute acts done in accordance with State law,[245] the federal government failed to provide any reassurance for medical practitioners. As a matter of practice, it is unlikely that doctors or VAD Care Navigators will be prosecuted, and none have been to date.[246] While the Commonwealth Director of Public Prosecutions has discretion whether to prosecute (based on public interest considerations),[247] so long as an offence is technically committed under the *Commonwealth Criminal Code*, prosecution remains a possibility.

It is clearly an undesirable legal situation where the residual uncertainty surrounding the application of the *Commonwealth Criminal Code* to medical practitioners, and others acting in accordance with State VAD laws, depends on an exercise of prosecutorial discretion.[248]

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[244] The Voluntary Assisted Dying Review Board Report includes an anecdotal report of a woman in significant pain spending a long day travelling to a specialist appointment in Melbourne: *VADRB Report* (n 34) 16.
[245] Western Australia, *Parliamentary Debates*, Legislative Assembly, 3 September 2019, 6315, 6326 (Roger Cook).
[246] The then Victorian Health Minister Jenny Mikakos stated: 'I cannot imagine for a moment, any prosecutor worth their salt at the Commonwealth level wanting to proceed with this offence': Cunningham (n 15). See also Atlay (n 12).
[247] Ben White and Jocelyn Downie, 'Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide: Autonomy, Public Confidence and High Quality Decision-making' (2012) 36(2) *Melbourne University Law Review* 656. Factors which might affect the decision whether or not to prosecute include the relative triviality of the alleged offence; that the offence is of a 'technical' nature only; the effect on public confidence in the administration of justice; the obsolescence or obscurity of the law; whether a prosecution would bring the law into disrepute; and whether the alleged offence is of considerable public concern: Commonwealth Director of Public Prosecutions, *Prosecution Policy of the Commonwealth* (Policy Guidelines) [2.10] <https://www.cdpp.gov.au/sites/default/files/Prosecution%20Policy%20of%20the%20Commonwealth.pdf>.
[248] See also comments of Georgie Haysom, Head of Research Education and Advocacy at Avant, a medical indemnity insurer: Atlay (n 12).

Federal government action is needed to clarify this unsatisfactory legal position and provide reassurance for doctors that their conduct is lawful, by amending the *Commonwealth Criminal Code* to provide that actions carried out under state VAD Acts do not breach the *Code*. This can be achieved by inserting a definition declaring that '"suicide" does not include voluntary assisted dying carried out lawfully pursuant to a law of a State or Territory'.[249] Such an exemption would not impact the *Commonwealth Criminal Code* offences' application to pro-suicide websites.

Because this solution requires Commonwealth legislative action, which is likely to be slow if it happens at all, in the interim it would be highly desirable for the Commonwealth Director of Public Prosecutions to issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the *Commonwealth Criminal Code* will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in State VAD laws.[250] This would also provide the necessary clarity to enable doctors and other practitioners to use telehealth and other electronic methods of communicating where necessary and appropriate to provide VAD services. If the *Commonwealth Criminal Code* is not amended, and prosecutorial guidelines are not issued, health practitioners face an unenviable choice between risking possible prosecution or insisting on some communications occurring in person, often involving cost and/or harm to them, their patients and the health system.

[249] An alternative option is to insert an anti-exclusivity clause in the *Commonwealth Criminal Code* (n 8) s 474.29A, to the effect that 'This Division is not intended to exclude or limit the operation of any law of the Commonwealth or any law of a State or Territory concerning voluntary assisted dying'. However, in our view, there remains a risk that this will not exclude direct inconsistency between the *Commonwealth Criminal Code* and a State VAD Act: see above Part IV(B). Thus, this option may be ineffective to provide the necessary certainty that actions under a State VAD law will not breach the *Commonwealth Criminal Code*.

[250] There is precedent for guidelines being issued in relation to the circumstances of particular offences, including child sex tourism, people smuggling, and disclosure offences committed by journalists in their professional capacity: Commonwealth Director of Public Prosecutions, *CDPP's Relationship with the Attorney-General* (National Legal Directions, October 2019) <https://www.cdpp.gov.au/sites/default/files/NLD%20-%20CDPP%27s%20%20Relationship%20with%20the%20Attorney-General%20Oct%202019_2.pdf>.

Appendix – Carriage Service Provisions of the Commonwealth Criminal Code

474.29A Using a carriage service for suicide related material

(1) A person commits an offence if:

(a) the person:

(i) uses a carriage service to access material; or

(ii) uses a carriage service to cause material to be transmitted to the person; or

(iii) uses a carriage service to transmit material; or

(iv) uses a carriage service to make material available; or

(v) uses a carriage service to publish or otherwise distribute material; and

(b) the material directly or indirectly counsels or incites committing or attempting to commit suicide; and

(c) the person:

(i) intends to use the material to counsel or incite committing or attempting to commit suicide; or

(ii) intends that the material be used by another person to counsel or incite committing or attempting to commit suicide.

Penalty: 1,000 penalty units.

(2) A person commits an offence if:

(a) the person:

(i) uses a carriage service to access material; or

(ii) uses a carriage service to cause material to be transmitted to the person; or

(iii) uses a carriage service to transmit material; or

(iv) uses a carriage service to make material available; or

(v) uses a carriage service to publish or otherwise distribute material; and

(b) the material directly or indirectly:

(i) promotes a particular method of committing suicide; or

(ii) provides instruction on a particular method of committing suicide; and

(c) the person:

(i) intends to use the material to promote that method of committing suicide or provide instruction on that method of committing suicide; or

(ii) intends that the material be used by another person to promote that method of committing suicide or provide instruction on that method of committing suicide; or

(iii)intends the material to be used by another person to commit suicide.

Penalty: 1,000 penalty units.

(3) To avoid doubt, a person does not commit an offence against subsection (1) merely because the person uses a carriage service to:

(a) engage in public discussion or debate about euthanasia or suicide; or

(b) advocate reform of the law relating to euthanasia or suicide;

if the person does not:

(c) intend to use the material concerned to counsel or incite committing or attempting to commit suicide; or

(d) intend that the material concerned be used by another person to counsel or incite committing or attempting to commit suicide.

(4) To avoid doubt, a person does not commit an offence against subsection (2) merely because the person uses a carriage service to:

(a) engage in public discussion or debate about euthanasia or suicide; or

(b) advocate reform of the law relating to euthanasia or suicide;

if the person does not:

(c) intend to use the material concerned to promote a method of committing suicide or provide instruction on a method of committing suicide; or

(d) intend that the material concerned be used by another person to promote a method of committing suicide or provide instruction on a method of committing suicide; or

(e) intend the material concerned to be used by another person to commit suicide.

474.29B Possessing, controlling, producing, supplying or obtaining suicide related material for use through a carriage service

(1) A person commits an offence if:

(a) the person:

(i) has possession or control of material; or

(ii) produces, supplies or obtains material; and

(b) the material directly or indirectly:

(i) counsels or incites committing or attempting to commit suicide; or

(ii) promotes a particular method of committing suicide; or

(iii)provides instruction on a particular method of committing suicide; and

(c) the person has that possession or control, or engages in that production, supply or obtaining, with the intention that the material be used:

(i) by that person; or

(ii) by another person;

in committing an offence against section 474.29A (using a carriage service for suicide related material).

Penalty: 1,000 penalty units.

(2) A person may be found guilty of an offence against subsection (1) even if committing the offence against section 474.29A (using a carriage service for suicide related material) is impossible.

(3) It is not an offence to attempt to commit an offence against subsection (1).

21

End of Life Decision-Making, Advance Care Planning and Estate Planning During a Pandemic

Kelly Purser, Lindy Willmott, Ben White, Eliana Close and Tina Cockburn

In Belinda Bennett and Ian Freckelton (eds), *Pandemics, Public Health Emergencies and Government Powers* (The Federation Press 2021).

This book chapter explores issues associated with end of life decision-making in the context of the COVID-19 pandemic. This chapter specifically addresses the following issues:

1. withholding or withdrawing life-sustaining treatment, including rationing;
2. voluntary assisted dying;
3. advance care planning; and
4. financial decision-making, including enduring powers of attorney for financial and/or health matters and wills.

The chapter reflects on issues such as vulnerability, safeguards required to balance protection of the vulnerable with autonomy, witnessing requirements, technology, and access to end of life decision-making.

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SUICIDES, ASSISTED SUICIDES AND 'MERCY KILLINGS': WOULD VOLUNTARY ASSISTED DYING PREVENT THESE 'BAD DEATHS'?

Katrine Del Villar, Lindy Willmott and Ben White[1]

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Abstract

Voluntary assisted dying (VAD) has recently been legalised in Victoria, and legalisation is being considered in other Australian States. One argument advanced in favour of legalisation of VAD is that terminally and chronically ill people are committing suicide, or asking friends or relatives to assist them to die, because they feel that they have no alternative. This article evaluates whether the Voluntary Assisted Dying Act 2017 (Vic) will prevent these 'bad deaths' from occurring. The article evaluates two important sources of evidence: coronial evidence from Victoria and Western Australia concerning suicides in the chronically and terminally ill; and Australian cases on assisted suicide and "mercy killings". It concludes that many of these cases would not have met the eligibility criteria for VAD under the Victorian model, and thus 'bad deaths' will continue to occur.

Key words: suicide; assisted suicide; mercy killings; voluntary assisted dying; coronial data; criminal prosecutions; parliamentary debates; law reform

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SUICIDES, ASSISTED SUICIDES AND 'MERCY KILLINGS': WOULD VOLUNTARY ASSISTED DYING PREVENT THESE 'BAD DEATHS'?

I INTRODUCTION

Voluntary assisted dying ('VAD') is a topic of widespread debate in Australian parliaments, media and the community. There has been considerable media attention given to recent cases of individuals, such as 104 year old botanist Professor David Goodall,[2] and 54 year old firefighter Troy Thornton,[3] who chose to travel to Switzerland to end their lives.[4] There has also been media reporting of family members assisting terminally ill relatives to commit suicide. Most recently, in July 2019, Penelope Blume's husband was charged with assisting his wife,[5] who was terminally ill with motor neurone disease, to commit suicide, although the charges were later dropped by the prosecution on public interest grounds.[6]

Against the background of this ongoing media attention, parliamentary committees in five Australian jurisdictions[7] have recently considered or are in the process of considering whether to permit VAD. In

[2] David Goodall was not ill, but was frail, and tired of living: Charlotte Hamlyn and Lisa McGregor, 'David Goodall's Final Hour: An Appointment with Death', *ABC News* (online, 12 July 2018) <https://www.abc.net.au/news/2018-07-10/david-goodalls-appointment-with-death-and-his-final-hour/9935152>.

[3] Troy Thornton suffered from multiple systems atrophy: Tracey Ferrier, 'Australian firefighter Troy Thornton dies after lethal injection in Swiss clinic', *Sydney Morning Herald* (online, 23 February 2019) <https://www.smh.com.au/national/australian-firefighter-troy-thornton-dies-after-lethal-injection-in-swiss-clinic-20190223-p50zr9.html>.

[4] Dignitas statistics record that 27 Australians travelled to Dignitas between 2003–2017: Dignitas, *Accompanied Suicides per Year and Residence* (Report, 2017) <http://dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2017.pdf>. Other clinics in Switzerland also provide treatment to foreign residents.

[5] We adopt his description of their relationship, although the couple were not legally married.

[6] DPP (ACT), 'Police v O - CC2019/3260 Charge of Aiding Suicide under section 17(1) *Crimes Act 1900'*, (Media Release, 28 June 2019) <https://www.dpp.act.gov.au/__data/assets/pdf_file/0007/1382353/Police-v-O-DPP-Statement-of-Reasons.pdf> ('*Police v O*'). The provision of public reasons for this decision was unusual. For a discussion of prosecutorial discretion in this area, including the desirability of providing such reasons, see Ben White and Jocelyn Downie, 'Prosecutorial guidelines for voluntary euthanasia and assisted suicide: Autonomy, public confidence and high quality decision-making' (2012) 36 *Melbourne University Law Review* 656.

[7] Victoria, Western Australia, the Australian Capital Territory, Queensland and South Australia.

2017, following an extensive process of parliamentary inquiry and community consultation,[8] Victoria became the first Australian State[9] to enact legislation permitting VAD under strictly controlled conditions.[10] In December 2019, the Western Australian Parliament also legislated to authorise VAD,[11] following a similar process of a parliamentary committee of inquiry,[12] and recommendations of a Ministerial Expert Panel as to the content of such legislation.[13]. In the ACT, a parliamentary inquiry noted that, while unable to recommend legislation for constitutional reasons,[14] a majority of the committee supported considering legalising VAD in future should the constitutional position change.[15] At the time of writing, Queensland[16] and South Australia[17] are both conducting parliamentary reviews of end of life issues, including VAD.

One argument advanced in favour of legalising VAD is that legislation will prevent 'bad deaths': that is, people taking their own lives in 'desperate, determined and violent ways',[18] because they feel that

[8] A parliamentary committee of inquiry recommended the enactment of VAD legislation: Legal and Social Issues Committee, Parliament of Victoria Legislative Council, *Inquiry into end of life choices: Final Report* (Parliamentary Paper No 174, 9 June 2016) ('Victorian Committee Report'). A multidisciplinary Ministerial Advisory Panel provided expert advice on the form of the legislation: Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) ('Victorian Advisory Panel Report'). See also Margaret O'Connor et al, 'Documenting the process of developing the Victorian voluntary assisted dying legislation' (2018) 42 *Australian Health Review* 621.
[9] VAD was briefly legal in the Northern Territory, until the *Rights of the Terminally Ill Act 1995* (NT) was overturned by the Federal Government pursuant to its constitutional power to legislate for the territories: *Euthanasia Laws Act 1997* (Cth). The first attempt at law reform occurred in 1993, with the Voluntary and Natural Death Bill 1993 (ACT). Since then, over 60 Bills have been introduced in various Australian jurisdictions seeking to legalise assisted dying: Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser, and Andrew McGee "(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics" (2016) 39(1) *University of New South Wales Law Journal* 1.
[10] The *Voluntary Assisted Dying Act 2017* (Vic) ('Victorian Act') commenced on 19 June 2019.
[11] The *Voluntary Assisted Dying Act 2019* (WA) was enacted on 10 December 2019, and is expected to commence mid-2021.
[12] Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (First Report, 23 August 2018) ('WA Committee Report').
[13] Department of Health, Government of Western Australia, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, June 2019) ('WA Expert Panel Report').
[14] Select Committee on End of Life Choices, Parliament of the ACT, *Select Committee on End of Life Choices in the ACT* (Report, March 2019) 89.
[15] Ibid 94. For this to occur, the Commonwealth would need to repeal the *Euthanasia Laws Act 1997* (Cth).
[16] In Queensland, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the Queensland Parliament released an Issues Paper: Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Parliament, *Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying* (Paper No 3, 14 February 2019). The inquiry is due to report in March 2020.
[17] In South Australia, the Joint Committee on End of Life Choices was established on 4 April 2019, and received submissions until 2 August 2019: Parliament of South Australia, *End of Life Choices* (Web Page) <http://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=2&CId=366>.
[18] The phrase is Coroner Caitlin English's: Victorian Committee Report (n 7) 197.

they have no alternative but to commit suicide when faced with irremediable pain and suffering or irreversible physical decline. Both the Victorian and Western Australian parliamentary committees were deeply affected by coronial evidence, as well as anecdotal reports, of suicides committed by people with terminal illnesses or suffering physical pain or deterioration.[19] In many of these cases, the death is violent, and some are unsuccessful. In addition to these suicides, they were also influenced by the prospect of friends or relatives, in cases such as Penelope Blume's, facing criminal prosecution for unlawfully assisting a loved one to die.

This paper aims to evaluate whether, had VAD been legal, these terrible deaths – some in lonely isolation, and others exposing family members or friends to the risk of criminal prosecution – might have been prevented. As the Victorian Parliament's Legal and Social Issues Committee 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.'[20]

Section 2 of this paper outlines the claim that legalising VAD is necessary to prevent 'bad deaths', whether by suicide, assisted suicide or 'mercy killing'. Next, section 3 provides an overview of the circumstances in which VAD is permitted in Victoria under the *Voluntary Assisted Dying Act 2017* (Vic) ('Victorian Act'), and Western Australia under the *Voluntary Assisted Dying Act 2019* (WA) ('WA Act).

Sections 4 and 5 then test the claim whether the availability of VAD could address these bad deaths. These sections evaluate two important sources of evidence advanced in debates leading up to the Victorian Act and the WA Act. In section 4, the coronial evidence from Victoria and Western Australia relating to suicides in the chronically and terminally ill is summarised and compared with the criteria for eligibility requirements under the Victorian Act and the WA Act. Section 5 considers Australian cases on assisted suicide and 'mercy killings', and evaluates these cases against the

[19] Victorian Committee Report (n 7) 173–180, 193–200; WA Committee Report (n 11) 138–146.
[20] Victorian Committee Report (n 7) 200.

eligibility criteria in the Victorian Act and the WA Act. 'Mercy killing' is not a legal term, but refers to 'an intentional killing which is prima facie murder but which is carried out for compassionate motives, often by a member of the family or a friend of the victim'.[21] It encompasses both cases where the person has decision-making capacity and requests to die, and where the person does not request assistance to die, but the act intended to cause death is motivated by a desire to relieve the person's pain or suffering. These cases are generally prosecuted as murder, or sometimes manslaughter (where a mitigating factor such as diminished responsibility or a suicide pact is present).[22]

The paper concludes that many of these cases of suicide, assisted suicide and mercy killing would not be eligible for VAD under the Victorian or Western Australian models. This is for two main reasons: because people with a variety of illnesses - not just terminal illness - have requested assistance to die; and because of the prevalence of mercy killings when the person lacks capacity or does not request assistance to die. 'Bad deaths' therefore may continue to occur in Victoria and Western Australia despite their VAD legislation, and are also likely to persist in other Australian jurisdictions if similarly narrow VAD laws are enacted.

II THE NEED TO PREVENT 'BAD DEATHS'

It is sometimes suggested that legalising VAD is necessary to prevent terminally or chronically ill people from committing suicide,[23] or from asking friends or family to assist them in their wish to die. Writing in 1993, Margaret Otlowski stated:

[21] Otlowski, Margaret, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17 *Criminal Law Journal* 10, 10.

[22] In other cases, facts amounting to murder or attempted murder have been prosecuted as lesser offences, such as manslaughter or assisting suicide, according to plea bargaining principles or in the exercise of prosecutorial discretion: Ibid 16–18. See also Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17 *Journal of Law and Medicine* 532, 547.

[23] Studies of suicide in the medically and terminally ill, or in the elderly, have not generally suggested this. See Phillip Kleespies, Douglas Hughes and Fiona Gallacher, 'Suicide in the Medically and Terminally Ill: Psychological and Ethical Considerations' (2000) 56(9) *Journal of Clinical Psychology* 1153; Yu Wen Koo, Kairi Kõlves and Diego De Leo, 'Suicide in older adults: differences between the young-old, middle-old, and oldest old' (2017) 29(8) *International Psychogeriatrics* 1297; D Lawrence et al, 'Suicide and attempted suicide among older adults in Western Australia' (2000) 30(4) *Psychological Medicine* 813.

> [I]f active voluntary euthanasia and doctor-assisted suicide were legalised, many cases of mercy killing by family or friends would be unnecessary. In quite a number of the cases dealt with in this study the deceased was either terminally or incurably ill, had expressed a wish to die, and had requested assistance in bringing about death. The defendant's response in complying with that request was, in most instances, a desperate act, reluctantly performed in the absence of any other perceived alternatives … If medically administered euthanasia or assisted suicide were an option for terminal or incurable patients, the defendants in these cases would probably not have felt compelled to take the matter into their own hands.[24]

It is asserted that regulating VAD will allow these people a 'good death': that is, a painless and quick death at the time of their choosing, rather than resorting to a desperate and often unlawful act, with a significant risk of failure, which must either be performed in the absence of any support from friends or family, or runs the risk of criminal prosecution and conviction of those providing support or assistance. This perspective received support in the Victorian and Western Australian parliamentary committees, and during the parliamentary debates in Victoria and Western Australia.

A *Parliamentary committees*

Both committees referred to evidence that significant numbers of people in their States were dying 'bad deaths'. Two types of bad deaths identified. First, some people chose suicide rather than dying in pain (whether pain from a terminal and degenerating condition such as cancer, or from a chronic condition such as arthritis) or experiencing ongoing deterioration and loss of function from progressive conditions such as motor neurone disease or dementia.[25] Secondly, some people unlawfully sought the assistance of relatives to die rather than commit suicide alone.[26]

[24] Otlowski (n 20) 38–39.
[25] Victorian Committee Report (n 7) 197–200.
[26] Ibid 173–180.

1 *Suicides*

Coronial evidence was presented to both the Victorian and Western Australian parliamentary inquiries concerning suicides committed by people suffering terminal and chronic illnesses.[27] Many of these people were elderly and frail, and frequently ended their lives alone, in secret, often by drastic or violent means.[28] The Victorian committee cited 'particularly disturbing evidence that around 50 Victorians a year are taking their lives after experiencing an irreversible deterioration in physical health.'[29] Victorian Coroner John Olle expressed the opinion that palliative care or support services could not reduce these deaths and that only making VAD legally available would assist: '… the people we are talking about in this small cohort have made an absolute clear decision. They are determined. The only assistance that could be offered is to meet their wishes, not to prolong their life.'[30] The Victorian committee accepted the Coroner's opinion.[31]

Similarly, coronial information in Western Australia indicated that over 10% of suicides are committed by people with a terminal, chronic or neurological condition.[32] The Western Australian parliamentary committee opined that some of these suicides were preventable if VAD were available. Finding 33 of the committee's report stated that the 'prohibition of a peaceful, assisted death has driven some terminally or chronically ill individuals to suicide using violent means'.[33]

The Western Australian committee went further than the Victorian parliamentary committee. It found that some people with terminal or chronic illnesses are choosing to take their lives early for fear of

[27] Coronial data prepared for the Queensland parliamentary inquiry does not differentiate between terminal or chronic conditions: National Coronial Information System, 'DATA REPORT DR19-26 Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland, 2016–2017' (Report, July 2019) <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2018/AgedCareEOLPC/cor-23Jul2019.pdf>.
[28] Victorian Committee Report (n 7) 169. An extreme example is the elderly man who committed suicide using a nail gun: Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy). Similarly, the WA Committee found that several elderly people had died by hanging or gunshot wound, and one had ingested a fatal quantity of weed killer: WA Committee Report (n 11) 141–142.
[29] Victorian Committee Report (n 7) 197.
[30] Ibid 172.
[31] Ibid 200.
[32] 199 out of 1720, or 11.5%: WA Committee Report (n 11) 140.
[33] Ibid 146.

losing physical or mental capacity to do so at some later stage,[34] or after receiving an unfavourable diagnosis.[35] This argument has also been accepted by courts in Canada and New Zealand.[36] Internationally, evidence supports the claim that this does occur in a percentage of suicides every year,[37] although reliable data on this point is unavailable domestically.

Police and coroners also reported community perceptions that some suicides in cases of terminal and incurable illness occur because VAD is not a lawful option. Victorian Coroner Caitlyn English referred to a case where a 93-year-old woman with crippling arthritis and back pain slit her wrists after she was admitted to an aged-care facility 'and she died of exsanguination with her arm dangling over the toilet bowl'.[38] Her daughter's view, which the Coroner found 'very compelling' was that there should be 'a better way that their loved ones did not have to die in such violent circumstances and alone.'[39] Acting Commander of the Victorian Police, Rod Wilson, also described the 'desperation' and 'frustration' felt by family that their loved ones were forced to commit suicide in violent, lonely circumstances because there was no alternative.[40]

2 *Assisted suicides and mercy killings*

The Victorian committee also detailed a number of Victorian cases where family or friends had been prosecuted for killing or assisting a loved one to die. It noted that a consistent theme of the cases is the 'remarkable degree of leniency shown to offenders, even though there was a clear violation of the criminal law'.[41] Unlike Otlowski, the Victorian committee stopped short of explicitly recommending VAD as a mechanism to render these cases unnecessary. However, the Committee did note the

[34] Finding 34, ibid xxiv. See also ibid 144–145.
[35] For example, William Philip gave evidence about his wife's attempt to commit suicide by overdose of prescription morphine when she received her diagnosis of adenoma: ibid 142–143.
[36] See *Seales v A-G* [2015] 3 NZLR 556, [29] (Collins J); *Carter v Canada (Attorney General)* [2012] BCSC 886, [1322] (Lynn Smith J); *Carter v Canada (Attorney General)* [2015] 1 SCR 33, [57]–[58].
[37] *Seales v A-G* (n 34) [51]–[52] (Collins J); *R (on the application of Nicklinson and another) v Ministry of Justice* [2015] AC 657, [14] (Lord Neuberger).
[38] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 7 (Caitlin English, Coroner).
[39] Ibid.
[40] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 15 (Rod Wilson, Acting Commander, Victorian Police).
[41] Victorian Committee Report (n 7) 173.

unsuitability of the law to achieve a just outcome in cases of mercy killings,[42] and questioned whether the law 'reflects the contemporary values of the Victorian community'.[43]

The Western Australian parliamentary committee's report did not expressly address mercy killing cases, possibly because—unlike Victoria—no cases of mercy killing have been reported in the last 20 years in that State.

B *Parliamentary debates*

Perhaps because of the coronial evidence and the findings of the parliamentary committees, these 'bad deaths' were considered at length during both the Victorian and Western Australian parliamentary debates.

1 *Suicides*

During debate on the Voluntary Assisted Dying Bill 2017 (Vic), numerous Members of Parliament ('MPs') mentioned terrible examples of individuals who had committed suicide rather than endure terminal or chronic illness.[44] Some were personally known to the MPs, others were told to them by constituents, and still others came from media reports or the evidence of the coroners. A particularly tragic example, mentioned by several MPs, was the case of a 90 year old man with brain cancer who killed himself with a nail gun.[45]

In Western Australia, a similar theme of suicide in the terminally and chronically ill was prominent in the parliamentary debate.[46] In particular, many MPs referred to the death of Clive Deverall, the former president of the Cancer Council of Western Australia, and a long-term sufferer of non-

[42] Ibid 176.
[43] Ibid.
[44] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy); 3056 (Daniel Andrews, Premier); 3081 (Martin Foley).
[45] Ibid 3054 (Emma Kealy); 3056 (Daniel Andrews, Premier); Victoria, *Parliamentary Debates*, Legislative Assembly, 18 October 2017, 3230–3231 (David Morris).
[46] See, eg, Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 5988–5989 (Mark McGowan, Premier); 6069 (Lisa Baker); 6076 (Matthew Hughes); 29 August 2019, 6139 (Yaz Mubarakai); 6158 (Jessica Shaw); 3 September 2019, 6313 (Roger Cook).

Hodgkin's lymphoma, who committed suicide on the day of the Western Australian election in 2017, making the statement 'suicide is legal, euthanasia is not'.[47] Several MPs commented that they were supporting the WA Bill in honour of Deverall's memory.[48]

Some MPs in both States had personal experience as emergency first responders attending the suicides of people with terminal and chronic illnesses. The Victorian member for Frankston, Mr Edbrooke, spoke of his personal experience serving as a firefighter, and attending trauma scenes of botched suicide attempts by terminally ill people. His evidence was graphic and compelling:

> They have lungs filled with fluid and are at risk of drowning in their own fluids. They have been unable to take a breath for a long time and are literally suffocating. They may be a fraction of their former weight. They may be in unimaginable pain and unmanageable pain. These are people begging their families to help them die, starving themselves to death over a month, stopping their dialysis or hoarding tablets to take a lethal dose.[49]

In Western Australia, Mr Folkard, the member for Burns Beach and a former senior police officer, similarly stated he had attended so many deaths over the years relating to chronic illness that they were too numerous to quantify: 'I have seen simple suicides after individuals have been advised that they have a terminal illness. Some have jumped in front of trains. I have even been to situations in which individuals have created complicated machines and used them to take their own lives.'[50]

The coronial evidence and anecdotal reports of suicide among terminally ill people deeply affected many MPs and influenced their desire to legalise VAD.[51] As member for Williamstown, Mr Noonan, stated: 'I cannot accept in those circumstances that maintaining the status quo, whilst people with

[47] Claire Moodie, 'Cancer pioneer Clive Deverall's death puts spotlight on voluntary euthanasia laws', *ABC News* (online, 22 March 2017) <https://www.abc.net.au/news/2017-03-22/cancer-pioneer-clive-deveralls-death-spotlight-on-euthanasia/8376890>.
[48] Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 5995 (John McGrath); 5989 (Mark McGowan, Premier); 6073 (Simone McGurk); 29 August 2019, 6093 (John Quigley); 6106 (Peter Rundle); 6138 (Yaz Mubarakai).
[49] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3133 (Paul Edbrooke). The member for Gippsland East had heard similar stories from police and paramedics: at 3135 (Timothy Bull).
[50] Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6132 (Mark Folkard).
[51] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3100 (Janice Edwards). See also at 3118 (Marsha Thomson).

incurable health conditions are killing themselves at a rate of one a week, is in any way acceptable. … The only sensible conclusion to draw from this is that the end-of-life care legal framework must be changed.'[52]

Several MPs, both in Victoria and Western Australia, made a clear link with VAD laws, which would prevent these types of desperate suicides, and give an individual the option 'to die peacefully at a time of his [sic] choosing, surrounded by loved ones and on his own terms'.[53] Some appeared to erroneously believe that all the suicides referred to by the coroners were of people with terminal illness who would be eligible for VAD,[54] whereas in fact these statistics (as will be discussed in section 4 below) included people who were both terminally and chronically ill (the latter not being eligible).

Not all MPs made the same link between these deaths and VAD. A smaller number of MPs considered the coronial evidence showed a problem with other underlying issues, such as mental illness,[55] loneliness and isolation,[56] inability to pursue enjoyable activities,[57] or chronic and unrelieved pain.[58] The member for Burwood, Mr Watt, was concerned about the use of suicide statistics to justify VAD, and observed that less than half of the suicides referred to by the coroners involved people with terminal illness.[59]

[52] Ibid 3097 (Wade Noonan).
[53] Ibid 3069 (Gabrielle Williams); 3097 (Wade Noonan); 3132 (Timothy McCurdy); 3118 (Marsha Thomson). Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6095 (Donald Redman) 6109 (Lisa O'Malley); 6110 (Amber-Jade Sanderson); 6134 (Cassandra Rowe); 3 September 2019, 6310 (David Michael).
[54] Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 6069 (Lisa Baker); 6076 (Matthew Hughes); 29 August 2019, 6114 (Elizabeth Mettam); 3 September 2019, 6283 (Antonio Krsticevic).
[55] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3088 (Graham Watt).
[56] Ibid.
[57] Ibid.
[58] Ibid 3058 (Robert Clark). See also at 3088 (Graham Watt).
[59] Mr Watt observed that 119 of 240 relevant Victorian suicides between 2009 and 2013 had chronic health issues or pain, but were not terminally ill:

> Of the remaining 121 with cancer or degenerative brain disorders, it is unclear how many had a prognosis of 12 months or less to live at the time of their suicide. So perhaps 24 suicides per year were of terminally ill Victorians. The Minister for Health should be careful about her facts on such an important issue. She has at least doubled the numbers in her count.

Ibid 3087 (Graham Watt).

2 *Assisted suicides and mercy killings*

Some MPs also mentioned people who were assisted to die by family members or medical professionals outside the law. 'There are people who are having all kinds of interventions by untrained family members, by doctors acting in a way that they would rather not and by nursing staff to take their lives in ways not contemplated by this Parliament and without any of the safeguards.'[60]

In Western Australia, Mr Folkard, the member for Burns Beach, stated that as a senior police officer, he had attended

> countless sudden death scenes that related to people passing from chronic illness. ... I have attended murder-suicides where partners have killed sick loved ones and then taken their own lives. I have attended scenes when partners have attempted to kill their sick loved ones and then taken their own lives, but have failed in taking the life of the sick partner, resulting in that partner dying in loneliness. I have attended scenes at which a partner has taken the life of a sick loved one but has been unsuccessful in taking their own life and has become nothing more than a living vegetable.[61]

Although there are no reported cases of people being prosecuted for their part in these murder-suicides in Western Australia, this evidence demonstrates that mercy killings are occurring in that State as they are in other States where prosecutions are recorded.

Many MPs felt that regulating VAD was a preferable way to 'monitor and manage this existing practice [of VAD]'.[62] This sentiment is best expressed in the submission of Dr Julia Anaf, who stated:

> Pre-emptive suicide, often by horrendous means, and so-called 'mercy killings' are both tragic consequences of the legal status-quo, and are an indictment on a civilised society. Until the law is changed there is a terrible legacy; both for the patient and their loved ones who face a complicated grief process.[63]

[60] Ibid 3060 (Martin Pakula, Attorney-General); 3062 (Samuel Hibbins).
[61] Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6132 (Mark Folkard).
[62] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy).
[63] Dr Julia Anaf, personal submission, quoted in Victorian Committee Report (n 7) 197.

III ELIGIBILITY AND VOLUNTARINESS REQUIREMENTS FOR VAD

In Victoria and Western Australia, VAD is (or will be) lawful in a narrow set of circumstances. As outlined in more detail below, a person must be an adult,[64] with decision-making capacity,[65] who is a resident of the State[66] and has a condition that is advanced, progressive and will cause death within six months or 12 months for a neurodegenerative condition.[67] In Victoria, the condition is also required to be 'incurable'.[68] The condition must also cause suffering that cannot be relieved in a way that the person considers tolerable.[69] In addition to being eligible, the person must make a voluntary request for assistance to die.[70] Providing assistance to a person with capacity who has not requested it, or who lacks capacity, is not permitted, and remains a criminal offence in all jurisdictions.[71]

Although the primary mode of death authorised under the Victorian Act is self-administration by the person,[72] administration of a lethal substance by a medical practitioner is also lawful if the person lacks the ability to physically ingest or swallow a lethal medication themselves.[73] The term VAD encompasses both of these practices. The WA Act also proposes self-administration as the default approach but more readily permits administration by a medical practitioner on grounds that self-administration would be considered 'inappropriate'.[74]

[64] Victorian Act s 9(1)(a); WA Act s 16(1)(a).
[65] Victorian Act s 9(1)(c); WA Act s 16(1)(d).
[66] Victorian Act s 9(1)(b); WA Act s 16(1)(b).
[67] Victorian Act s 9(1)(d), 9(4); WA Act s 16(1)(c)(i) and (ii).
[68] Victorian Act s 9(1)(d)(i).
[69] Victorian Act s 9(1)(d)(iv); WA Act s 16(1)(c)(iii).
[70] Victorian Act ss 20(1)(c), 29(1)(c), s 65(2)(a)(ii), 66(1)(c); WA Act s 16(1)(e).
[71] In both Victoria and Western Australia, intentional killing of another person is murder: *Crimes Act 1958* (Vic) s 3; *Criminal Code Act 1913* (WA), s 279(4). However, it may be prosecuted as manslaughter if extenuating circumstances, such as diminished responsibility, exist: *Crimes Act 1958* (Vic) s 5; *Criminal Code Act 1913* (WA), s 280(1). In Victoria, the specific statutory crime of manslaughter by suicide pact also exists: *Crimes Act 1958* (Vic) ss 6B(1), 6B(1A).
[72] Victorian Act ss 45, 47.
[73] Referred to as 'practitioner administration': Victorian Act ss 46, 48.
[74] WA Act s 56(2).

A *Eligibility requirements*

1 *Adult*

Only a person aged 18 years or over is eligible to access VAD in Victoria or Western Australia.[75]

2 *Capacity*

To be eligible, a person must have decision-making capacity specifically in relation to VAD.[76] In Victoria, decision-making capacity is defined as comprising four abilities: to understand relevant information, to retain that information for the purposes of making a decision about VAD, to use or weigh that information in making a decision, and to communicate the decision.[77] In Western Australia, the criteria are broadly similar, although there is no explicit requirement to retain information to make a decision about VAD.[78]

3 *Condition is incurable, advanced, progressive and will cause death*

The Victorian Act permits a person to receive assistance to die if the person has an incurable disease, illness or medical condition that is advanced, progressive and is expected to cause death within six months.[79] The WA Act follows the Victorian approach but does not require the condition to be incurable.[80] The timeframe to death is extended in both models to 12 months for neurodegenerative conditions.[81]

Disability and mental illness alone are not grounds to request VAD,[82] but a person with a disability or mental illness who is also suffering from a terminal medical condition may be eligible for VAD if he or she meets the other eligibility criteria.

[75] Victorian Act s 9(1)(a); WA Act s 16(1)(a).
[76] Victorian Act s 9(1)(c); WA Act s 16(1)(d).
[77] Victorian Act s 4(1).
[78] The WA Act also sets out in more detail the information and matters that must be understood: WA Act s 6(2).
[79] Victorian Act s 9(1)(d).
[80] WA Act s 16(1)(c)(i) and (ii).
[81] Victorian Act s 9(4); WA Act s 16(1)(c)(ii).
[82] Victorian Act s 9(2)-(3); WA Act s 16(2).

4 *Suffering*

Both the Victorian Act and the WA Act require that the person must be experiencing suffering caused by the condition that cannot be relieved in a manner that the person considers tolerable.[83] Whether this eligibility requirement would have been met in the cases of suicides, assisted suicide or mercy killing considered in sections 4 and 5 will not be discussed further in this paper. That is, we will consider whether the other VAD eligibility requirements would be met *on the assumption that the person is experiencing intolerable suffering*. We take this approach for two reasons. Firstly, it is reasonable to assume that a person who chooses to suicide in the circumstances discussed in section 4 would be suffering, as they would not otherwise take such action. The same assumption is reasonable for cases of assisting a suicide. For cases of mercy killing, the accused would have at the very least perceived the person to be suffering, although the authors accept that this perception may not correspond to the person's actual suffering. Secondly, and more importantly, it is not possible to make a categorical determination of whether intolerable suffering was present in the suicide, assisted suicide, or mercy killing cases, as such determinations were not needed from the coronial review or in the criminal law cases.

5 *Residence requirement*

A final criterion under both the Victorian Act and the WA Act is that the person requesting VAD must have been ordinarily resident in the State for at least 12 months before making the first request.[84] The residence requirement raises issues which are distinct from the central argument of this paper, so will not be discussed further.

B *Voluntary request for VAD*

Even if the person is eligible to access VAD under the Victorian Act or WA Act, the person must make a voluntary request for assistance to die. Under the Victorian model, each medical practitioner

[83] Victorian Act s 9(1)(d)(iv); WA Act s 16(1)(c)(iii).
[84] Victorian Act s 9(1)(b); WA Act s 16(1)(b).

assessing a person's eligibility must certify that the request was made 'voluntarily and without coercion'.[85] A medical practitioner administering VAD must also certify that the request for practitioner administration was made voluntarily and without coercion.[86] In Western Australia, this requirement of voluntariness is specifically included as part of the eligibility criteria.[87]

IV SUICIDES IN THE TERMINALLY AND CHRONICALLY ILL

As mentioned, evidence was presented to both the Victorian and Western Australian parliamentary committees concerning suicides committed by terminally and chronically ill people. The Victorian and Western Australian Coroners provided statistical estimates of the scale of the problem, broken down according to the condition from which the person was suffering. The Coroners also provided case reports detailing the circumstances of particular cases, to provide a human context for the problem. This was supplemented by reports from individual relatives and friends recounting the suicides of loved ones. This section considers that evidence and whether the cases reported would be eligible for access to VAD under the Victorian and Western Australian models outlined above.

At the outset, it is important to note that this analysis is inevitably limited, because it depends on the Coroners' summaries of cases, and statistics prepared by the Coroners and their researchers. Without access to coronial files, this analysis can only be partial and conclusions can only be tentative. The following analysis depends on two data sets from Victoria and one data set from Western Australia, each of which was generated by researchers by reference to their own guidelines. The publicly available data includes the Coroners' submissions to the Parliamentary committees in both Victoria[88]

[85] Victorian Act ss 20(1)(c), 29(1)(c).
[86] Victorian Act s 66(1)(c). For practitioner administration, the independent witness must also attest that the request for VAD was made voluntarily and without coercion: Victorian Act s 65(2)(a)(ii).
[87] WA Act s 16(1)(e).
[88] Coroner's Court of Victoria, Submission No 755 to Legal and Social Issues Committee, *Inquiry into End of Life Choices* (26 August 2015) ('Victorian Coroner's Court Submission 755'); Coroner's Court of Victoria, Submission No 1037 to Legal and Social Issues Committee, *Inquiry into End of Life Choices* (20 May 2016) ('Victorian Coroner's Court Submission 1037').

and Western Australia;[89] and the oral evidence given by Coroners to the committees.[90] The data are not directly comparable across jurisdictions, and indeed, there are inconsistencies evident even within a jurisdiction.[91] Nonetheless, this analysis is important, because the publicly available summaries of the coronial data were relied on by many members of Parliament in reaching the conclusion that law reform to permit VAD was necessary and desirable.[92]

A *Victoria*

In Victoria, the Coroners Prevention Unit, an internal research group within the Coroners Court, conducted an analysis of all suicides between 2009 and 2012. The data was prepared at the request of Coroner Caitlin English, who had carriage of a number of suicide cases where the deceased experienced an irreversible decline in physical health.[93] The Coroner did offer to make full versions of the findings in all these cases available to the committee, but this offer was not taken up.[94] Supplementary summary statistics were later prepared by the Coroners Prevention Unit at the request of the parliamentary committee, after two of the Coroners gave oral evidence before the committee.[95]

The initial data from 2009-2012 identified a cohort of suicides committed by people suffering "irreversible deterioration in physical health".[96] The criteria for inclusion were:[97]

[89] Coroner's Court of Western Australia, Submission to Joint Select Committee on End of Life Choices, Parliament of Western Australia*, Questions on Notice from Public Hearing* (11 April 2018) ('Coroner's Court of Western Australia Submission').
[90] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015; Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018.
[91] An example of this is that the National Coronial Information Service initially reported that 240 cases over the period 1 January 2012 to 5 November 2017 involved a terminal or debilitating illness: National Coronial Information Service, *Intentional Self-harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012–2017* (Coronial Report: CR17-61, 6 November 2017) 4 ('NCIS Nov 2017'). It later reported that 41 cases were erroneously included, and there were in fact 199 cases which involved either a terminal or debilitating illness: National Coronial Information Service, *Intentional Self-harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012–2017* (Coronial Report: CR17-61.1, 24 May 2018) ('NCIS May 2018').
[92] See section 2 above.
[93] Victorian Coroner's Court Submission 755 (n 88) 3. The research was requested to assist in making a submission to the inquiry: ibid 6.
[94] Ibid, 5.
[95] Victorian Coroner's Court Submission 1037 (n 88) 1.
[96] This term was not defined in the Coroner's submissions, but the inclusion and exclusion criteria provide some indication of the scope of the term.
[97] Victorian Coroner's Court Submission 755 (n 88) 3.

- Deterioration in physical health as a result of a diagnosed terminal disease (the period of time considered to be 'terminal' was not specified);
- Deterioration in physical health as a result of an incurable chronic disease that was not expected to cause death; and
- Permanent physical incapacity and pain, as a result of an injury, that could not be relieved.

Cases were excluded where:[98]

- the deterioration in physical health was a symptom or manifestation of mental ill health;
- there was insufficient evidence to conclude the disease was incurable;
- there was insufficient evidence to conclude that the deterioration was irreversible; or
- the deceased was elderly and feared future loss of independence, isolation or deterioration, but there was insufficient evidence to conclude that the deterioration had already occurred.

There were 197 of these cases, representing 8.6% of suicides over that period.[99] Table 1 summarises the information provided by the Victorian Coroner.

Table 1: Victorian suicides for irreversible physical decline 2009–2012[100]

Percentage of suicides[101]	**Condition**	**Examples**
40%	Cancer	
24%	Multiple medical interrelated issues which are incurable and deteriorating	• heart disease, prostate issues and lumbar spinal osteoarthritis • diabetes, stroke, hypertension and heart disease

[98] Ibid 3-4.
[99] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 3 (John Olle, Coroner).
[100] Ibid 5 (Dr Jeremy Dwyer). Dr Dwyer leads the Coroners Prevention Unit, a specialist research unit within the Coroners Court of Victoria.
[101] Dr Dwyer divided these suicides into physical illness (80%) and physical injury (20%), then subdivided the cases of physical illness into 50% cancer cases, 30% with multiple medical issues, 15% incurable conditions and 5% unrelievable pain. We have re-calculated these numbers as a percentage of the total number of suicides attributable to irreversible decline, whether from physical illness or physical injury, which accounts for the divergence from Dr Dwyer's figures.

		• breast cancer, hypertension, spondylosis, pancreatic cyst and shingles
12%	Advanced and incurable conditions	• cerebral palsy • Parkinson's disease • multiple sclerosis • muscular dystrophy • degenerative brain and nerve disorders
4%	Unrelievable pain disorders	
20%	Major physical injury followed by long-term slow decline in quality of life	• motor vehicle accident • workplace injury

The Coroners Prevention Unit provided a supplementary submission to update this information to include cases from 2013 (making a total of 240 deaths from irreversible physical decline between 2009 and 2013).[102] Unfortunately the presentation of the data does not allow for Table 1 to be updated, but information was provided about means of death for this updated cohort. The greatest number, approximately one third, of these deaths occurred by poisoning due to drug overdose,[103] but many of these deaths occurred by violent methods, such as hanging,[104] gunshot wound, or stabbing. Nineteen deaths occurred by a threat to breathing, most of which used the 'Exit bag method championed by Exit International, usually using helium or nitrogen as the irrespirable atmosphere'.[105]

B *Western Australia*

The Western Australian Coroner also provided a report in relation to suicides in Western Australia where the deceased had a 'terminal or debilitating illness'.[106] This report was prepared by the National Coronial Information System (NCIS), an independent national repository of coronial data, at the request of the State Coroner, to assist in the preparation of a submission to the parliamentary

[102] Victorian Coroner's Court Submission 1037 (n 88) 4.
[103] 74 deaths out of 240: ibid 6. See also Victorian Committee Report (n 7) 171–2.
[104] 64 out of 240: Victorian Coroner's Court Submission 1037 (n 88) 6.
[105] Ibid 5.
[106] NCIS May 2018 (n 91). Neither the term 'terminal' nor the term 'debilitating' is defined in the NCIS report, so it is unclear what criteria the researchers used to include or exclude cases on this basis.

inquiry.[107] Cases were identified for manual screening by searching 37 key words, most of which were specific physical or mental conditions (such as cancer, tumour, bipolar, or schizophrenia).[108] The criteria for inclusion or exclusion by the researcher conducting the manual screening were not specified. However, cases were excluded where the suicide was primarily as a result of a mental illness rather than a physical illness.[109]

Based on the report of 199 cases over a period of nearly 6 years, the parliamentary committee estimated that approximately 10% of all suicides in Western Australia are committed by persons suffering from a terminal or debilitating illness.[110]

Suicides occurred in relation to a variety of conditions, and many people suffered from multiple physical conditions. Those most commonly represented were the same as in Victoria, although in different proportions, namely:

- cancer, in approximately 21% of cases (42/199)
- cardiovascular disease, in approximately 32% of cases (64/199)
- diabetes, in approximately 14% of cases (28/199)
- arthritis, in approximately 12% of cases (23/199), and
- Parkinson's disease, in approximately 5% of cases (10/199).[111]

In 100 cases, the deceased person experienced a noted physical decline prior to their death. Of these cases, 48% were considered to be suffering from a terminal condition,[112] whereas 52% had a debilitating but not terminal condition.[113] Of the 99 cases in which there was no physical decline

[107] NCIS Nov 2017 (n 91) 2.
[108] Ibid 3.
[109] Ibid 4. The NCIS noted that in some cases where the deceased had both a physical and a mental illness, it was difficult for the researcher to identify which condition made a more significant contribution to a person's suicide: ibid 4; NCIS May 2018 (n 91) 5. Although this inevitably affects the reliability of the numerical data, it does not significantly impact the qualitative conclusions.
[110] WA Committee Report (n 11) 140.
[111] NCIS May 2018 (n 91) 3. Although the NCIS data are reported as a proportion of 240 cases, 41 cases were erroneously included which involved neither a terminal nor a debilitating illness. The figures provided above are a proportion of the 199 cases which involved either a terminal or debilitating illness. It should also be observed that these statistics are significantly different from those presented in the original NCIS report: NCIS November 2017 (n 91) 4.
[112]NCIS May 2018 (n 91) 8.
[113] Ibid 9.

evident prior to suicide, no breakdown as to the proportion of people suffering from a terminal condition is provided.

As in Victoria, these deaths were carried out by a variety of means, predominantly poisoning (including 17 cases using pentobarbitone),[114] Nineteen cases of plastic bag asphyxiation,[115] and more violent means such as hanging, gunshot, knife injuries, carbon monoxide poisoning and fire related deaths.[116]

C *Will VAD laws prevent these suicides?*

The evidence presented to the parliamentary committees suggests that a significant number of terminally or chronically ill people are committing suicide because they perceive no other alternative is available. However, it is important to consider whether the Victorian Act or the WA Act will address these concerns. While it is difficult to conclusively answer this question, given the incomplete set of publicly available data mentioned earlier, the analysis below suggests that the VAD system may be less effective in reducing suicides than some may have contemplated.

Some of the eligibility criteria would appear to be met. All of the cases of suicide in those with terminal or debilitating illness reported on by the Victorian and Western Australian Coroners involved adults. The decision to commit suicide in each case appeared to be voluntary and not the subject of coercion: indeed, the suicide was often (but not always) an unwelcome shock to those closest to the deceased. Although some of those committing suicide experienced mental illness in addition to their physical conditions, there is no evidence that the mental illness was such as to compromise the decision-making capacity of the deceased or the voluntariness of the decision. Both the Victorian and

[114] 19 cases involving pentobarbitone were manually counted, but two (cases 13 and 25) were excluded as not involving terminal or debilitating illness: ibid.
[115] Table 3 states that 17 cases involved plastic bag asphyxiation, but a manual search of the case summaries reveals 20 cases, of which case 41 was excluded as the person did not have a terminal or debilitating illness.
[116] See generally Table 3: NCIS May 2018 (n 91) 7. Note, however, that these figures include the 41 cases erroneously included (see n 91).

Western Australian data sets employed case selection criteria which specifically excluded cases of suicide where mental illness was a dominant factor.[117]

However, many of these people would not qualify for VAD because they did not have a terminal illness. In Western Australia, of 100 cases involving a person whose physical condition was noted to have declined prior to suicide, less than half had a terminal condition. (In this regard, the authors note that the phrase 'terminal illness' was not defined, so it is unclear whether those who committed suicide would have been diagnosed as having less than six months to live.[118]) Of the remaining 99 cases, where there was no evidence of decline prior to suicide, no data is available on the proportion of people who were suffering from a terminal illness.[119] In Victoria, the coronial data did not expressly distinguish between those whose conditions were terminal and those whose were not.[120] It was noted that 40% of the relevant suicides involved persons with cancer, but it is not stated that all were incurable and that the disease had progressed to a stage where they were expected to have less than six months to live. In cases involving multiple chronic conditions, or a progressive incurable condition such as Parkinson's disease or multiple sclerosis (together 36% of suicides), it is again not clear from the data whether the person's condition had progressed sufficiently to constitute a terminal illness with the relevant 6 or 12 month life expectancy. Those with chronic pain or suffering from a major disability or injury would not qualify for VAD, as neither of those conditions is a terminal illness.

Evidence presented to the Victorian and Western Australian parliamentary committees further demonstrates that people commit suicide for a variety of reasons, only some of which may be

[117] Ibid 4; Victorian Coroner's Court Submission 1037 (n 88) 3.
[118] As is required under the WA Act s 16(1)(c)(ii) unless the terminal condition is neurodegenerative, in which case the time period is 12 months.
[119] The Western Australian Coroner was specifically asked to provide information as to how many people would have a terminal illness and be expected to die within 6 months: Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018, 15. However, the Coroner's office was unable to provide detailed information about the medical diagnosis: Coroner's Court of Western Australia, Submission (n 89) 2.
[120] The criteria for the suicides included in the Coroners Prevention Unit's report used three distinct categories: a diagnosed terminal illness, an incurable chronic disease not necessarily expected to cause death in the near future, and permanent physical incapacity and pain as a result of an injury or accident. These data would have enabled a clearer picture but the number of cases in each of these categories was not reported.

addressed by VAD legislation. The most commonly cited reasons were terminal illnesses such as cancer;[121] progressive degenerative illnesses such as motor neurone disease,[122] multiple sclerosis[123] or Parkinson's disease; severe pain;[124] and pre-emptive death after a diagnosis of dementia.[125]

Neither the Victorian Act nor the WA Act will assist those with debilitating chronic illnesses, such as diabetes, arthritis or chronic pain, or those experiencing progressive decline from an illness which will not on its own lead to death (such as most cases of multiple sclerosis, Parkinson's disease, or loss of abilities consequent on major physical injury). Accordingly, while the Victorian Act or WA Act may lead to a decline in the number of 'bad deaths' by suicide, the above discussion demonstrates that there will still be many cases which fall outside the legal framework.

V CASES ON ASSISTED SUICIDES AND MERCY KILLINGS

Cases where a relative or friend assisted another to die, or took active steps to bring about the death of a loved one, are rarer than the cases of suicide described above. Over a similar period to that in which the Victorian Coroner reported 240 relevant suicides, the Victorian police database recorded only 5 cases of aiding and abetting suicide,[126] none of which were prosecuted.[127]

Nevertheless, assisted suicides and mercy killings do occur in Australia, despite the criminal prohibitions on homicide and assisting suicide. Over the last few decades, there have been several

[121] See Victorian Committee Report (n 7) 194-199. Some of these are pre-emptive deaths after a cancer diagnosis, for example WA Committee Report (n 11) 141–143.
[122] Including pre-emptive suicide rather than endure continued degeneration: WA Committee Report (n 11) 145.
[123] For example, Mark Brennan, suffering from multiple sclerosis, killed himself pre-emptively, alone and in a violent manner, to avoid the risk of being unable to do so at a later stage when his illness had deteriorated: Victorian Committee Report (n 7) 199; WA Committee Report (n 11) 144–145.
[124] Case 7.2 describes a 93 year old woman with crippling pain and arthritis who slit her wrists and died alone in an aged care facility: Victorian Committee Report (n 7) 198. Several cases reported by the Western Australian Coroner also described people in severe and chronic pain who took their own lives: Cases 87, 126, 134, 162 in WA Committee Report (n 11) 141.
[125] Laura Gaal explained how a friend diagnosed with dementia committed suicide by driving head on into a truck: Victorian Committee Report (n 7) 199.
[126] Evidence to Standing Committee on Legal and Social Issues, Parliament of Victoria, Melbourne, 7 October 2015, 15 (Rod Wilson, Acting Commander, Victorian Police). The police records cover the 5 year period from 2010–2014, whereas the coronial evidence relates to the 5 years from 2009–2013. Nevertheless, the comparison is stark.
[127] Acting Commander Wilson observed that in his entire career in homicide squad he had only ever seen one prosecution for aiding and abetting suicide, and that was in the 1980s: ibid 16. (The case referred to is probably *R v Larkin* [1983] Vic SC 122).

prosecutions brought against family and friends for assisting with or causing the death of a loved one.[128] Like the suicides discussed in section 4 above, these cases directly raise the issue that 'bad deaths' are occurring because of the absence of a lawful alternative. Some of the deceased persons,[129] or those who assisted in a suicide[130] were members of Exit International or other pro-euthanasia organisations. Some had received assistance from such organisations, including information on how to import prohibited euthanasia drugs from Mexico,[131] instructions about methods of asphyxiation,[132] email support[133] or visits from Exit members to discuss end-of-life options.[134]

In some of the cases, judges made observations apparently accepting that killing occurred in an environment of increasing societal tolerance or even acceptance of euthanasia. In *Pryor*, for example, where a 45 year old nurse was convicted for assisting her terminally ill father to die, and had earlier attempted to kill her demented mother due to her quality of life in a residential aged care facility, the judge observed: 'Euthanasia was a subject openly discussed in the Grant household'.[135] In *Sutton*, parents killed their son who had severe disabilities and was due to undergo surgery which would deprive him of most of his remaining senses. The father in this case commented that this was necessary 'because there was no euthanasia'.[136]

[128] These cases have previously been the subject of detailed analysis in Otlowski (n 20); Bartels and Otlowski, (n 21), and are briefly discussed in Jocelyn Downie, 'Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions' (2016) 16 *QUT Law Review* 84, 103–4. Similar cases have been reported in Canada and New Zealand: see Downie at 100–103; Andrew Geddis 'The case for allowing aid in dying in New Zealand' [2017] *New Zealand Criminal Law Review* 3.
[129] Mrs Rijn was a member of Exit International, and Mrs Godfrey had been 'an outspoken member of first, the Victorian, and later, the Tasmanian, Euthanasia Society': *R v Rijn* (Melbourne Magistrates Court, Mag Lethbridge, 23 May 2011); *R v Godfrey* (Supreme Court of Tasmania, Underwood J, 26 May 2004), 1.
[130] Shirley Justins' friend, Caryn Jenning, was an office holder of Exit International: *Justins v The Queen* [2008] NSWSC 1194, [8].
[131] *R v Nielsen* [2012] QSC 29, 1–7; *Justins v The Queen* (n 130) [16].
[132] Rijn and Maxwell killed themselves in accordance with the helium balloon method they had read about in the 'Final Exit' book: *R v Rijn* (n 129); *R v Maxwell* [2003] VSC 278, [21]. Penelope Blume attended an information evening run by a euthanasia organisation on how to die painlessly: *Police v O* (n 5).
[133] Klinkermann had been in email contact with Exit International: *R v Klinkermann* [2013] VSC 65, [8].
[134] Graeme Wylie was visited by Dr Philip Nitschke, the founder of Exit International in Australia, to assess his capacity for the purposes of applying to Dignitas: *Justins v The Queen* (n 130) [14]–[15]. Frank Ward had two visits from members of Nancy's Friends, a group within Exit International, to discuss end-of-life options and explain how to obtain pentobarbital from Mexico: *R v Nielsen* (n 131) 1–7.
[135] *R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005), 1. Pryor was sentenced to 12 months wholly suspended for assisting her father's suicide, and 18 months wholly suspended for the attempted murder of her mother.
[136] *R v Sutton* [2007] NSWSC 295, [16]. The Suttons were convicted and sentenced to a five year good behaviour bond for the murder of their son.

At times, judges themselves intimate their concern about the harshness of the criminal law in the context of such deaths. In *Klinkermann*, King J commented:

> Our law does not permit people to behave in that manner towards other human beings. It is permissible of course to end the life of a suffering animal but in terms of a human being that remains an exceedingly contentious issue in our community and as a result you have been charged with the offence of attempted murder of the wife that you loved and adored.[137]

Some judges have referred to the broader law reform movement in passing sentence. In *Nielsen*, Dalton J compared the facts of that case to 'theoretical legal models that are proposed … for medically-assisted suicide, and the laws in countries where medically assisted suicide is possible'.[138] In *Riordan* and *Rolfe*, Cummins J went so far as to consider academic writings on euthanasia by Glanville Williams and Margaret Otlowski, as well as law reform proposals in England and Victoria, before passing sentence on two elderly gentlemen convicted of the mercy killings of their wives.[139] Nevertheless, judges have been at pains to emphasise that in pronouncing sentence they are not ruling on the merits of VAD law reform: 'the Court's role is to impose a sentence according to the law and not involve itself in any debate on the difficult topic of euthanasia.'[140]

While the case law provides examples of sympathetic statements regarding an accused's motivations for actions[141] as well as lenient sentences, for the purpose of this paper it is important to identify and examine the facts of these cases to determine if the deceased would have been eligible to receive assistance to die under the Victorian Act or the WA Act.

A *Method for identification of cases*

[137] *R v Klinkermann* (n 133) [11], [26].
[138] Ibid.
[139] *DPP v Riordan* (Supreme Court of Victoria, Cummins J, 20 November 1998), 33–34; *DPP v Rolfe* [2008] VSC 528, [28].
[140] *R v Pryor* (n 135) 2; *R v Nestorowycz* [2008] VSC 385, [5]; *DPP v Rolfe* (n 139) [27]–[28]; *R v Nielsen* (n 131) 1–17.
[141] See, eg, *R v Maxwell* (n 132) [2]; *R v Mathers* [2011] NSWSC 339, [85]; *DPP v Riordan* (n 139) 35; *R v Hollinrake* [1992] VSC 289, 40.

This component of the research aimed to identify all publicly available Australian cases (reported or unreported) concerning assisted suicide and mercy killings, and for which there were sentencing remarks or some other formal set of reasons. The departure point for this review was the group of cases identified by Bartels and Otlowski in 2010.[142] Searches were then conducted on Jade Case Citator, seeking to identify all subsequent cases which referred to any of the cases in the Bartels and Otlowski study. The review also included wider and systematic searches for any relevant cases about assisted suicide or mercy killing. Databases searched were Austlii, Jade Case Citator and the unreported judgments repositories of each of the State and Territory Supreme Courts. A range of search terms were employed including 'mercy killing', 'euthanasia', 'compassion NEAR death', 'assisting suicide' and variations of these terms. As noted, the focus of this review was on cases where sentencing remarks or other formal reasons were available, as they contain an authoritative description, at least from a legal perspective, of the facts of a case. However, a small number of matters not available as reported or unreported judgments were included when there was reliable, publicly available information contained in secondary sources[143] or media reports[144] that provided sufficient details to enable those cases to be included in the proposed analysis. For reasons of convenience, we have only included cases where no judgment is available if they occurred after 2000.[145]

Further criteria for inclusion were that family or friends were prosecuted for murder, manslaughter, attempted murder, attempted manslaughter, or assisting suicide, in circumstances where the offender knowingly caused or assisted in the death of another person motivated solely by a compassionate desire to end their suffering. Cases were excluded when:

[142] Bartels and Otlowski (n 21).
[143] *R v Thompson* (Local Court of NSW, Mag Railton, 21 February 2005) reported in Nick Cowdery, 'Dying with Dignity' (2011) 86 *Living Ethics* 12 and Sarah Steele and David Worswick, 'Destination death: a review of Australian legal regulation around international travel to end life' (2013) 21 *Journal of Law and Medicine* 415, 420.
[144] See, eg, the recent case of *R v Nixon* (Supreme Court of Queensland, 7 December 2017) resulted in an acquittal, hence there was no record of judgment and no sentencing remarks. Information concerning this case is derived solely from newspaper reports.
[145] Otlowski's research details a long line of similar cases stretching back to at least the 1960s: Otlowski (n 20) 17, 18, 20, 28. However, as sentencing remarks are not publicly available for these and other older cases, they are not part of this review.

- the motive for the killing appears to be a mistaken conception of mercy caused by psychiatric disturbance[146] or personality disorder in the offender;[147]
- the killing was not pre-meditated but appears to have been a reaction *in extremis* to circumstances of stress, including the burden of care;[148]
- the offender's motivation appears to be malice or self-interest, rather than compassion for the condition of the victim;[149] or
- the killing was claimed to be a mercy killing but this was found not to be established on the evidence.[150]

A further three cases were excluded because, although the motive appeared to be to comply with the expressed wishes of the person seeking assistance to die, the cases involved pre-existing drug users supplying (and in some cases using) heroin to cause death. The involvement of drug users rendered these cases more complicated than traditional mercy killings.[151]

Twenty-seven cases were identified using this method, salient features of which are included in Table 2 below. Whether the deceased in these cases would have been eligible for VAD is explored in more detail below, however at the outset it is important to observe two main points. Firstly, although all cases of assisted suicide involve a person who wishes to die, the mercy killing cases encompass both voluntary requests to die, as well as cases where a person knowingly caused the death of another who had not requested assistance to die, albeit from motives of mercy or compassion towards the victim.

[146] See, eg, *R v Cheatham* [2002] NSWCCA 360, where the offender killed his wife and daughter while suffering from the delusional belief that he had infected them with AIDS; *R v Duthie* [1999] NSWSC 1224, where the offender was a prisoner suffering from the effects of drugs when he formed a suicide pact with his cellmate.
[147] An example is the paranoid and anti-social personality of the offender in *R v Howard* [2009] VSC 9.
[148] See, eg, *R v Dawes* [2004] NSWCA 363, where a mother strangled her 10 year old autistic son, affected by numerous personal stressors such as her marriage breakdown, the death of her father, sexual abuse of her daughter, and major depression.
[149] See, eg, *R v Davis* [2016] NSWSC 1362, and *Haines v R* [2018] NSWCCA 269, where nurses in two separate aged care facilities administered large doses of insulin to residents, resulting in their deaths. They were charged with murder.
[150] See *R v McGrath* [2000] NSWSC 419, where the offender initially claimed he killed the victim at his request, and that he had only 6 weeks to live, but he later admitted that he murdered him because of allegations the victim had sexually abused children of friends.
[151] *Carter v A-G* [2003] 2 Qd R 402; (2003) 141 A Crim R 142; [2014] 1 Qd R 111 and *Walmsley v The Queen* (2014) 253 A Crim R 441 involved assisting the suicide of depressed drug addicts. In *R v Cooper* [2019] NSWSC 1042, a woman in chronic physical pain asked her partner to give her a heroin overdose to end her life.

Secondly, these assisted suicide and mercy killing cases involve people suffering a wide range of conditions including those that are not terminal including chronic pain, degenerative illnesses, dementia, mental illness, and disability.

Table 2 below summarises the facts of the cases reviewed that are relevant to assessing eligibility for VAD. Because of the significance of a person's condition in making that assessment, the cases have been grouped by condition. The authors note that in some cases, the victim had more than one type of condition: these cases have been included under a primary condition but are noted with an asterisk below.

Table 2: Assisted Suicide and Mercy Killing Cases

CASE	MEDICAL CONDITION	METHOD OF DYING	CHARGE
TERMINAL ILLNESS GENERALLY			
***R v Maxwell* [2003] VSC 278**	Mrs Maxwell, age 59, was terminally ill with painful and debilitating cancer.	Asphyxiation with helium balloon	Aid and abet suicide
***R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005)**	Ms Pryor's father was a retired doctor who had terminal colon and bowel cancer.	Injections of pethidine and insulin, then asphyxiation	Assisted suicide
***R v Attenborough* (NSW District Court, Graham AJ, 30 May 2019)**	Attenborough's father was in palliative care suffering a twisted stomach, hiatus hernia and heart condition	Overdose of morphine, other drugs and alcohol	Administer a poison with intent to murder
***Police v O* CC2019/3260[152]**	Ms Blume was terminally ill with motor neurone disease, and wanted to commit suicide.	Not stated, but following a method prescribed by a euthanasia organisation	Aiding suicide (charges were later dropped by the prosecution on public interest grounds)

[152] *Police v O* (n 5).

DEMENTIA			
***DPP v Riordan*, (Supreme Court of Victoria, Cummins J, 20 November 1998)**	Mrs Riordan had had advanced Alzheimer's disease for more than a decade, and was in a residential aged care facility. She had no control over her bodily functions, could not feed herself, was barely able to chew, and continuously cried out in a loud and pitiful way.	Not stated	Attempted murder
***R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005)**	Ms Pryor's mother had severe dementia and was very difficult to care for. She was discovered by ambulance officers and revived, and died several months later of unrelated causes	Insulin injection (did not succeed)	Attempted murder
R v Klinkermann* [2013] VSC 65	Mrs Klinkermann had severe dementia and Parkinson's disease. Mr Klinkermann did not want to place her in full-time palliative care.	Gassing in bedroom (both survived)	Attempted murder
***DPP v Rolfe* [2008] VSC 528**	Mrs Rolfe had vascular dementia, needed assistance to walk and could no longer communicate. She needed to go into a care home. Mrs Rolfe died but Mr Rolfe was resuscitated by paramedics.	Gassing in bedroom (husband survived)	Manslaughter by suicide pact
***Justins v The Queen* [2008] NSWSC 1194**	Graeme Wylie suffered from advanced Alzheimer's disease. He had made two previous suicide attempts, and had applied to go to Switzerland to access VAD, but his application was rejected due to concerns about his capacity.	Drank Nembutal	Manslaughter (1st trial); Assisting suicide (re-trial)
***R v Nixon* (Supreme Court of Queensland, 7 December 2017)**	Nixon's father, aged 88, had dementia and was unable to walk, or go to the toilet independently.	Drank a dissolved mixture of Valium and oxycodone.	Assisting suicide
CHRONIC PAIN			
***R v Marden* [2000] VSC 558**	Mrs Marden suffered constant pain from severe rheumatoid arthritis. Mr Marden had heart problems and a pacemaker inserted. Their only son's marriage broke down and they lost regular contact with their grandsons.	Electrocution, then suffocation. Mr Marden attempted overdose of pills (survived).	Manslaughter by suicide pact

R v Godfrey **(Tasmanian Supreme Court, Underwood J, 26 May 2004)**	Godfrey's 88 year old mother was chronically ill. She had undergone a bowel resection for colon cancer. She had chronic back pain, severe rheumatic joint pain and was doubly incontinent.	Suffocation with plastic bag	Assisting suicide
R v Mathers **[2011] NSWSC 339**	Mathers' partner, Eva Griffiths, had severe back pain arising from osteoporosis, arthritis and sciatica, and wished to die rather than ending up in a residential aged care facility.	Suffocation with pillow and plastic bag, after overdose of pills	Manslaughter (diminished responsibility)
R v Rijn **(Melbourne Magistrates Court, Mag Lethbridge, 23 May 2011)**	Mrs Rijn suffered chronic hip pain, which could not be relieved by surgery or pain relief.	Suffocation using kit purchased from Exit International	Inciting suicide
DEGENERATIVE CONDITION			
R v Thompson **(Local Court of NSW, Mag Railton, 21 February 2005)**	Thompson's wife had multiple sclerosis. She had been repeatedly saying she did not want to go into a residential aged care facility, or to have palliative care.	Suffocation with pillow after overdose of pills	Aid and abet suicide
STROKE			
R v Tait **(Supreme Court of Victoria, Winneke CJ, 8 August 1972)**	Tait's mother suffered a stroke, leaving her virtually helpless and disoriented in mind. She needed care in a residential aged care facility, which upset her greatly.	Tait slit his mother's throat while she slept	Murder
R v Hollinrake **[1992] Vic SC 289**	Mrs Hollinrake, age 77, had suffered a major stroke.	Mr Hollinrake cut his wife's wrist, then slit his own wrists (both survived).	Attempted murder
DISABILITY			
R v Nicol **[2005] NSWSC 547**	Mrs Nicol had a foot amputated, then developed infection and gangrene and had half her leg amputated. She did not adjust well to the prosthetic limb so became dependent on her husband.	Beating with an iron bar, then suffocating her, before attempting suicide via overdose	Murder (pleaded guilty to manslaughter)

***R v Sutton* [2007] NSWSC 295**	The parents of 29 year old adult man with severe disabilities (Trisomy 13 syndrome) killed him to avoid future planned surgery that would leave him substantially deaf and unable to speak.	Not stated	Manslaughter
R v Nestorowycz* [2008] VSC 385	Mr Nestorowycz was a double amputee with dementia and diabetes. He resided in a nursing home, because his wife could no longer care for him.	Stabbed in stomach then stabbed herself (both survived).	Attempted murder
***R v Dowdle* [2018] NSWSC 240**	Dowdle was the mother of a man who had acquired severe disabilities as a result of a car accident. He had become an alcoholic and drug user and was abusive towards her.	Suffocation with a plastic bag	Manslaughter (substantial impairment)
R v Nielsen* [2012] QSC 29	Mr Ward, a 76 year old man, earlier suffered a minor stroke. He had a subsequent medical event (details unknown) that impaired mobility but not significantly. He did not want medical care or to become dependent on anyone.	Drank Nembutal Nielsen bought for him in Mexico	Assisting suicide
MENTAL ILLNESS			
***R v Larkin* [1983] Vic SC 122**	Larkin's lover had manic depression, and had made several suicide attempts.	Overdose of sleeping pills Larkin then injected him with a fatal dose of insulin	Aiding and abetting suicide
***The Queen v Johnstone* (1987) 45 SASR 482**	Mrs Johnstone had suffered from severe bipolar disorder for 30 years of their 36 year marriage, as well as prolonged alcoholism. She was miserable and suicidal.	Electrocution	Murder
***R v ANG* [2001] NSWSC 758**	ANG's uncle suffered depression and wanted to end his life.	Overdose of pills. Then ANG rolled his body into the river, where he drowned	Manslaughter by criminal negligence
***R v Hood* (2002) 130 A Crim R 473**	Hood's flatmate and former lover had depression and decided to commit suicide, because he had lost his job and his relationship had ended. He arranged a farewell party, at which he told his friends and family (untruthfully) that he had a serious brain tumour, and would rather die with dignity than become a vegetable.	Overdose of pills	Aiding and abetting suicide

***DPP v Karaca & Price* [2007] VSC 190**	Bruce Levin suffered serious depression. He put pressure on Karaca and Price to assist him with his planned suicide.	Levin overdosed on pills. Price then hit him twice over the head with an iron bar (he survived)	Attempted murder

B *Eligibility requirements*

In this section, the cases above are reviewed to determine whether the deceased would have satisfied the individual eligibility requirements of the Victorian Act or the WA Act. While this analysis considers each criterion separately, it is noted that all eligibility criteria must be met to access VAD and this is discussed further below.

1 *Adults*

All cases involved adults, so this criterion of the Victorian Act and WA Act would have been satisfied.

2 *Capacity*

It is not possible to make a categorical determination of whether the deceased would have had capacity in all cases. This is because the focus of a criminal trial is on the actions of the offender. Accordingly, the following conclusions are tentative only, based on the comments made in judicial sentencing remarks, and assumptions about the ordinary impact of illnesses such as cancer and dementia on capacity. Nevertheless, these tentative conclusions are illustrative of the broader point. A review of the above 27 cases reveals the following:

- the deceased appeared to have decision-making capacity in 12 cases;[153]

[153] *R v Maxwell* (n 132); *R v Pryor* (n 135) (assisting the suicide of the father); *R v Attenborough* (NSW District Court, Graham AJ, 30 May 2019); *Police v O* (n 5); *R v Marden* [2000] VSC 558; *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129); *R v Thompson* (n 143); *R v Nicol* [2005] NSWSC 547; *R v Nielsen* (n 131); *R v Dowdle* [2018] NSWSC 240. Although Dowdle's son had sustained a severe disability in a car accident, there was no indication that he lacked decision-making capacity, at least when not under the influence of alcohol and drugs. In *R v Attenborough*, there was 'no suggestion that [the deceased] was suffering from any particular or

- the deceased appeared to lack decision-making capacity in 9 cases; and
- in 6 cases, it could not be reasonably determined whether the deceased had decision-making capacity at the time of death.[154]

Of those cases where the deceased appeared to lack capacity, six involved elderly adults with severe dementia or advanced Alzheimer's disease,[155] two involved elderly women who had suffered a major stroke which significantly affected their cognitive functioning and ability to communicate,[156] and one concerned the death of a severely intellectually impaired young adult at the hands of his parents.[157] While it is not explicitly stated in most of the cases[158] that any of these people lacked decision-making capacity, the description of their level of functioning appears to indicate that they did. For example, Mrs Riordan had advanced Alzheimer's disease causing severe dementia, and was unable to talk or communicate at all.[159]

There were a further six cases where the decision-making capacity of those who made a voluntary request to die may also have been questioned. For example, Mrs Rolfe had vascular dementia, and was unable to communicate, although medical evidence suggested she retained the ability to understand what was being said to her and assent to her husband's suicide pact plan.[160] Similarly, a number of cases involved the deaths of younger people with severe mental illness, whose suicidal ideation may have cast doubt on their decision-making capacity.[161]

3 *Condition is incurable, advanced, progressive and will cause death*

impairing form of mental condition, whether dementia or other mental health issues', although he was in significant pain and at times distressed on account of the pain: at 3.
[154] *DPP v Rolfe* (n 139); *R v Larkin* (n 127); *R v Hood* (2002) 130 A Crim R 473; *DPP v Karaca & Price* [2007] VSC 190; *R v ANG* [2001] NSWSC 758; *The Queen v Johnstone* (1987) 45 SASR 482.
[155] *R v Nestorowycz* (n 140); *DPP v Riordan* (n 139); *R v Pryor* (n 135) (in respect of the mother); *R v Klinkermann* (n 133); *Justins v The Queen* (n 130); *R v Nixon* (n 144).
[156] *R v Tait* (Supreme Court of Victoria, Winneke CJ, 8 August 1972); *R v Hollinrake* (n 141).
[157] *R v Sutton* (n 136).
[158] The exception is *Justins v The Queen* (n 130). In that case, Graeme Wylie's lack of capacity was demonstrated by the fact that some months earlier his application for VAD in Switzerland was rejected by Dignitas, due to concerns about his cognitive capacity. Specifically, the evidence stated that during capacity assessment he was unable to recall his date of birth or the number, age or sex of his children: at [10]–[11].
[159] *DPP v Riordan* (n 139) 28.
[160] *DPP v Rolfe* (n 139) [10].
[161] *R v Larkin* (n 127); *R v Hood* (n 154); *DPP v Karaca & Price* (n 154); *R v ANG* (n 154); *The Queen v Johnstone* (n 154).

Under the Victorian Act, only those who suffer from a condition which is incurable, advanced, progressive and is expected to cause death within 6 months, or a neurodegenerative condition which is expected to cause death within 12 months, will be eligible to seek medical assistance to die.[162] As outlined earlier, the criterion in the WA Act is the same except there is no requirement for the condition to be 'incurable'.

However, the case review reveals that only a small minority of deaths involved a person suffering from a progressive terminal condition. Maxwell's wife and Pryor's father both suffered terminal cancer,[163] Attenborough's father was in palliative care for a range of health concerns and was estimated to have one to three months left to live,[164] and Penelope Blume was in the final stages of motor neurone disease.[165]

Dementia is also a progressive and terminal medical condition for which there is no cure,[166] and seven cases involved the intentional killing of an elderly spouse or parent with dementia.[167] These killings were motivated by compassion for the deceased's perceived poor quality of life, or out of respect for previously expressed wishes.[168] Although dementia is incurable, progressive and will cause death, we cannot state with certainty whether the patients in these cases would have satisfied the criterion of causing death within the prescribed 12 month period set out in the legislation for neurodegenerative conditions.[169]

[162] Victorian Act s 9(1)(d).
[163] *R v Pryor* (n 135); *R v Maxwell* (n 132).
[164] *R v Attenborough* (n 153).
[165] *Police v O* (n 5).
[166] Mari Lloyd-Williams and Sheila Payne, 'Can multidisciplinary guidelines improve the palliation of symptoms in the terminal phase of dementia?' (2002) 8(8) *International Journal of Palliative Nursing* 370–375.
[167] Five cases involved an elderly spouse: *DPP v Riordan* (n 139); *R v Nestorowycz* (n 140); *R v Klinkermann* (n 133); *Justins v The Queen* (n 130); *DPP v Rolfe* (n 139) [10]. Two cases involved an elderly parent: *R v Nixon* (n 144); *R v Pryor* (n 135) (in relation to Pryor's mother).
[168] See, eg, *R v Pryor* (n 135) (in relation to Pryor's mother); *Justins v The Queen* (n 130).
[169] Further, as noted above, six of these seven adults would be unlikely to have satisfied the capacity criterion for VAD under the Victorian Act or the WA Act. The exception is *DPP v Rolfe* (n 139), as described above: at [10].

Of the 27 cases, 4 involved requests for assistance to die from people who were suffering from chronic pain in some form.[170] Two cases involved a person suffering from a degenerative but not imminently fatal illness: Thompson's wife had multiple sclerosis, and Mrs Klinkermann suffered from Parkinson's disease in addition to advanced dementia.[171] These people, although also suffering serious and incurable conditions, would not be eligible for VAD under the Victorian Act or WA Act.[172]

Some of the cases involved people with disabilities who found their situation sufficiently intolerable that they sought to end their lives. For example, disability was the primary reason for Mrs Nicol asking her husband to 'put me out of my misery'[173] as she was not adjusting to the dependency she experienced as an amputee, and did not want to go into care.[174] Fear of future disability or dependence was also the primary motivation of the deceased in *R v Nielsen* in seeking assistance to commit suicide, despite having earlier had only a 'relatively minor' stroke and currently experiencing a loss of function, the cause and duration of which was unknown because of an unwillingness to seek medical advice.[175]

The review also identified cases involving a disability where there was no request to die made by the deceased. Two cases involved elderly people with physical and intellectual impairment following a major debilitating stroke.[176] Mrs Nestorowycz's attempt to murder her disabled husband, who had become a double amputee as a result of diabetes, arose because of concerns about his quality of life. Mr Nestorowycz also had dementia. Similarly, the Suttons, although described as devoted and loving parents, chose to end the life of their severely disabled son because they found it intolerable that he required further surgery which would have deprived him of the ability to communicate. In Victoria

[170] *R v Marden* (n 153); *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129).
[171] Parkinson's disease and multiple sclerosis are progressive and degenerative but are not generally considered terminal, although in some cases they may be when accompanied by other co-morbid conditions: *R v Thompson* (n 143); *R v Klinkermann* (n 133).
[172] Victorian Advisory Panel Report (n 7) 69.
[173] *R v Nicol* (n 153) [10].
[174] Ibid.
[175] *R v Nielsen* (n 131) 1–4.
[176] *R v Hollinrake* (n 141); *R v Tait* (n 156).

and in Western Australia, people with disabilities are not eligible for VAD in the absence of terminal illness.[177]

Five of the people who sought assistance to die were suffering from mental illness, without a terminal condition.[178] While having a mental illness is not an exclusionary factor under the Victorian Act or the WA Act if all the other eligibility criteria are met,[179] mental illness on its own is not sufficient to meet the eligibility criteria for VAD.[180] These five people therefore would not have been eligible under the Victorian or Western Australian legislation.

Based on the above analysis, of the 27 cases described in Table 2, only 11 meet the criterion in the Victorian Act or WA Act of an advanced, progressive and incurable disease, illness or medical condition which is expected to cause death. However, 7 of these 11 cases involved people with dementia so, although terminal, death may not have resulted within 12 months (and in at least 6 of those cases it is unlikely that the person would have had the requisite capacity). Clearly, cases of assisted suicide and mercy killings in Australia have not been restricted to people suffering as a result of terminal illnesses such as cancer or progressive degenerative diseases. Many more involved an elderly person in considerable suffering due to chronic pain,[181] or suffering loss of abilities due to stroke,[182] amputation[183] or other disability.[184] In many of these cases, part of the impetus for suicide or seeking assistance to die was the fear of ending up incapacitated in a residential aged or disability care facility.[185] Thus, enacting legislation which permits VAD only for people suffering from a terminal illness would not prevent the majority of these unlawful deaths from occurring.

[177] Victorian Act s 9(3); WA Act s 16(2).
[178] *R v Larkin* (n 127); *The Queen v Johnstone* (n 154); *R v ANG* (n 154); *DPP v Karaca & Price* (n 154); *R v Hood* (n 154). See also *Carter v A-G* (n 151); *Walmsley v The Queen* (n 151).
[179] Ministerial Panel Recommendation 5, see Victorian Advisory Panel Report (n 7) 80–82 (in respect of mental illness).
[180] Victorian Act s 9(2); WA Act s 16(2).
[181] *R v Marden* (n 153); *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129).
[182] *R v Hollinrake* (n 141); *R v Tait* (n 156).
[183] *R v Nestorowycz* (n 140); *R v Nicol* (n 153).
[184] *R v Thompson* (n 143).
[185] This was a significant factor in *R v Godfrey* (n 129); *R v Justins* [2011] NSWSC 568, [23]; *R v Marden* (n 153); *R v Nicol* (n 153) [9]; *R v Mathers* (n 141) [17]; *R v Nielsen* (n 131); *DPP v Rolfe* (n 139) [7], [13], [14]; *R v Tait* (n 156) 3. In *R v Klinkermann* (n 133), this factor was significant to the husband, who refused to countenance his wife going into care, although she was no longer competent to express her own views on the

C *Voluntary request for assistance*

The Victorian Act and WA Act, like VAD regimes around the world, only apply to voluntary requests for assistance to die. Many, but by no means all, of the Australian mercy killing cases involved a voluntary request to die.

In five of the cases set out in Table 2, the deceased person wished to die and had taken active steps to bring about his or her death, and the offender's role was to provide assistance in a manner requested by the deceased.[186] That is, the action of the accused was assisting the suicide rather than bringing about the death themselves. In one case, this involvement was restricted to the provision of emotional support. In *R v Hood*, the offender sat by his friend's bedside after he took an overdose of pills, and read tributes from his condolence book until his friend lost consciousness.[187] In four other cases, the accused assisted to prepare the means for suicide, such as handing the deceased a glass of Nembutal[188] or purchasing or preparing the equipment used to cause death.[189]

In a further five cases, the accused took active steps to complete a suicide attempt after the deceased had begun the process.[190] Examples include suffocating a person who has taken an overdose and is already unconscious;[191] Larkin injecting her lover with insulin, at his request, to ensure his overdose was successful;[192] and Price complying with his flatmate's demands to bludgeon him with an iron bar, after he took an overdose of sleeping tablets.[193]

issue. The husband in *R v Nestorowycz* (n 140) and the mother in *R v Pryor* (n 135) were already in residential care, and the evidence was that this distressed them, which influenced the actions of the relatives in attempting to end their lives to end that suffering.

[186] *R v Hood* (n 154) (overdose of pills); *R v Maxwell* (n 132) (helium balloon asphyxiation); *R v Rijn* (n 129) (asphyxiation); *R v Nielsen* (n 131) (dose of Nembutal); *Police v O* (n 5) (mode of death not stated).

[187] Hood had briefly attempted to suffocate his friend once he became unconscious, by placing his hand over his nose and mouth, but this act made him feel ill, so he desisted, and there was no suggestion that this caused the victim's death. This is why he was convicted of assisting suicide, for being present while his friend died, rather than murder: *R v Hood* (n 154) [23]–[24].

[188] *R v Nielsen* (n 131).

[189] *R v Rijn* (n 129); *R v Maxwell* (n 132); *Police v O* (n 5).

[190] These cases in law technically constitute murder, as the act of the defendant (rather than the unsuccessful suicide attempt of the deceased) was the direct cause of death. However, we have categorised them as actions taken to complete a suicide, recognising that the deceased had instigated the process of causing death, which the offender then completed.

[191] *R v Godfrey* (n 129); *R v Mathers* (n 141).

[192] *R v Larkin* (n 127).

[193] *DPP v Karaca & Price* (n 154).

Seven of the cases involved prosecutions for murder or manslaughter rather than assisting a suicide. In these cases, the accused took action to bring about the person's death, in order to end their pain or suffering, albeit at the request of the deceased. Three of these cases involved a suicide pact between husband and wife,[194] two involved individuals suffering mental illness who persuaded a relative to assist them to die,[195] one involved a terminally ill man,[196] and one involved a woman with multiple sclerosis whose condition had been progressively deteriorating and who wished to avoid going into nursing care.[197]

In the 17 cases considered above, the requirement under the Victorian Act or the WA Act that a person's request for assistance to die is voluntary and not the product of undue influence or coercion[198] would have been satisfied.

However, there were also several mercy killing cases in Australia which would not satisfy the voluntariness criterion. In these cases, a friend or relative acted to cause the death of a loved one for compassionate motives, seeking to end their suffering, but without any explicit request to do so. Four of these cases involved a victim with severe dementia whose spouse or adult child killed them to end their suffering.[199] There were also two cases where a person had suffered a severe stroke, and the act causing death occurred in the context of previous discussions about not wanting to be dependent or to be institutionalised.[200] And there were also two reports of parents who killed their adult children with disabilities in order to ease their suffering.[201] In addition to these cases, in two instances a person

[194] *R v Marden* (n 153); *R v Nicol* (n 153); *DPP v Rolfe* (n 139). In both *Marden* and *Nicol*, the husband took the actions which killed the wife before attempting his own suicide, and the wife did not actively participate in the acts causing death, although both wives had requested their lives to end. In *DPP v Rolfe* (n 139), the husband attempted to gas both himself and his wife, but he was found unconscious and revived by paramedics.
[195] *R v Johnstone* (n 154); *R v ANG* (n 154).
[196] *R v Attenborough* (n 153). In that case, the charge was the statutory offence of administering a poison, not murder: *Crimes Act 1900* (NSW) s 27.
[197] *R v Thompson* (n 143).
[198] It should be noted that under the Victorian Act, a medical practitioner is permitted to actively perform an act causing death (termed practitioner administration) only when a person's medical condition prevents them from physically administering or digesting a VAD substance. However, for the purposes of this discussion, it is presumed that a person who otherwise met the eligibility criteria for VAD would have chosen to perform VAD in accordance with the method authorised under the Victorian Act.
[199] *DPP v Riordan* (n 139); *R v Pryor* (n 135) (in relation to Pryor's mother); *R v Nestorowycz* (n 140); *R v Klinkermann* (n 133).
[200] *R v Tait* (n 156); *R v Hollinrake* (n 141).
[201] *R v Sutton* (n 136); *R v Dowdle* (n 153).

with advanced dementia voluntarily drank a lethal substance prepared for him by relatives, but the assistance to die appears to have been provided at the initiative of the relative, rather than as a response to a voluntary request from the person concerned.[202] Legalising VAD in accordance with the Victorian or Western Australian models, both of which require voluntariness as a key precondition, will not prevent the unlawful killing of a person who has not requested to die.

In summary, of the cases set out in Table 2, 17 involved a voluntary wish to die sufficient to satisfy the voluntariness requirement. However, 10 cases involved the death of a person who had not expressed a voluntary request to die (9 of whom are likely to have lacked capacity).[203] None of these latter cases would have been eligible for VAD.

D *Will VAD prevent these bad deaths?*

Given the narrow eligibility criteria in the Victorian Act and WA Act, and the broad range of circumstances in which assisted suicides or mercy killings have occurred in Australia, it appears unlikely that enactment of VAD legislation based on the Victorian model will address the situations raised in these cases. Table 3 presents a summary of the findings from the cases relating to each *individual* VAD eligibility criterion, noting of course, as discussed below, that eligibility to access VAD depends on fulfilling *all* criteria. While all cases involved an adult and the majority made a voluntary request to die, a major issue was that just over one-third involved people with an advanced and progressive terminal illness.

Table 3: Assisted Suicide and Mercy Killing Cases: Summary of Findings

Criterion of VAD	Yes	No	Unsure
Adult	27	0	0
Capacity	12	9	6
Terminal illness[204]	11	16	0

[202] *Justins v The Queen* (n 130); *R v Nixon* (n 144).
[203] With the probable exception of *R v Dowdle* (n 153).
[204] This figure includes seven cases of people with dementia. As noted above, it is not possible to accurately ascertain from the case reports whether each of them would have satisfied the requirement that death was

Voluntary	17	10	0

It can be seen that, of the 27 cases described in this paper, all involving adults, 10 concerned a death which was not at the voluntary request of the person concerned. In 9 cases, the person clearly lacked capacity to make a request to die, by reason of severe dementia, disability or stroke. In a further 6 cases there was at least some unresolved question of decision-making capacity. Finally, and most significantly, only 11 of the 27 cases involved people with terminal illness (some of whom may not have died within the required statutory period).

The key finding from this analysis, however, relates to how many of the cases would have satisfied *all* of the criteria for eligibility for VAD in Victoria or Western Australia. On our assessment, these criteria were met in only 4 of the 27 cases: *Maxwell*, *Pryor* (in relation to Pryor's father not mother), *Attenborough* and *O*.[205] In the remaining 23 cases where the offender has acted out of compassion for the suffering of the deceased rather than at their request, or the deceased was not suffering from a terminal illness, , the offenders' actions would fall outside the statutory VAD statutory regime.

This is arguably a striking conclusion. The authors acknowledge that these cases provide only a partial picture of the operation of the criminal justice system. As noted earlier, some cases of assisted suicide or mercy killings are not prosecuted and so fall outside the methodology of this review. While it is unknown, it is possible that those cases which were not prosecuted involved a greater proportion of fact scenarios that would be eligible for VAD under the Victorian Act or the WA Act. Nevertheless, the finding that only 4 out of 27 cases considered in this analysis would have been eligible for access to VAD raises important questions about the role of this argument in the VAD reform debate.

expected within 12 months. Further, as already noted, even if they were to meet the terminal illness requirement, if their dementia had progressed to that point, it is very likely they would lack decision-making capacity.

[205] *R v Maxwell* (n 132); *R v Pryor* (n 135); *R v Attenborough* (n 153); *Police v O* (n 5).

VI CONCLUSION

With Victoria and Western Australia recently enacting legislation permitting VAD, other Australian States are likely to follow.[206] The purpose of this paper was to examine two key sources of evidence that informed the debates surrounding these laws: coronial data about suicides in the chronically and terminally ill, and information about prosecuted cases of assisted suicide or mercy killings. Both sources of evidence were advanced as reasons supporting VAD reform. It was proposed that changing the law to permit VAD could decrease the number of suicides of individuals who are chronically or terminally ill, and could decrease the number of cases where families or friends take the law into their own hands to facilitate or cause a loved one's death. To test these claims, we evaluated whether cases from these two sources of evidence would be eligible to access VAD under the Victorian Act and the proposed WA Bill.

Our conclusions were mixed. Although the suicide statistics provided by the Victorian and Western Australian coroners are not conclusive, many of the deaths reported do not appear to involve people with a terminal illness. Given the eligibility requirements of both the Victorian Act and the WA Act require a person to have a condition expected to cause death within 6 months (or 12 months for neurodegenerative conditions), this means many of the 'bad deaths' identified would not be addressed by this legal model.

The findings in relation to prosecutions of assisted suicide or mercy killings were more conclusive. Although cases may have satisfied various individual eligibility criteria, only 4 of the 27 cases would have satisfied all the criteria to be eligible to access VAD under the Victorian Act or the WA Act. It is important to note, though, that such cases do not provide a full picture of the criminal justice system's response to this issue, as in some instances the prosecution may exercise a discretion not to proceed, or to discontinue a case, or a jury may choose to acquit against the weight of the evidence.

[206] Ben White and Lindy Willmott, 'Future of assisted dying reform in Australia' (2018) 42 *Australian Health Review* 610.

These findings have implications for debates about VAD and law reform. One is about the scope of an appropriate VAD law. Both the suicide data and the cases on assisted suicide and mercy killings provide evidence that, for many people, the desire to die stems from intractable chronic pain[207] or a degenerative but non-terminal illness.[208] The mercy killing cases also include several examples where a friend or relative became involved in assisting or completing the suicide of a person with mental illness.[209] Some may use this evidence to argue that the 'bad deaths' in these non-terminal situations should be addressed by widening access to VAD. In other words, this evidence could be said to demonstrate a need for broader eligibility criteria, such as those contained in VAD systems in countries such as the Netherlands and Belgium.[210] This, however, is not an argument the authors endorse. Limiting VAD to those with a terminal illness is justifiable by reference to a number of fundamental societal values,[211] and the model proposed elsewhere by two of the authors confines VAD to circumstances where a person has a condition that will cause his or her death.[212]

Another implication of these findings is that a VAD law may not bring the expected degree of benefit in terms of preventing people dying 'bad deaths'. The system of VAD in existence in the Victorian Act, and in the WA Act, is likely to provide a lawful alternative option for only some of the suicides, assisted suicides and mercy killings discussed in this paper. This demonstrates the need for precise evidence to inform law-making in this complex and contested area.[213] Given the engagement by the parliamentary committees and MPs outlined above, it is reasonable to conclude that the coronial evidence about suicide statistics had at least some influence on the decision to recommend VAD reform. For some of the cases of suicide outlined in that data, this was appropriate. Those cases

[207] See *R v Marden* (n 153); *R v Godfrey* (n 129), *R v Mathers* (n 141); *R v Rijn* (n 129).
[208] See statistics discussed above in sections 4 A and B. See also the cases of *R v Klinkermann* (n 133); *R v Thompson* (n 143).
[209] See *R v Larkin* (n 127); *The Queen v Johnstone* (n 154); *R v ANG* (n 154); *DPP v Karaca & Price* (n 154); *R v Hood* (n 154). See also *Carter v A-G* (n 151); *Walmsley v The Queen* (n 151). Cases of suicide where mental illness was a factor were specifically excluded by the coroners when compiling evidence about suicide in the chronically and terminally ill.
[210] Willmott, Lindy and Ben White, 'Assisted dying in Australia: A values-based model for reform' in Ian Freckelton and Kerry Petersen (eds), *Tensions and traumas in health law* (Federation Press, Sydney, 2017) 479, 484–486.
[211] Ibid.
[212] Reference removed for anonymity reasons.
[213] See Ben White and Lindy Willmott, 'Evidence-based law making on voluntary assisted dying' (2020) Australian Health Review (available early online, forthcoming).

involved ‘bad deaths’ that could have been prevented if VAD had been lawful, because they would be eligible under the Victorian Act or WA Act. But many of the cases fell outside the scope of that law and so do not provide support for the reform that occurred. Based on the data examined in this article, it cannot be claimed that legalising VAD in accordance with the Victorian or Western Australian legislation would avoid all ‘bad deaths’. Optimal law-making occurs when there is precision about data such as this and when parliaments consider which cases support reform and which do not.

A further implication is that there remains an urgent need for detailed research and accurate evidence to inform the parliamentary and community debate about VAD law reform. For example, the coronial evidence was not able to identify the percentage of suicides which involved a person who was terminally ill, compared with those which involved a person with chronic illness. Although these distinctions had not been precisely conceptualised until the Victorian model of VAD was formulated,[214] when asked directly to provide an indication, the Western Australian Coroner stated that their data does not contain the information, as it requires a detailed medical prognosis prior to death.[215] Further, the Coroner’s Court of Western Australia stated that it did not have the capacity to produce detailed reports, as it does not have research staff embedded within its office.[216] Another point on which further research is required is the number of cases of assisted suicide and mercy killings which are not prosecuted or are discontinued, and what criteria are employed by prosecutors in making decisions in these cases. A further matter worthy of investigation is the prevalence of jury acquittals in such cases, although the reasons for jury verdicts are inscrutable.

A final observation is that this review highlights the ongoing role that criminal law will need to play even if VAD legislation is enacted. While the majority of the prosecuted cases identified here involved a voluntary desire to die, 10 of the 27 Australian cases involved mercy killings of people who lacked capacity, including those with dementia, stroke victims and people with disabilities. As

[214] This was particularly a challenge for the Victorian Coroner, providing evidence to the parliamentary committee prior to the drafting of proposed VAD legislation.
[215] Coroner’s Court of Western Australia Submission (n 89) 2.
[216] Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018, 13 (Rosalinda Fogliani, Coroner).

Bartels and Otlowski have observed, there is a need for safeguards in any law permitting VAD, to prevent the deaths of people who lack capacity.[217] Even with the legalisation of VAD in Victoria, and possibly other Australian jurisdictions, there will remain an important role for the criminal law. It protects vulnerable people from the unilateral unlawful killing by a trusted family member, sending a message to the community that it is not for others to judge that a person's quality of life is intolerable.

VAD is an important and complex social policy issue and there will be diverse views about the desirability for reform. This paper has highlighted one key argument in these debates: whether VAD reform could help address a cohort of identified 'bad deaths'. The evidence demonstrates that while some of these deaths may be addressed by VAD laws, under the model of VAD adopted in Victoria and Western Australia, many will not. Not all mercy killings are carried out at the voluntary request of the deceased person, and many deaths—whether by suicide, assisted suicide or mercy killing—do not involve a person with a terminal illness. To return to the media reports with which this paper began, while Penelope Blume and Troy Thornton would have qualified for VAD once they were assessed as having less than 12 months to live, Professor Goodall would not have been eligible for VAD (even if the WA Act had commenced or he was resident in Victoria at the time of his death), and he would still have had to travel to Switzerland.[218] A more nuanced understanding of this evidence is important for the Australian state parliaments currently, and in the future, considering VAD reform.

[217] Bartels and Otlowski (n 21) 549.
[218] Frailty or being 'tired of living' does not fall within the terminal illness criterion in the VAD Act.

ASSISTED SUICIDES AND 'MERCY KILLINGS': VOLUNTARY REQUESTS, OR VULNERABLE ADULTS? A CRITIQUE OF CRIMINAL LAW AND SENTENCING

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This article explores the criminal law's response to cases of 'mercy killing' or assisting suicide, in which relatives or friends act outside the law to end the suffering of a loved one with a terminal or chronic illness. It examines the sentencing remarks in all the publicly reported Australian cases on assisted suicide and mercy killing since 1980. Pronounced leniency in sentencing is observed, across the spectrum of cases, which demonstrates a gap between the law on the books and the sentences imposed in practice. Judicial reasons for sentencing are analysed to elucidate themes, which confirm that many of the traditional aims of sentencing – such as specific deterrence, retribution or rehabilitation – are inapposite in cases involving compassion for the suffering of a loved one. The review also identifies inconsistent outcomes, both in charges laid and sentences imposed, which have the potential to undermine public confidence in the rule of law. The article concludes that criminal law simultaneously provides both too much protection and not enough protection for members of the community, and recommends law reform to enable judges to make a greater distinction between voluntary and non-voluntary assisted suicides and mercy killings.

I. INTRODUCTION[1]

Although not frequent, there are regular reports of cases in which individuals—generally a spouse or child, but sometimes also a friend or other relative—take the law into their own hands through 'mercy killing' or assisting suicide. Two recent cases are illustrative. In May 2019, Kenneth Attenborough was convicted of administering a poison with intent to murder his father, who was at the time in palliative care with a

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limited life expectancy.[2] This attempted 'mercy killing', done with the consent of his father, attracted a sentence of 20 months to be served by way of an intensive corrections order. And in April 2019, Neil O'Riordan admitted assisting his wife Penelope Blume (who was in the terminal stages of motor neurone disease) to commit suicide before her disease robbed her of the capacity to do so.[3] The ACT Director of Public Prosecutions exercised his discretion not to prosecute Mr O'Riordan, in the public interest.[4] These cases often feed into the current debate on voluntary assisted dying, raising the question of how best to balance the competing policy considerations of respecting the autonomous choices of competent adults, and protecting those who may be considered vulnerable.[5]

The purpose of this article is not to assess if regime change—whether through the legislation permitting voluntary assisted dying recently enacted in Victoria, Western Australia and Tasmania,[6] or other proposed regulatory models—will contain sufficient safeguards to protect the vulnerable. Rather, this article explores the status quo: how the criminal law system responds to individuals who have been involved in the death of a loved one with a terminal or chronic illness, whether through assisting suicide like Neil O'Riordan, or active involvement in 'mercy killing' as was attempted in Kenneth Attenborough's case. 'Mercy killing' is not a legal term of art, but simply refers to 'an intentional killing which is prima facie murder but which is carried out for compassionate motives, often by a member of the family or a friend of the victim,'[7] whether or not the person had expressly requested to die. Other terms used in this article include 'offender' to describe the person who was convicted of the relevant offence, and 'deceased' to describe the person who died as a result.[8]

2 *R v Attenborough* (NSW District Court, Graham AJ, 30 May 2019) ('*Attenborough*'). This case is discussed further below.

3 Michael Inman, 'Assisted suicide charges dropped against Canberra man who helped end wife's life', *ABC News* (online, 2 July 2019) <https://www.abc.net.au/news/2019-07-02/assisted-suicide-charges-dropped-in-canberra-court/11270040>.

4 Neville Shane Drumgold, Director of Public Prosecutions (ACT), *Police v O - CC2019/3260: Charge of Aiding Suicide under section 17(1) Crimes Act 1900* (Decision, 28 June 2019) <https://www.dpp.act.gov.au/__data/assets/pdf_file/0007/1382353/Police-v-O-DPP-Statement-of-Reasons.pdf> ('*Police v O - CC2019/3260*').

5 Western Australia, *Parliamentary Debates,* Legislative Assembly, 7 August 2019, 5137 (Roger Cook); Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3060 (Martin Pakula, Attorney-General), 3062 (Samuel Hibbins).

6 *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)'); *Voluntary Assisted Dying Act 2019* (WA) ('*VAD Act* (WA)'); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ('*EOLC Act* (Tas)'). Katrine Del Villar, Lindy Willmott and Ben White, "Suicides, Assisted Suicides and 'Mercy Killings': Would Voluntary Assisted Dying Prevent these 'Bad Deaths'?" (2020) 46(2) *Monash University Law Review* (in press) considers whether any of the deceased or injured persons in the assisted suicide or mercy killing cases would have been eligible for voluntary assisted dying if the laws were in operation in the jurisdiction in which they died. It is concluded that only a small minority of people suffered from a qualifying terminal illness.

7 Margaret Otlowski, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17(1) *Criminal Law Journal* 10, 10. Although in law, these actions constitute murder, the difference between 'mercy killing' and murder lies in the motivation — in the former case, the killing is intended to be an act of 'mercy' or compassion to the deceased, whereas in the latter case, the killing is motivated by an intention to cause harm.

8 This latter term was chosen because it is more neutral than 'victim', which is less apt to describe some cases, such as where the deceased was taking their own life and insistent on help from a loved one. However, acknowledging that the term 'deceased' is not appropriate to use in those cases where the person did not die, it remains necessary in some instances to use alternative terms such as 'victim'.

This article categorises all the publicly reported Australian cases on assisted suicide and mercy killing since 1980 according to the nature of the actions of the accused: whether assisting a person to die at their request; completing a suicide attempt; causing the death of a competent person at that person's request; or causing the death of a person (whether or not competent) without that person's request. It then explores the sentences imposed and the reasons for sentencing, to evaluate how the criminal law currently responds to actions that result in the death of a potentially vulnerable person.

The argument proceeds as follows. Part II briefly outlines the criminal law which is applicable to cases of assisted suicide or mercy killing. Part III then provides an overview of the Australian assisted suicide and mercy killing cases, and compares the actual sentences to the maximum penalty which may be imposed. The pronounced leniency which is observed demonstrates a significant gap between the law on the books and judicial sentencing practice. Insight into the reasons for leniency in sentencing can be obtained from a detailed examination of judges' sentencing remarks. Part IV explores the sentencing remarks concerning the traditional goals of the criminal justice system—protection of the community, prevention of crime, and punishment of wrongdoing. It concludes that many of the traditional aims of sentencing are inapposite in cases involving compassion for the suffering of a loved one. Part V then identifies some significant themes emerging from the sentencing remarks. A dominant theme was the compassionate motive of the offender. Many cases also emphasised the deceased's desire to remain autonomous and avoid dependence or nursing home care. However, the potential vulnerability of the victim was not often mentioned.

Part VI argues that in many cases, the law is not in line with community values where there was a compassionate motive for causing death. This discrepancy is ameliorated through discretion in charges laid and sentences imposed. But when the just application of the law depends on prosecutorial and judicial discretion, inevitably there will be inconsistent outcomes in some cases, which may undermine public confidence in the rule of law. This leads to recommendations for law reform,[9] which may include introducing a specific offence of mercy killing, a partial defence of compassionate motive, or an offence of completing a suicide, so that the offence charged more accurately reflects community values.

However, we also argue that the lenient sentences imposed in cases of non-voluntary mercy killing reflect too great a preoccupation with the motive of the offender, and too little respect for the vulnerability of the deceased. We recommend excluding non-voluntary mercy killings from the proposed law reforms, to ensure the law provides sufficient protection for vulnerable people.

II. CRIMINAL LAW

Assisted dying is currently illegal in every Australian jurisdiction, except in Victoria where a person has a terminal illness and meets the eligibility criteria for voluntary assisted dying.[10] Although suicide—the intentional taking of one's own life—is no

9 These recommendations are set out in Part VII.

10 *VAD Act* (Vic) (n 6) s 9. Assisted dying will become lawful in Western Australia on 1 July 2021 when the *VAD Act* (WA) (n 6) commences. Tasmania's *EOLC Act* (Tas) (n 6) was passed in March 2021, and is expected to commence mid- to late-2022.

longer a criminal offence in Australia,[11] and there is no duty of care to prevent a person from committing suicide,[12] every State and Territory retains the offence of *assisting suicide* or encouraging[13] another person to commit suicide.[14] Assisting or encouraging suicide is unlawful even where assistance is provided at the request of the person who wishes to die. The maximum penalty varies from five years to life imprisonment.[15]

A person who takes active steps to cause the death of another person also commits a criminal offence. Legally, the intentional killing of another person is classified as *murder*, even if performed at that person's request. It is punishable in all Australian jurisdictions by life imprisonment.[16] The alternative verdict of *manslaughter* is possible where mitigating circumstances exist, such as diminished responsibility or killing another pursuant to a suicide pact.[17] The maximum penalty for manslaughter ranges from 20 years to life imprisonment.[18] In three states, when death occurs pursuant to a

11 The common law offences of suicide and attempted suicide were abrogated in 1967 in Victoria, 1983 in NSW and South Australia, and 1990 in the ACT: *Crimes Act 1958* (Vic) s 6A ('*Crimes Act* (Vic)'); *Crimes Act 1900* (NSW) s 31A ('*Crimes Act* (NSW)'); *Criminal Law Consolidation Act 1935* (SA) s 13A(1) ('*Criminal Law Consolidation Act*'); *Crimes Act 1900* (ACT) s 16 ('*Crimes Act* (ACT)'). In the Code jurisdictions, the crime of suicide was abolished in 1899 in Queensland, 1902 in Western Australia, 1924 in Tasmania and 1996 in the Northern Territory: *Criminal Code 1899* (Qld) s 300 ('*Criminal Code* (Qld)'); *Criminal Code Act 1913* (WA) s 277 ('*Criminal Code* (WA)'); *Criminal Code* (Tas) s 153(1) ('*Criminal Code* (Tas)'); *Criminal Code* (NT) ss 156(1)(b), 160(b) ('*Criminal Code* (NT)'). See Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining A Suicide Under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 358–9; John Barry, 'Suicide and the Law' (1965) 5(1) *Melbourne University Law Review* 1, 9; Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Thomson Reuters, 4th ed, 2017) 567.

12 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, [87].

13 The precise terminology of the offence varies between jurisdictions and includes aiding, abetting, assisting, procuring, instigating, encouraging, counselling, commanding or inciting a person to commit suicide.

14 For detail as to the terminology employed in the different jurisdictions, see Bronitt and McSherry (n 11) 531–2.

15 In Victoria, the maximum penalty is 5 years: *Crimes Act* (Vic) (n 9) s 6B(2). In NSW and the ACT, it is 10 yrs: *Crimes Act* (ACT) (n 9) s 17; *Crimes Act* (NSW) (n 9) s 31C(1). In SA, it is 14 years: *Criminal Law Consolidation Act* (n 9) ss 13A(5), 13A(6)(a)(i). In Tasmania, it is 21 years: *Criminal Code* (Tas) (n 9) ss 163, 389. In the Northern Territory, Queensland and Western Australia, the maximum penalty is life imprisonment: *Criminal Code* (NT) (n 9) s 162; *Criminal Code* (Qld) (n 9) s 311; *Criminal Code Act* (WA) (n 9) s 288.

16 In Queensland, South Australia and the Northern Territory, the prescribed sentence for murder is 'mandatory life imprisonment': *Criminal Code* (NT) (n 9) ss 156, 157; *Criminal Code* (Qld) (n 9) ss 302, 305; *Criminal Law Consolidation Act* (n 9) s 11. In Western Australia, a life sentence is mandatory unless this would be clearly unjust in the circumstances, and the person is unlikely to be a threat to community safety, in which case a sentence of up to 20 years may be imposed: *Criminal Code Act* (WA) (n 9) s 279(4). In NSW, Victoria, Tasmania and the ACT, life imprisonment is the maximum sentence which may be imposed for the crime of murder: *Crimes Act* (ACT) (n 9) s 12(1); *Crimes Act* (NSW) (n 9) ss 18(1)(a), 19A(1); *Criminal Code* (Tas) (n 9) ss 157, 158; *Crimes Act* (Vic) (n 9) s 3.

17 Otlowski also notes cases where facts amounting to murder or attempted murder have been prosecuted as lesser offences, such as manslaughter or assisting suicide, according to plea bargaining principles or in the exercise of prosecutorial discretion: Otlowski (n 7) 16–18. See also Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17(4) *Journal of Law and Medicine* 532, 547.

18 In the ACT and Victoria, the maximum penalty is 20 years: *Crimes Act* (ACT) (n 9) s 15(2); *Crimes Act* (Vic) (n 9) s 5. In Tasmania it is 21 years: *Criminal Code* (Tas) (n 9) ss 159, 389. In NSW it is 25 years: *Crimes Act* (NSW) (n 9) ss 18(1)(b), 24. In the Northern Territory, Queensland, South Australia and Western Australia, the maximum penalty is life imprisonment:

suicide pact, the survivor will not be charged with murder, but with a lesser offence, such as *manslaughter by suicide pact*.[19]

III. ASSISTED SUICIDE AND MERCY KILLING CASES

In Australia, there have been numerous cases where relatives or friends have been prosecuted for assisting the suicide of a loved one, or causing a family member's death out of compassionate motives.[20] The facts of these cases vary: some involved a failed or partially successful suicide pact between an elderly couple;[21] while others concerned a gravely ill[22] or mentally distressed person who requested assistance to take his or her own life.[23] In addition to assisting suicide, in several cases charges of murder[24] or attempted murder[25] have been brought concerning mercy killings, even where the deceased requested assistance to die.

Criminal Code (NT) (n 9) ss 160, 161; *Criminal Code* (Qld) (n 9) ss 303, 310; *Criminal Law Consolidation Act* (n 9) s 13(1); *Criminal Code Act* (WA) (n 9) s 280(1).

19 The maximum penalty is 5 years in South Australia and 10 years in Victoria: *Criminal Law Consolidation Act* (n 9) ss 13A(3), 13A(6)(b); *Crimes Act* (Vic) (n 9) ss 6B(1), 6B(1A). In NSW, the charge is assisting or encouraging suicide, for which the maximum penalty is 10 years: *Crimes Act* (NSW) (n 9) ss 31B(1), 31C.

20 See Otlowski (n 7); Bartels and Otlowski, (n 17). Similar cases have been reported in Canada and New Zealand: see Jocelyn Downie, 'Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions' (2016) 16(1) *QUT Law Review* 84, 100–3; Andrew Geddis, 'The case for allowing aid in dying in New Zealand' [2017] *New Zealand Criminal Law Review* 3.

21 *R v Marden* [2000] VSC 558 ('*Marden*'); *DPP v Rolfe* [2008] VSC 528 ('*Rolfe*'); *R v Maxwell* [2003] VSC 278 ('*Maxwell*'). See also *Walmsley v The Queen* (2014) 253 A Crim R 441 ('*Walmsley*') for a suicide pact between drug addicts.

22 *R v Godfrey* (Supreme Court of Tasmania, Underwood J, 26 May 2004) ('*Godfrey*'); *R v Rijn* (Melbourne Magistrates Court, Magistrate Lethbridge, 23 May 2011) ('*Rijn*'), *R v Pryor* (Supreme Court of Tasmania, Hill AJ, 19 December 2005) ('*Pryor*') (assisting suicide of father). In *R v Nielsen* [2012] QSC 29 ('*Nielsen*'), Frank Ward also felt he was seriously ill, but may not have been.

23 *R v Carter* (Supreme Court of Queensland, Byrne J, 24 July 2001) ('*Carter 2001'*); *R v Carter* (Supreme Court of Queensland, Mullins J, 17 July 2003) ('*Carter 2003*'); *R v Hood* [2002] VSC 123 ('*Hood*'); *DPP v Karaca & Price* [2007] VSC 190 ('*Karaca & Price*'); *R v Larkin* [1983] VSC 122 ('*Larkin*').

24 *R v Johnstone* (1987) 45 SASR 482 ('*Johnstone*'); *Carter 2001* (n 23) (murder of Gail Marke); *Carter 2003* (n 23) (retrial for murder of Gail Marke); *R v Nicol* [2005] NSWSC 547 ('*Nicol*'); *R v Cooper* [2019] NSWSC 1042 ('*Cooper*'); *R v Blaauw* [2008] VSC 129 ('*Blaauw*').

25 *R v Klinkermann* [2013] VSC 65 ('*Klinkermann*'); *R v Nestorowycz* [2008] VSC 385 ('*Nestorowycz*'); *R v Hollinrake* [1992] VSC 289 ('*Hollinrake*'); *DPP v Riordan* (Victorian Supreme Court, Cummins J, 20 November 1998) ('*Riordan*'); *Pryor* (n 22) (attempted murder of mother).

This part describes all Australian cases of mercy killing or assisting suicide judicially decided since 1980,[26] whether reported or unreported,[27] for which sentencing remarks are publicly available.[28] All cases where the dominant motive was compassion for the suffering of the deceased,[29] or a desire to comply with the deceased's expressed wishes,[30] have been included even if they were not classified as mercy killings by the sentencing judge. Cases were excluded where the motive for the killing:

- was mis-conceptualised as 'mercy' by the offender due to psychiatric disturbance[31] or personality disorder;[32]
- was solely selfish, such as a desire for financial gain[33] or to be free of the burden of care;[34]

26 The cases up to 2010 have been described in detail in Otlowski (n 7); and Bartels and Otlowski (n 17) 544. The cases up to 2016 have also been briefly listed in Downie (n 20), 103–4. However, the focus of their analysis has been on the fact of leniency in the exercise of prosecutorial discretion or judicial discretion in sentencing, rather than a detailed analysis of the reasons for this leniency. There was also only limited mention made of leniency in cases of non-voluntary mercy killings.

27 The methodology used to identify these cases is set out in Del Villar, Willmott and White, (n 6), XX. A range of search terms were employed across online case reporting databases Austlii and Jade Case Citator, as well as the unreported judgments repositories of each of the State and Territory Supreme Courts. Because most sentencing cases constitute the unreported judgment of a single judge, many are not publicly available. It is unusual for unreported judgments to be publicly available prior to the mid-1990s, except in Victoria. Otlowski's research demonstrates that there are also many other similar cases stretching back to at least the 1960s: Otlowski (n 7) 17–18, 20, 28. For most of these cases, the sentencing remarks are not publicly available.

28 Because the primary document analysed is the sentencing remarks after criminal conviction, this excludes consideration of discretionary decisions by police and prosecutors not to proceed to trial and conviction. For a more detailed analysis of these decisions, involving interviews with police, all State and Territory public prosecutors, and parole board representatives, see Otlowski (n 7). In most cases written reasons for the prosecution's decision are not publicly available. For exceptional examples where reasons are provided, see Nick Cowdery, 'Dying with Dignity' (2011) 86 *Living Ethics* 12; *Police v O - CC2019/3260* (n 4). It also excludes cases where there is a trial by jury, and the jury chooses to acquit a sympathetic accused against what appears to be the weight of the evidence, such as *R v Nixon* (Queensland Supreme Court, 7 December 2017), referred to in *R v Morant* [2018] QSC 222, [28]–[32] (Davis J). See also Otlowski (n 7) 18–19.

29 *Blaauw* (n 24).

30 Two cases involved drug addicts assisting other drug addicts to commit suicide at their request: *Carter 2001* (n 23); *Walmsley* (n 21).

31 Such as *R v Cheatham* [2002] NSWCCA 360, where the offender killed his wife and daughter while suffering from the delusional belief that he had infected them with AIDS; *R v Duthie* [1999] NSWSC 1224, where the offender was a prisoner suffering from the effects of drugs when he formed a suicide pact with his cellmate; and *DPP v Boodhoo* [2016] VSC 458, where an offender suffering from major depression with psychotic symptoms, including paranoia and delusions, tried unsuccessfully to kill himself and his wife in what he considered to be an act of mercy.

32 An example is the paranoid and anti-social personality of the offender in *R v Howard* [2009] VSC 9.

33 In *R v Morant* [2018] QSC 251 ('*Morant*'), a man was convicted of inciting his mentally ill wife to commit suicide, and providing her with the means to do so, so he could obtain the benefit of three significant life insurance policies he had taken out over her life.

34 In *R v Ritchie* [2003] NSWSC 864 ('*Ritchie*'), a son suffocated his terminally ill mother, claiming she had begged him repeatedly to end her pain. Barr J did not believe his mother had requested to die and found instead that the murder was motivated by his desire to be free from the burden of caring for her. In *R v McLaren* [2011] NSWDC 115, a paid live-in home carer attempted to kill an elderly man with motor neurone disease, due to his frustration at having to care for him.

- appears to have been a heat-of-the-moment reaction to extreme stress;[35] or
- appears to have been malice, rather than compassion for the deceased.[36]

This method resulted in a final sample of 28 cases.[37] Table 1 provides a brief summary of these cases, together with the charges, the sentences imposed and the maximum possible sentence. The Table groups the cases into the following four categories: assisting suicide, completing a suicide, voluntary mercy killing (deceased had capacity and voluntarily requested death) and non-voluntary mercy killing (deceased did not have capacity and/or request death).

Table 1—Sentences for assisting suicides and mercy killings

Case	Deceased/ victim's relationship to offender	Deceased/ victim's situation/ condition	Mode of death or injury	Offender's act or assistance	Charge	Maximum penalty	Actual sentence
Assisting suicide							
R v Carter (Supreme Court of Queensland, Byrne J, 24 July 2001)[38]	Friend (see also below in Table 1)	Depressed and suicidal	Heroin overdose	Supplied heroin	Aiding and abetting suicide of Smyth	Life imprisonment	2 years imprisonment [39]
R v Hood [2002] VSC 123	Flatmate and former lover	Financial and relationship troubles; depressed	Overdose of pills	Emotional support and was present until his friend died	Aiding and abetting suicide	5 years imprisonment	18 month suspended sentence
R v Justins [2008]	Partner of 20 years	Advanced Alzheimer's; prior suicide attempts	Drank Nembutal	Supplied Nembutal which a friend obtained illegally in Mexico	Manslaughter	25 years imprisonment	At first instance: 22 months periodic detention (weekends)

35 Such as *R v Dawes* [2004] NSWCA 363, where a mother strangled her 10 year old autistic son, to whom she was devoted, when he refused to get ready for school. This out-of-character act was described as the cumulative result of numerous personal stressors such as her marriage breakdown, the death of her father, revelations that her daughter had been sexually abused by her stepfather, and major depression.

36 For example, in *R v Davis* [2016] NSWSC 1362, and *Haines v R* [2018] NSWCCA 269, nurses in two separate aged care facilities administered large doses of insulin to residents, resulting in their deaths. They were charged with murder. The precise motive for doing so is not specified in the judgment in *Davis*, but in *Haines* it was alleged that the offender murdered two residents after they made complaints about her.

37 There were 26 separate proceedings. However, the sentencing remarks in *Pryor* (n 22) cover two separate offences: assisting the suicide of her father, and the attempted murder of her mother. Similarly, Carter was convicted of assisting the suicide of Patrick Smyth and the murder of Gail Marke: *Carter 2001* (n 23). Each of these offences is counted as a separate 'case', although the sentencing remarks are combined.

38 Carter pleaded guilty to assisting the suicide of Smyth, and was convicted of the murder of Marke after a jury trial: *Carter 2001* (n 23). On appeal, that conviction for murder was set aside: *R v Carter* [2003] 2 Qd R 402 ('*Carter Appeal 1'*). On retrial, Carter again pleaded not guilty to murder but guilty of assisting Marke commit suicide. He was again convicted by a jury of murder and sentenced to life imprisonment: *Carter 2003* (n 23). His appeal against that second conviction was dismissed: *R v Carter* (2003) 141 A Crim R 142 ('*Carter Appeal 2'*). This paper refers to the reasons for sentence in both *Carter 2001* (n 23) and *Carter 2003* (n 23). Some relevant facts are taken from other judicial decisions on this matter.

39 *Carter 2001* (n 23). A summary is contained in *R v Carter* [2016] QSC 86, [3].

NSWSC 1194[40]							and 8 months of parole
R v Rijn (Melbourne Magistrates Court, Magistrate Lethbridge, 23 May 2011)	Elderly wife	Chronic hip pain	Suffocation	Purchased equipment from Exit International	Inciting suicide	5 years imprisonment	3 years good behaviour bond
R v Nielsen [2012] QSC 29	76 year old man, friend from meditation group	Minor stroke; further minor medical condition, undiagnosed; fear of dependence	Drank Nembutal	Went to Mexico to purchase Nembutal	Aiding and abetting suicide	Life imprisonment	3 years in prison (6 months non-parole)
Walmsley v The Queen (2014) 253 A Crim R 441	Girlfriend	Depressed and suicidal	Heroin overdose	Purchased heroin; agreed to suicide pact	Aiding and abetting suicide	10 years imprisonment	2 years 9 months imprisonment
Completing a suicide							
R v Larkin [1983] Vic SC 122	Patient, then lover	Bipolar or schizophrenic, depressed and suicidal	Overdose of pills; Insulin injection	Injected insulin	Aiding and abetting suicide	14 years imprisonment	3 year good behaviour bond
R v Maxwell [2003] VSC 278	59 year old wife	Terminal cancer	Helium balloon asphyxiation method from the book *Final Exit*	Crushed the pills and fixed the plastic bag over her head	Aiding and abetting suicide	5 years imprisonment	18 months suspended sentence
R v Godfrey (Supreme Court of Tasmania, Underwood J, 26 May 2004)	88 year old mother	Chronic pain and refused to go into care	Overdose of pills, then suffocation	Son assisted by suffocating her in a plastic bag	Assisting suicide	21 years imprisonment	12 months suspended sentence
R v Pryor (Supreme Court of Tasmania, Hill AJ, 19 December 2005)	79 year old father (see also below in Table 1)	Terminal cancer	Injections of pethidine and insulin, then suffocation	Prepared initial injections; administered further injections; suffocated him with a plastic bag	Assisting suicide	21 years imprisonment	12 months wholly suspended
DPP v Karaca & Price [2007] VSC 190	30 year old flatmate (offenders were 18 years old)	Depressed	Overdose of pills, then bludgeoning with iron bar	Hit him over head with iron bar; left him for dead (he survived)	Attempted murder	25 years imprisonment	3 year suspended sentence

[40] The initial conviction for manslaughter was quashed on appeal: *Justins v The Queen* (2010) 79 NSWLR 544. On the retrial, Justins pleaded guilty to assisting suicide. No additional sentence was imposed, as the first sentence had already been served in full: *R v Justins* [2011] NSWSC 568. This paper focusses on the reasons for sentence in the initial proceedings.

R v Mathers [2011] NSWSC 339	78 year old long term partner	Severe back pain	Overdose of pills, then suffocation	After 36 hours, suffocated her with a pillow	Manslaughter (diminished responsibility)	25 years	2 year good behaviour bond
Voluntary mercy killing							
R v Johnstone (1987) 45 SASR 482	Wife of 36 years	Severe bipolar disorder for 30 years; prolonged alcoholism	Electrocution	Electrocuted wife at her request	Murder	Mandatory life imprisonment	Mandatory life imprisonment; non-parole 10 days
R v Marden [2000] VSC 558	Wife of 48 years	Severe pain; lost contact with their grandsons	Electrocution, then suffocation	Electrocuted then suffocated wife; suicide pact (he survived)	Manslaughter by suicide pact	10 years imprisonment	2 year suspended sentence
R v ANG [2001] NSWSC 758	31 year old uncle (offender was 16 years old)	Depressed and suicidal	Overdose of pills; drowning	Pushed him into the river as requested	Manslaughter by criminal negligence	25 years imprisonment	2 years wholly suspended with good behaviour bond
R v Carter (Supreme Court of Queensland, Mullins J, 17 July 2003)	Friend of boyfriend (boyfriend was Smyth: see above).	Depressed and suicidal	Heroin overdose	Supplied heroin and injected heroin	Murder of Gail Marke	Mandatory life imprisonment	Life imprisonment
R v Nicol [2005] NSWSC 547	Wife of 63 years	Half leg amputation; avoiding move into a nursing home	Blunt trauma to head, then suffocation	Beat wife with a metal rod, then plastic bag asphyxiation; he then attempted suicide	Murder (pleaded guilty to manslaughter (substantial impairment))	25 years imprisonment	2 years suspended sentence
DPP v Rolfe [2008] VSC 528	85 year old wife of 55 years	Vascular dementia; avoiding care home	Gassing	Gassing in bed; suicide pact (he survived)	Manslaughter by suicide pact	10 years imprisonment	2 year suspended sentence
R v Attenborough (NSW District Court, Graham AJ, 30 May 2019)	82 year old father	In palliative care due to a twisted stomach, hiatus hernia and heart condition	Overdose of morphine and other drugs via his syringe driver	Loaded medication into syringe driver, and pushed button (his father survived)	Administering a poison with intent to murder	25 years imprisonment	20 months intensive corrections order (supervision in the community and 100 hours community service)
R v Cooper [2019] NSWSC 1042	Semi-estranged partner	Chronic pain	Overdose of heroin	Supplied heroin and injected heroin	Murder	Life imprisonment	13.5 years imprisonment
Non-voluntary mercy killing							
R v Hollinrake [1992] Vic SC 289	77 year old wife of 51 years	Major stroke; did not want to be dependent	Slit wrists	Slit her wrists; then attempted suicide (both survived)	Attempted murder	25 years imprisonment	3 year good behaviour bond
DPP v Riordan, (Victorian Supreme	71 year old wife of 48 years	Advanced Alzheimer's disease for	Suffocation	Smothered her then slit her wrists; he also attempted	Attempted murder	25 years imprisonment	3 year good behaviour bond

Court, Cummins J, 20 November 1998)		more than a decade		suicide (both survived)			
R v Pryor (Supreme Court of Tasmania, Hill AJ, 19 December 2005)	74 year old mother	Dementia	Insulin injection	Injected insulin (she survived)	Attempted murder	21 years imprisonment	18 months wholly suspended
R v Sutton [2007] NSWSC 295	29 year old son	Trisomy 13 syndrome	Not stated	Not stated	Manslaughter (substantial impairment)	25 years imprisonment	5 year good behaviour bond
R v Nestorowycz [2008] VSC 385	Husband of 45 years	Double amputee with dementia and diabetes	Stabbing	Stabbed him in stomach; also stabbed herself (both survived)	Attempted murder	25 years imprisonment	2 years 9 months suspended sentence
R v Blaauw [2008] VSC 129	54 year old wife	Paranoid schizophrenia	Stabbing	Slit her throat	Murder	Life imprisonment	11 years; non parole 7 years
R v Klinkermann [2013] VSC 65	84 year old wife	Severe dementia; Parkinson's disease; needed full-time care	Gassing	Piped car exhaust through the bedroom window; he also attempted suicide (both survived)	Attempted murder	25 years imprisonment	18 month community correction order
R v Dowdle [2018] NSWSC 240	27 year old son	Severe disability from car accident, alcoholic and drug user	Suffocation	Gave him sleeping tablets and placed a plastic bag over his head	Manslaughter (substantial impairment)	25 years imprisonment	2 years non-parole plus balance of 1 year release on parole

The subsections below describe the sentences imposed for the four categories of cases above. As will be observed, broadly the same approach regarding leniency in sentencing is taken in the majority of cases, regardless of the offender's level of involvement, the violence of the act or the potential vulnerability of the deceased.

A. Assisting suicide

The maximum sentence for assisting a suicide varies greatly, ranging from 5 years in Victoria[41], to 10 years in NSW and the ACT,[42] 21 years in Tasmania,[43] and life imprisonment in Queensland.[44] Despite this variance in head sentence between jurisdictions, there is little variance in the actual sentences imposed. In both cases where the assistance to commit suicide was characterised solely as an act of compassion, the

41 *Hood* (n 23), *Rijn* (n 22).
42 *R v Justins* [2008] NSWSC 1194; *Walmsley* (n 21).
43 *Criminal Code* (Tas) (n 9) ss 163, 389. See *Pryor* (n 22).
44 *Nielsen* (n 22); *Carter 2001* (n 23).

defendant received a wholly non-custodial sentence, accompanied only by a short good behaviour bond of 18 months or 3 years.[45]

In the other four cases of assisting a suicide, short custodial sentences were imposed, but all included complicating factors detracting from the purity of the offender's compassionate motivation. Two cases involved a financial motivation arising under the deceased's will,[46] and two involved criminal activity—the procurement of illegal narcotics (in both cases heroin)—without a clear motivation of compassion, aside from complying with the request of the deceased.[47]

B. Completing a suicide

The boundary between assisting suicide and mercy killing is blurred in cases where the accused takes active steps to complete a suicide attempt after the deceased had begun the process. Examples include suffocating a person who has taken an overdose and is already unconscious;[48] and injecting a person with insulin, at their request, to ensure the overdose was successful.[49]

Technically in law, an action causing death performed with the intention to cause death constitutes murder. Attempted murder was the charge laid in *Karaca and Price*,[50] but in most cases the offender was charged with assisting suicide instead.[51] Notwithstanding the very substantial head sentence applicable in most cases (ranging from 14 years[52] to 25 years imprisonment[53]), in all six cases of completing a suicide the offender received a wholly suspended sentence, ranging from 12 months[54] to 3 years.[55]

45 *Hood* (n 23); *Rijn* (n 22). These sentences can be contrasted with the sentence of 10 years imposed on Morant for assisting in his wife's suicide. Although his actions in purchasing and preparing the equipment for his wife's suicide are comparable with the actions of Rijn and Godfrey, his motivation was different. He was not motivated by a compassionate desire to ease his wife's suffering, but by a desire to benefit from the three large life insurance policies he had deliberately taken out in his wife's name, worth a total of $1.4 million. Morant had actively encouraged his wife to commit suicide so he could use the proceeds from the insurance payouts to set up a religious community: *Morant* (n 33) [18]–[35] (Davis J).

46 In *Justins* (n 42), the offender's primary motivation was compassion and a desire to give effect to her partner's enduring wish to die. However, a week before his death she had procured an alteration to her partner's will in her favour: at [19] (Howie J). At first instance she was sentenced to 22 months periodic detention: at [36]–[37]. In *Nielsen* (n 22), the deceased had executed a will in favour of Nielsen, whom he knew only as a friend through attendance at a meditation group: at 1-8; 1-16 (Dalton J). He was sentenced to 3 years imprisonment.

47 *Carter 2003* (n 23) [2] (Mullins J); *Walmsley* (n 2121) [7]–[9] (Ross J, Refshauge and Penfold JJ agreeing). In *Walmsley* (n 21), the judge doubted that it amounted to a mercy killing: stating that the offence was 'more serious than a "mercy killing" at the lower end of the spectrum, in that it was not within the same range of circumstances as assisting a terminally ill person who is in a lot of pain': at [33].

48 *Pryor* (n 22); *R v Mathers* [2011] NSWSC 339 ('*Mathers*'); *Godfrey* (n 22).

49 *Larkin* (n 23).

50 Where the charge was attempted murder. In *Mathers* (n 48), the charge or murder was reduced to manslaughter on the ground of diminished responsibility.

51 *Larkin* (n 23); *Maxwell* (n 21); *Pryor* (n 22) (father); *Godfrey* (n 22).

52 *Larkin* (n 23). When s 6B was first inserted into the *Crimes Act* (Vic) (n 9) by the *Crimes Act 1967* (Vic) s 2, the maximum penalty was 14 years imprisonment. This was reduced to 5 years in 1991: *Sentencing Act 1991* (Vic) s 119(1) and sch 2 ('*Sentencing Act* (Vic)'). Maxwell was therefore subject to the reduced maximum of 5 years: *Maxwell* (n 21).

53 *Karaca & Price* (n 23); *Mathers* (n 48).

54 *Pryor* (n 22) (assisting suicide of father).

55 *Larkin* (n 23); *Karaca & Price* (n 23).

These sentences are directly comparable to the two suspended sentences imposed for assisting suicide solely from compassionate motives (discussed directly above).[56]

Further, leniency is evident irrespective of the nature of the offender's act. The defendant Price received a 3 year good behaviour bond for attempting to complete a suicide by violently beating his friend with an iron bar,[57] whereas Rijn received a 3 year suspended sentence for merely assisting his wife's suicide by purchasing equipment.[58]

C. Voluntary mercy killing

Sentences were similarly lenient in cases of voluntary mercy killings: where the offender performed the act causing death out of compassion for the deceased and at their request. In most of these cases, the offender was charged with murder or manslaughter – crimes of the utmost seriousness.[59] The maximum penalty for murder in all jurisdictions is life imprisonment, and in several jurisdictions this sentence is mandatory.[60] Despite the heavy head sentences, most offenders received a sentence of two years or less, wholly suspended,[61] which is dramatically less than the average sentence for murder.[62] The most striking example is the early case of *Johnstone*, where the trial judge imposed the mandatory life sentence on a husband who electrocuted his mentally ill wife, then fixed a non-parole period of only 10 days.[63]

In this context of overwhelming leniency, the substantial custodial sentences imposed in *Carter*[64] (life imprisonment) and *R v Cooper*[65] (13.5 years imprisonment) for injecting a person with heroin at their request appear anomalous. In both cases, the offender was complying with an explicit request from the deceased,[66] and was motivated solely by compassion for the deceased's suffering, which in one case was depression caused by heroin addiction,[67] and in the other was chronic physical pain.[68] One case was described by the judge as a mercy killing,[69] but the other was not.[70]

56 *Hood* (n 23); *Rijn* (n 22). Note that although Hood had briefly attempted to suffocate his friend once he became unconscious, by placing his hand over his nose and mouth, but this act made him feel ill, so he desisted, and there was no suggestion that this caused the deceased's death: *Hood* (n 23) [23]–[24] (Coldrey J).

57 *Karaca & Price* (n 23).

58 *Rijn* (n 22).

59 Two cases involved the lesser statutory offence of manslaughter by suicide pact: *Marden* (n 21); *Rolfe* (n 21).

60 This was the case in *Johnstone* (n 24) in South Australia; *Carter 2001* (n 23) and *Carter 2003* (n 23) in Queensland.

61 *Marden* (n 21); *R v ANG* [2001] NSWSC 758 ('*ANG*'); *Nicol* (n 24); *Rolfe* (n 21). Attenborough's 20 month intensive corrections order was served in the community, but included 100 hours community service: *Attenborough* (n 2).

62 For example, in Victoria, the average sentence for murder from 1997-2001 was 17-18 years. The average sentence for murder of a child or other family member was 13 years: Victorian Law Reform Commission, *Defences to Homicide: Options Paper* (September 2003), [2.78]-[2.79].

63 The prosecution appealed from this sentence, but although the Court of Appeal considered that it was too lenient, they declined to alter it: *Johnstone* (n 24).

64 *Carter 2001* (n 23); *Carter 2003* (n 23).

65 *Cooper* (n 24).

66 In *Carter 2003* (n 23), these entreaties were repeated over a period of about two years: at 2 (Mullins J).

67 Ibid.

68 *Cooper* (n 24).

69 Ibid [78] (Hidden AJ).

70 *Carter 2003* (n 23) 3 (Mullins J). This may be due to the lack of a close relationship between Carter and the deceased, or perhaps because he used illegal drugs to end her life.

Possible reasons for this different approach to sentencing are explored in Parts IV and V below.

D. Non-voluntary mercy killing

There are also several mercy killing cases where an offender killed or attempted to kill a spouse, parent or child who had not made a competent request to die.[71] Although these actions were undertaken for compassionate motives, almost all cases[72] involved a person who was not competent to ask for assistance in dying, by reason of dementia,[73] major stroke,[74] or severe disability.[75] In most of these, the preferred charge was murder or attempted murder, unless diminished responsibility reduced the charge to manslaughter.[76] Despite the seriousness of the offence, and the severity of the maximum penalty (ranging from 21 years to life), in most cases the sentences imposed were no different from those imposed for assisting suicide, completing a suicide or voluntary mercy killing. In five cases, the sentences for attempting to murder a spouse or parent who suffered a major stroke or dementia ranged from 18 months[77] to 3 years,[78] wholly suspended. The Suttons' sentence for the murder of their adult son who had a disability was a 5 year good behaviour bond. The defendant in *Dowdle* did receive a short custodial sentence of 2 years[79] for the murder of her adult son with a disability, which may reflect the mixture of motives: namely, compassion for her son's psychological pain as well as her inability to continue to bear the burden of care for her son, who was an alcoholic and drug user, and abusive towards her.[80]

A different approach to sentencing was taken in *R v Blaauw*. Although Forrest J accepted that Blaauw's primary motivation in killing his wife was to relieve the pain and psychological suffering he felt she was experiencing as a result of her schizophrenia,[81] nevertheless he did not consider that the case constituted a mercy killing. It is unclear whether this is because she had not expressed a wish to die, or because she suffered from a mental illness rather than a terminal or chronic physical condition.[82] Consequently, Blaauw was sentenced to 11 years in prison for murder.

71 In two cases there was a suggestion that, although the act intended to cause death was not specifically requested at the time, it was consistent with earlier discussions about the desire to avoid dependence (*Hollinrake* (n 25) 38 (Coldrey J)) or desire for euthanasia (*Pryor* (n 22) 1 (Hill AJ)).

72 The exceptions are *Blaauw* (n 24) and *R v Dowdle* [2018] NSWSC 240 ('*Dowdle*').

73 *Riordan* (n 25); *Pryor* (n 22); *Nestorowycz* (n 2525); *Klinkermann* (n 25).

74 *Hollinrake* (n 25).

75 *R v Sutton* [2007] NSWSC 295 ('*Sutton*').

76 As in the cases of *Sutton* (n 75) and *Dowdle* (n 72).

77 *Pryor* (n 22); *Klinkermann* (n 25).

78 *Riordan* (n 25); *Hollinrake* (n 25). In *Nestorowycz* (n 25), the sentence was 2 years 9 months, wholly suspended.

79 The head sentence was 3 years but she was released to parole after serving 2 years: *Dowdle* (n 72) [37]–[38] (Hamill J).

80 Ibid.

81 *Blaauw* (n 24) [36] (Forrest J).

82 Ibid [38].

IV. PURPOSES OF SENTENCING

As demonstrated in Part III, with few exceptions,[83] courts have shown extraordinary leniency to friends or relatives convicted of assisting or causing the death of a family member who has a serious illness or disability for motives of compassion. Very few cases resulted in any form of custodial sentence.[84] In this part, we analyse the sentencing remarks on the purposes of sentencing, in search of possible reasons for this leniency. The purposes of the sentencing can broadly be divided into two categories:[85] protecting the community (through rehabilitation and deterrence); and punishing the offender (through retribution and denunciation).[86] As will be revealed below, in the unique circumstances of cases where assisting suicide or causing death occurs out of compassion, imposing a strict sentence may not promote the purposes of the criminal law. This is because there is little risk of recidivism (so limited need for public protection), and no need to rehabilitate or reform the offender.

A. Protection of the community

Three of the core purposes of the criminal law are future-focussed, with the goal of protecting the community by preventing future harm to others.[87] These are: rehabilitation,[88] specific deterrence[89] and general deterrence,[90] all of which aim to prevent future crime, either committed by that particular offender or by other potential offenders.

83 Notably *Carter 2001* (n 23) (2 years imprisonment for assisting the suicide of Smythe, life imprisonment for the murder of Marke); *Carter 2003* (n 23) (life imprisonment for murder); *Cooper* (n 24) (13.5 years imprisonment); *Blaauw* (n 24) (11 years imprisonment).

84 Exceptions are, as noted above *Blaauw* (n 24); *Cooper* (n 24); *Carter 2001* (n 23); *Carter 2003* (n 23); as well as *Dowdle* (n 72) (3 years, 2 years non-parole); *Nielsen* (n 22) (3 years); *Walmsley* (n 21) (2 years 9 months); *Justins* (n 42) (22 months periodic detention); (10 days before parole is so little as to not be counted: *Johnstone* (n 24)).

85 Lanham also lists a third purpose of the criminal law: protection of the offender: David Lanham, 'The Purposes of the Criminal Law' in David Lanham, David Wood, Bronwyn Bartal, Rob Evans (eds), *Criminal Law in Australia* (Federation Press, 2006) 1. However, this purpose compares the criminal law to other, less appropriate, methods of dealing with wrongful action—private revenge or executive control. When considering the purposes of sentencing within the criminal law system, only two purposes are relevant: protection of the community and punishment of the offender.

86 See, eg, *Crimes (Sentencing) Act 2005* (ACT) s 7 ('*Crimes (Sentencing) Act* (ACT)'); *Crimes (Sentencing Procedure) Act 1999* (NSW) s 3A ('*Crimes (Sentencing Procedure)* Act (NSW)'); *Penalties and Sentences Act 1992* (Qld) s 9(1) ('*Penalties and Sentences Act* (Qld)'); *Sentencing Act* (Vic) (n 52) s 5(1). See also Kathleen Daly and Rick Sarre, 'Criminal Justice System: Aims and Processes' in Darren Palmer, Willem de Lint, and Derek Dalton (eds), *Crime and Justice: A Guide to Criminology* (Lawbook, 5th ed, 2017) 357. In some jurisdictions, 'accountability' is included as a goal, the purpose of which is also linked to punishing the offender: *Crimes (Sentencing Procedure) Act* (NSW) (n 87) s 3A(e); *Crimes (Sentencing) Act* (ACT) (n 87) s 7(e). Because accountability is a factor named only in some jurisdictions, and because it overlaps with retribution and denunciation to some extent, it will not be separately considered here.

87 See generally Lanham (n 85).

88 Rehabilitation aims to reform the offender to reduce their risk of future offending.

89 Specific deterrence aims to protect the community from future criminal acts by that offender by incarcerating the offender and by dissuading the person from further offending in the future.

90 The function of general deterrence is to send a message to deter others from committing similar crimes.

1. Rehabilitation

Rehabilitation[91] was not a significant factor in sentencing in most cases of compassionate killing or assisting suicide,[92] because the criminal act was often totally out of character, occurred in unique circumstances and was unlikely to be repeated.[93] In some cases it was considered that a custodial sentence would actually hamper the goal of rehabilitation, such as where the offender had made good progress in reintegrating into community life during the pre-trial period,[94] or where the offender had responsibilities for the care of children.[95] In *Sutton*, where parents killed their adult son, who had severe disabilities, to prevent him undergoing surgery leading to further loss of sensory function, it was noted that separating the couple and imprisoning them would deprive them of support, which would jeopardise any chance of rehabilitation, and pose a real risk of suicide.[96] So in these cases, leniency in sentencing reflected the specific life circumstances of the offender, and the need to place rehabilitation in its social context.

In contrast, in *Walmsley* and *Cooper*, long term drug users with ongoing mental health issues were perceived to have more limited prospects of rehabilitation unless they agreed to participate in treatment addressing their substance abuse. Both were sentenced to significant terms of imprisonment.[97]

2. Specific deterrence

In the cases on assisting suicide, completing a suicide and mercy killing, it was almost uniformly observed that specific deterrence[98] was not a factor relevant to be considered in sentencing. This was because most offenders were considered to be responsible citizens who had led 'unblemished lives',[99] and were not at any risk of reoffending.[100]

91 Rehabilitation refers to providing conditions and education to enable the offender to be reintegrated into society and to reduce the likelihood of that person reoffending.

92 It was frequently remarked that rehabilitation of the offender was not required to be considered in sentencing. See, eg *Hollinrake* (n 25), 42 (Coldrey J); *Nicol* (n 24) [23] (Hulme J); *Blaauw* (n 24) [31] (Forrest J).

93 Rehabilitation may have a role to play in cases where a medical professional or euthanasia advocate repeatedly assists people to die in open contravention of legal prohibitions, such as Dr Jack Kevorkian in the USA, Dr Phillip Nitschke in Australia, or Sean Davison. Davison was a euthanasia advocate who assisted his terminally ill mother to die in New Zealand: *R v Davison* [2011] NZHC 1677. He later went on to provide assistance to three people he was not related to in South Africa: Philani Nombembe, 'Right-to-die activist Sean Davison gets three years' house arrest for murders', *Sunday Times Live* (online, 19 June 2019) <https://www.timeslive.co.za/news/south-africa/2019-06-19-right-to-die-activist-sean-davison-gets-three-years-house-arrest-for-murders/>.

94 ANG enjoyed the support of his parents, wider family and counsellors: *ANG* (n 61) [27]–[28] (Ireland AJ).

95 *Larkin* (n 23) 42 (Nicholson J); *Pryor* (n 22) 2 (Hill AJ).

96 Experts agreed that the best chance of rehabilitating them was for them to receive psychiatric treatment in the community, while continuing to support each other. *Sutton* (n 75) [39]–[41] (Barr J).

97 *Walmsley* (n 21) [36(iii)]; *Cooper* (n 24) [81] (Hidden AJ).

98 Specific deterrence refers to imprisonment or other punishment in order to dissuade or deter an offender from committing a crime in the future.

99 See, eg, *Godfrey* (n 22) 1 (Underwood J); *Maxwell* (n 21) [38] (Coldrey J); *Larkin* (n 23) 46 (Nicholson J); *Mathers* (n 48) [81(7)] (Hall J); *ANG* (n 61) [23] (Ireland AJ); *Hood* (n 23) [52] (Coldrey J).

100 See, eg, *Dowdle* (n 72) [30] (Hamill J); *Blaauw* (n 24) [31] (Forrest J); *Attenborough* (n 2) [30] (Graham AJ).

In these circumstances, there was no need for imprisonment for the protection of the community. Again, the only exceptions to this were *Walmsley* and *Cooper*, whose substance abuse issues posed a risk of reoffending.[101]

3. General deterrence

General deterrence[102] is usually the most significant factor considered by judges in sentencing,[103] but was only sometimes significant in circumstances of mercy killing or assisted suicide. In some cases, general deterrence was considered important, sending a message to the community that, contrary to public and media perceptions, assisting suicide and mercy killing are not justifiable.[104] It is important to remind the community that '[p]eople cannot be permitted to take life in defiance of the law, however altruistic their personal motives may be',[105] and even where that person has requested assistance to die.[106]

However, empirical evidence fails to demonstrate that more severe sentences have an effect in deterring members of the public from committing crimes.[107] Further, community opinion on sentencing consistently rates general deterrence to be the least significant factor in the criminal justice process.[108] Several judges in sentencing a person for mercy killing or assisted suicide have openly doubted whether imposing a stringent sentence is likely to deter others when faced with a loved one in these unusual

101 A sentence of 2 years and 9 months imprisonment for assisting suicide by purchasing heroin was imposed in *Walmsley* (n 21) [36(iii)]. Walmsley was considered a medium to high risk to others, given his lack of commitment to redressing his drug abuse problem. Specific deterrence was also a relevant factor in the 13 and a half year sentence imposed on Cooper, because (despite the fact that Hidden AJ considered him unlikely to reoffend in relation to a serious offence such as murder), he had a lengthy criminal history as well as a history of non-compliance with treatment for schizophrenia: *Cooper* (n 24) [80] (Hidden AJ).

102 The purpose of general deterrence is to impose a sentence of sufficient gravity to dissuade or deter members of the broader community from committing a similar crime in the future.

103 According to the Victorian Jury Sentencing Study, which compared the attitudes of jurors and judges in sentencing: Kate Warner et al, 'Why sentence? Comparing the views of jurors, judges and the legislature on the purposes of sentencing in Victoria, Australia' (2019) 19(1) *Criminology & Criminal Justice* 26, 34.

104 In *Justins* at first instance, general deterrence was considered to be a highly significant matter because of media attitudes 'that somehow the conduct of the offender … was justifiable or at least of a different moral order than other criminal conduct that results in the loss of life': *Justins* (n 42) [43] (Howie J).

105 *Johnstone* (n 24) 485 (King CJ). As Hulme J remarked in *Nicol,* in the context of a voluntary murder-suicide: 'The Court cannot so deal with the Applicant that a message is sent to the community that old persons, even those suffering from an abnormality of mind and with an intention to kill themselves, can kill their partners with impunity: *Nicol* (n 24) [31] (Hulme J). See also *Justins* (n 42) [43] (Howie J); *Rolfe* (n 21) [27] (Cummins J); *Pryor* (n 22) 2 (Hill AJ); *Maxwell* (n 21) [41] (Coldrey J).

106 *Riordan* (n 25), 34 (Cummins J); *Nielsen* (n 22) 1-26 (Dalton J).

107 Andrew Ashworth, *Sentencing and Criminal Justice* (Cambridge University Press, 2010), 79-80. See also Warner et al (n 103), 40;

108 In the Victorian Jury Sentencing Study, of the six purposes of sentencing contained in legislation, general deterrence was ranked 6th by jurors (only 9% of jurors ranked general deterrence most important): ibid., 31. Earlier studies of jurors and Australian public opinion have confirmed that general deterrence is the least significant factor among the purposes of sentencing: Kate Warner et al, *Jury Sentencing Survey* (Report, Criminology Research Council, 2010); Caroline Spiranovic et al, 'Public preferences for sentencing purposes: What difference does offender age, criminal history and offence type make?' (2012) 12(3) *Criminology & Criminal Justice* 289; K Gelb, *Purposes of Sentencing: Community Views in Victoria* (Report, Sentencing Advisory Council, 2011).

circumstances.[109] Additionally, some judges have doubted the need for general deterrence on the basis that such cases occur only rarely.[110]

B. Punishment of the offender

In addition to goals of sentencing which aim to protect the community from future offending, some of the purposes of the criminal law are focussed on the past. They involve the punishment of the offender for wrongful conduct, through retribution and denunciation.[111] These are the primary purposes of sentencing, according to community values.[112] However, these factors did not figure prominently in sentencing in cases of mercy killing or assisted suicide, because of the unique circumstances of many of those cases.

1. Retribution

Retribution—the punishment of the offender by setting an appropriate penalty in proportion to the gravity of the offence—is one of the primary aims of the criminal law.[113] However, this factor was not significant in sentencing in most cases of mercy killing, assisting or completing a suicide. In the overwhelming majority of these cases, the sentencing judge remarked that there was no need to punish the offender or bring them to account for their actions, despite the gravity of the offence. Such observations are only explicable if retribution is focussed primarily on the offender's moral state rather than the gravity of the offence.

Judicial comments in the Australian cases of assisted suicides and mercy killings have focussed on the offender's conduct after the offence. Most offenders had made a full and early confession of guilt,[114] and cooperated fully with police. Many were full of remorse for their actions.[115] In some cases, it was noted that the loss of the loved one was punishment enough.[116] In other cases, the fact of being charged with a serious offence (such as murder) and undergoing a criminal trial was considered sufficient

109 See *Nicol* (n 24) [24] (Hulme J); *Godfrey* (n 22) 2 (Underwood J); *Larkin* (n 23) 46 (Nicholson J); *Marden* (n 21) [18] (Vincent J); *ANG* (n 61) [34] (Ireland AJ); *Mathers* (n 48) [98]–[99] (Hall J); *Sutton* (n 75) [33] (Barr J).

110 *Godfrey* (n 22) 2 (Underwood J); *Hollinrake* (n 25) 42 (Coldrey J); *Rijn* (n 22) 4 (Magistrate Lethbridge). Cf *Pryor* (n 22), where Hill AJ took the view that general deterrence was a relevant factor to consider in sentencing, although the circumstances of the case were rare: at 2.

111 See generally Lanham (n 86).

112 The recent Victorian Jury Sentencing Study found that 29% of jurors selected retribution as the most important purpose of sentencing, and a further 19% considered denunciation the most important: Warner et al (n 103), 31.

113 Lanham (n 86) 1, 6–7.

114 Illustrative examples of this were *Karaca & Price* (n 23) [9] (Teague J); *Marden* (n 21) [23] (Vincent J); *ANG* (n 61) [23] (Ireland AJ); *Mathers* (n 48) [81] (Hall J); *Attenborough* (n 2) 2 (Graham AJ).

115 Notable examples were *Maxwell* (n 21) [33] (Coldrey J), who was described as 'a distressed and confused man who is struggling to come to terms with what he has done'; *ANG* (n 61) [23], [27] (Ireland AJ); *Hood* (n 23) [53] (Coldrey J).

116 The most tragic example in this regard is *Klinkermann* (n 25), where although his wife survived the attempted murder-suicide, she was placed in a nursing home where her devoted husband was prevented from seeing her, either supervised or unsupervised: at [10], [23]–[24] (King J). This was also the case in *Attenborough* (n 2), where he was unable to see his father again before his death, due to being in custody awaiting trial: at 26 (Graham AJ). See also *Sutton* (n 75) [38] (Cummins J); *Rolfe* (n 21).

punishment in the circumstances.[117] The exceptional cases, where no acknowledgement of guilt was made,[118] or where the offender lied to police,[119] all resulted in a custodial sentence.

However, retribution is not solely about the moral responsibility of the offender: it is also about the gravity of the offence. While acknowledging the imperative to consider the other sentencing principles as well, the punishment would generally be expected to be proportionate to the gravity of the offence, not to the offender's level of guilt or remorse. So, for example, the offender in cases of assisting suicide would generally receive a lesser punishment than cases of mercy killing, because the action causing death is that of the deceased, rather than the offender. As Underwood J stated in *R v Godfrey*: 'It must not be forgotten that the crime of aiding suicide is quite different from what is sometimes called "mercy killing", for the latter constitutes murder, being a death by the hand of another.'[120] However, this review indicates that the sentences imposed in the Australian cases do not reflect a clear distinction between acts assisting suicide and acts of mercy killing.

Similarly, although cases of mercy killing or suicide pact fall at the lower end of seriousness in terms of types homicide,[121] the violence of the assault[122] and the vulnerability of the victim[123] affect the gravity of the offence. Despite this, the violence of the assault did not appear to be relevant to the punishment imposed in cases such as *Nestorowycz, Nicol, Marden* or *Johnstone*.[124] Rather the focus was on the offender's

117 Such as for the grieving parents in *Sutton*: *Sutton* (n 75) [35] (Barr J), and the elderly husband in *Maxwell: Maxwell* (n 21) [40] (Coldrey J).

118 Justins only accepted responsibility for her actions towards the conclusion of the trial, and did not appear to fully recognise the extent to which her conduct was morally culpable: *Justins* (n 42) [43] (Howie J). Nielsen and Walmsley also failed to express moral responsibility for their actions: *Nielsen* (n 22); *Walmsley* (n 21).

119 Walmsley consistently lied to police about his involvement in his friend's suicide: *Walmsley* (n 21) [14]. Nielsen also told many lies in the police interview: *Nielsen* (n 22) 1–20 (Dalton J). Another falling outside the cases in this analysis, see also *Ritchie* (n 34), where the assertion of a compassionate motive for killing was not believed, because of the extenuating facts of hiding his mother's body in bushland and denying responsibility for her death for over 3 months, despite repeated questioning by police: at [2]–[3] (Barr J).

120 *Godfrey* (n 22) 2 (Underwood J).

121 *R v Edwards* [2003] VSC 510, [35]–[36] (Gillard J); *R v Vosikata (No 2)* [2016] ACTSC 391, [104] (Burns J); *R v Hoerler* (2004) 147 A Crim R 520, 528 (Spigelman CJ); *R v Cassidy* [2008] ACTSC 13, [18] (Higgins CJ); *Atherden v The State of Western Australia* [2010] WASCA 33, [30] (Wheeler JA, McLure P and Owen JA agreeing).

122 Violence is explicitly recognised as an aggravating factor in many sentencing laws. See, eg, *Crimes (Sentencing Procedures) Act* (NSW) (n 87) s 21A(2)(b); *Sentencing Act 1995* (NT) s 6A(f); *Penalties and Sentences Act* (Qld) (n 87) s 9(3)(e); *Sentencing Act 1997* (Tas) s 11A(1)(e), 19(1); *Sentencing Act* (Vic) (n 52) ss 6C(3)(a), 9B, 10.

123 *R v JPD* [2001] VSC 204, [18] (Vincent J) (an 80 year old physically infirm woman, who was savagely murdered with a garden fork for the purpose of stealing her car was described as an 'extremely vulnerable victim'); *R v Goral, Goral & Akcay* [2001] VSC 208, [12] (Teague J) (a 56 year old publican who was frail and in poor health was gagged, bound and beaten as part of an armed robbery. Teague J stated that 'his vulnerability made him an easy target'). The vulnerability of the victim is expressly stated to be relevant in some sentencing legislation: *Sentencing Act 2017* (SA) s 11(1)(b); *Sentencing Act 1995* (WA) s 6(2)(b). See also Victorian Sentencing Advisory Council, *Homicide in Victoria: Offenders, Victims and Sentencing* (Report, November 2007) [2.1.3.3], [2.2.3.4]; Andrew Ashworth, *Sentencing and Criminal Justice* (Cambridge University Press, 2010), and the cases mentioned at 162–3.

124 In *Nestorowycz* (n 25), Harper J briefly referred to the 'nature of your attack upon your husband', but this was not considered a circumstance of aggravation: at [7].

remorse and acknowledgement of guilt. Similarly, the vulnerability of the deceased did not feature in the assessment of retribution, despite the killing of a vulnerable person generally being treated as a case of higher gravity.[125]

2. Denunciation

The final factor relevant to sentencing is denunciation.[126] Both judges and jurors[127] consider it important to express community disapproval or condemnation of the offending conduct, with the goal of moral education of the offender and the community as to accepted standards of behaviour. Although individual-focussed, it is also a public reaffirmation of community values.

Denunciation was clearly expressed in the caselaw. Almost every judgment referred to the fact that the offence involved the loss of human life or the attempted taking of life.[128] One of the criminal law's core functions is to protect the sanctity of life,[129] irrespective of age, illness, or disability, and to prevent life from being deliberately taken by another.[130] Life is valued so highly that in law it cannot even voluntarily be relinquished. As was noted by the first trial judge in *Justins*, '[t]he law holds human life so sacred that a person cannot give some other person permission to take his or her life.'[131]

Despite the denunciation of the taking of life, in some cases sympathy was expressed for the offender's actions in the circumstances. For example, in *R v Klinkermann*, King J stated:

> Our law does not permit people to behave in that manner towards other human beings. It is permissible of course to end the life of a suffering animal but in terms of a human being that remains an exceedingly contentious issue in our community and as a result you have been charged with the offence of attempted murder of the wife that you loved and adored.[132]

Given the gravity of the offences, and the fact that the taking of life was involved or intended in all cases, it is difficult to interpret the leniency of the sentences (generally, non-custodial) as containing any significant element of denunciation or community condemnation, despite the rhetoric in some cases. In addition, there did not appear to be a greater level of denunciation in relation to the non-voluntary mercy killing of vulnerable individuals (including adults with dementia, disability or stroke). The lenient

125 This will be considered further in Part V.D.

126 Some commentators consider denunciation should not have much of an independent role to play in the criminal law, aside from other aims of punishment such as retribution and deterrence: Lanham (n 86) 14.

127 This goal is the second most important factor in sentencing, according to both judges and jurors: Warner et al (n 103), 35.

128 Illustrative examples can be found at *Blaauw* (n 24) [42] (Forrest J); *Marden* (n 21) [18] (Vincent J); *ANG* (n 61) [35] (Ireland AJ). See also *Morant* (n 33) [124] (Davis J).

129 As Hall J stated in *Mathers*: 'There is, of course, nothing more precious than human life.' *Mathers* (n 48) [36].

130 As Hamill J remarked concerning the mercy killing of Dowdle's son: 'Sympathy which is legitimately aroused, and leniency and compassion that should properly be afforded, must never mask the objective gravity of any offence of homicide, especially a homicide such as this one, where an offender has set about to take human life and acted with an intention to kill': *Dowdle* (n 72) [8]. See also *Nestorowycz* (n 25) [4], where Harper J remarked: 'Judges do not have the right to decide whether someone else should live or die. Neither do you. Life—any life—is too important for that.'

131 *Justins* (n 42) [30] (Howie J).

132 *Klinkermann* (n 25) [11], [26] (King J).

sentences described earlier do not convey the law's or the community's denunciation of such killings.

V. THEMES IN SENTENCING

As described in Part IV, in the majority of the cases in this analysis, the traditional purposes of criminal sentencing—protecting the community and punishing the offender—were not promoted by imposing harsh sentences on the accused. Accordingly, non-custodial sentences were generally imposed. However, the leniency of sentences fails to reflect the gravity of the offence where significant violence was involved, where the victim was particularly vulnerable, or the act intended to cause death was not voluntarily requested. It is argued that sentencing should be appropriate to sufficiently denounce the seriousness of such conduct.

This part continues the analysis of the sentencing remarks, going beyond these traditional principles to elucidate four prominent themes that appear to be unique to cases of assisting suicide and mercy killing. The first theme is the (lack of) *moral culpability of the offender*, emphasising factors such as: a close relationship with the deceased; a willingness to shoulder the burden of care; a compassionate motive; and the presence of mental illness in the offender.[133] The second theme concerns *community values*, particularly changing views about the sanctity of life and euthanasia or assisted dying. The third theme is *personal autonomy*, which concerns the deceased's reason for wishing to end their life - whether to avoid becoming dependent, to avoid going into institutional care, or to end pain and suffering. The final theme is the failure of courts to consider the *vulnerability of the deceased*.

Part V considers whether the traditional sentencing principles considered in Part IV are apposite in this context. Changing community values centrally affect sentencing principles, as sentencing aims to express the community's denunciation or conduct which is seen as morally blameworthy,[134] and to protect the community from conduct which offends those values. It is observed that leniency is in step with community attitudes in these types of cases. Some themes that were particularly significant in these cases (e.g. the offender's motive of compassion in ending a loved one's suffering,[135] and the victim's motive of autonomy which underpins the desire to end their life) are matters which are not usually considered under traditional sentencing principles. Other issues which are traditionally regarded as critical when passing judgement (e.g. the need to protect the vulnerable within our community) were *not considered* in these cases. The relationship between these themes and traditional sentencing principles will be explored further below.

133 Several of these factors, notably compassionate motives, a close and loving relationship, and the depressed or imbalanced state of mind of the offender, were identified by Otlowski (n 7) 26.

134 See Jeremy Horder, 'Some Reflections on Beecham's case' (1988) 52(3) *Journal of Criminal Law* 309, 310.

135 As to the irrelevance of motive, see JA Laing, 'Assisting Suicide' (1990) 54(1) *Journal of Criminal Law* 106, 108.

A. Moral culpability of the offender

1. *Close relationship*

The overwhelming majority of these cases of assisted suicide, completing a suicide and mercy killing occurred in the context of a close domestic relationship, generally between spouses,[136] but sometimes also between parent and child.[137] Many of these relationships were extremely long-lasting, ranging from 20 years[138] to over 50 years of marriage (see Table 2).[139] These close and enduring relationships were, almost without exception, described as characterized by love and devotion.[140] The cases where parents received extremely lenient sentences for killing their adult children with disabilities also demonstrated extremely close, loving relationships where the parents had selflessly and devotedly borne the burden of caring for their children.[141]

Only a small number of cases involved less intimate relationships. Those involving one flatmate assisting another to commit suicide also received suspended sentences.[142] In the three cases involving friends or acquaintances who did not cohabit, the lack of a close relationship combined with other factors to lessen judicial sympathy towards the offender's conduct, and all three received custodial sentences.[143]

Table 2—Relationship between deceased and offender in assisted suicide and mercy killing cases

Deceased/victim is spouse/partner over 30 years	Deceased/victim is spouse/partner under 30 years	Child offender—parent deceased/ victim	Parent offender—child deceased	Other relationship with deceased/victim
Nicol (wife of 63 years)	*Mathers* (78 year old partner of 22 years)	*Godfrey* (88 year old mother)	*Sutton* (29 year old son)	*Hood* (30 year old flatmate and ex-lover)
Rolfe (wife of 55 years)	*Maxwell* (wife of 20 years)	*Pryor* (74 year old mother; 79 year old father)	*Dowdle* (27 year old son)	*Karaca and Price* (30 year old flatmate)

136 *Blaauw* (n 24); *Justins* (n 42); *Klinkermann* (n 25); *Larkin* (n 23); *Marden* (n 21); *Maxwell* (n 21); *Nestorowycz* (n 25); *Nicol* (n 24); *Mathers* (n 48); *Riordan* (n 25); *Rolfe* (n 21); *Hollinrake* (n 25); *Rijn* (n 22).

137 *Pryor* (n 22); *Godfrey* (n 22). See also *R v Tait* (Supreme Court of Victoria, 13 June 1972) (Winneke J) ('*Tait*'), although it occurred prior to the time period considered in the present study.

138 See, eg, *Justins* (n 42), *Maxwell* (n 21); *Mathers* (n 48).

139 The Hollinrakes had been married for 51 years, the Rolfes for 55 years, and the Nicols for 63 years: *Hollinrake* (n 25); *Rolfe* (n 21); *Nicol* (n 24).

140 The comment in *Nicol* that 'right up until Mrs Nicol's death the marriage was happy and both persons were devoted to one another' is representative of this: *Nicol* (n 24) [2] (Hulme J). Even the relatively short relationship between Lynda Larkin, a nurse, and the troubled James Pick, a patient who had been certified insane and whom she brought home to live with her, was characterized by the sentencing judge as one of 'deep attachment' and 'natural compassion': *Larkin* (n 23) 42–3 (Nicholson J). Similarly, the relationship between Cooper and his estranged partner was described as characterised by love, despite his presence at her house being in breach of bail and an ADVO, indicating that she was vulnerable in relation to him: *Cooper* (n 24) [78]–[79] (Hidden AJ).

141 *Sutton* (n 75); *Dowdle* (n 72).

142 *Hood* (n 23); *Karaca & Price* (n 23).

143 *Nielsen* (n 22); *Carter 2001* (n 23); *Walmsley* (n 21). It is unclear whether Walmsley and Lisa McDonald (the deceased) were friends or lovers.

Hollinrake (wife of 51 years)	*Justins* (partner of 20 years)	*Attenborough* (82 year old father)		*ANG* (31 year old uncle)
Marden (wife of 48 years)	*Klinkermann* (84 year old wife of 10 years)			*Carter* (friend, acquaintance)
Riordan (wife of 38 years)	*Larkin* (31 year old lover)			*Walmsley* (girlfriend)
Nestorowycz (husband of 36 years)	*Rijn* (elderly wife of 15 years)			
Johnstone (wife of 36 years)	*Cooper* (separated domestic partner)			
Blaauw (wife of 30 years)				

2. *Accept the burden of care*

The second factor frequently remarked on in sentencing, which is intimately connected to the close and loving relationship between the offender and the deceased, is that many offenders had willingly borne the burden of care for a spouse who was ill, frail or had a disability, often over a period of many years.[144] Similar patterns of devotion to care also exist in cases concerning children who were involved in the deaths of their elderly parents (such as *Pryor*[145] and *Godfrey*[146]), and in the cases of parents who killed their children with disabilities (such as *Dowdle*[147] and *Sutton*[148]).

The high level of devotion and care shown by the offender is significant, not because killing a loved one or assisting them to die is seen as a legitimate response when the burden of care becomes unmanageable, but rather because it provides strong evidence of the depth of love and devotion to the deceased's wellbeing. It also gives credibility to claims that the offender's actions in assisting their loved one to die or causing their death were motivated by compassion and mercy (discussed below).

144 For example, Riordan's wife suffered from Alzheimer's disease, and he was her primary carer for 10 years before she needed to be placed in a care home. Thereafter, he continued to devotedly visit her every day and feed her and take her for a walk: *Riordan* (n 25) 28–30 (Cummins J). See also *Klinkermann* (n 25); *Marden* (n 21); *Rolfe* (n 21); *Nestorowycz* (n 25); *Maxwell* (n 21); *Nicol* (n 24); *Mathers* (n 48).

145 Pryor's mother lived in a nursing home, but her daughter was described as having 'a close and loving relationship with her mother': *Pryor* (n 22).

146 Godfrey, together with other family members, took turns spending the night at his mother's house, and tried to persuade her to accept nursing home care: *Godfrey* (n 22). See also *Tait* (n 137), where the offender had lived alone with his mother for decades, after the death of her second husband, and had never married partly because of his devotion to her.

147 Susan Dowdle had been her adult son's carer for 8 years since a car accident left him brain damaged and with severe disabilities. She remained 'relentless in her pursuit of his needs and was his staunchest advocate', despite the fact that as an alcoholic and drug user he was often abusive towards her: *Dowdle* (n 72) [2] (Hamill J).

148 The Suttons were described as having 'devoted the best years of their lives to Matthew and to his welfare. No demand was too much for them. They gave up everything for him': *Sutton* (n 75) [42] (Cummins J). See also: at [5].

3. Motive was compassion

Consistent with the themes of a close loving relationship, and a willingness to accept the burden of care, in almost all cases, the offender was said to be motivated solely by a compassionate desire to end the pain or suffering of their loved one.[149] In many cases, the compassion was apparent as the deceased person begged for assistance to die and the offender agreed to assist, sometimes reluctantly.[150] However, even in cases where the person had not expressly requested to die, the offender's conduct was frequently described as 'compassionate'.[151] The motive of compassionately providing release from pain and suffering was also powerfully evident in cases where parents killed their children with disabilities.[152]

The emphasis on compassionate motive is contrasted with killing for selfish motives, such as to avoid the burden of caring. For example, it was noted that Marden agreed to the suicide pact with his wife out of love and compassion, not out of 'any sense of frustration arising from the nature and extent of her disabilities.'[153] By contrast, cases where death was motivated by a desire to avoid the burden of care were not dealt with as mercy killings (and therefore fell outside our sample of cases), and the offender received a substantial term of imprisonment.[154]

Compassionate motives are also contrasted with financial motives. In both assisted suicide cases where the offender had a financial motive under the deceased person's will in addition to compassionate motives, a custodial sentence was imposed.[155] A

149 For example, Mathers' action in suffocating his partner 36 hours after her attempt to suicide by overdose was described as 'a selfless act borne out of the love the offender held for her and what the offender understood to be in accordance with the deceased's express wishes': *Mathers* (n 48) [85] (Hall J).

150 See especially *Maxwell* (n 21); *Carter 2003* (n 23) 2 (Mullins J) (in the latter case, the defendant had been resisting the deceased's entreaties for about 2 years).

151 For example, Klinkermann attempted to kill his wife 'to relieve [her] from the advanced dementia and Parkinson's Disease, which in [his] perception now caused her to have a dreadful quality of life, with no hope for improvement': *Klinkermann* (n 25) [28] (King J). Riordan was described as a 'person of compassion and selflessness, totally devoted to his wife,' who acted as he did with the intention to relieve her of her 'terrible suffering and indignity': *Riordan* (n 25) 35 (Cummins J). Similarly, Anastasia Nestorowycz stabbed her husband because she 'believed that [her] husband was suffering by being kept in a nursing home', not 'out of hatred or because [she] didn't want him around any more.' *Nestorowycz* (n 25) [18] (Harper J). Hollinrake was described as having a 'motivation, misguided though it was, born of love and compassion': *Hollinrake* (n 25) 40 (Coldrey J).

152 For example, Dowdle stated that her motive in killing her son was 'to just stop the pain … I've reached out for years and years and years and watched his pain, pain, pain, pain.' *Dowdle* (n 72) [25] (Hamill J). Likewise, the Suttons 'released [their son] from any more pain and suffering—he had had enough.' *Sutton* (n 75) [12] (Barr J).

153 *Marden* (n 21) [22] (Vincent J). See also *Larkin* (n 23) 41 (Nicholson J).

154 See *Ritchie* (n 34) (son frustrated at having to care for his terminally ill mother sentenced to 15 years imprisonment for her murder): [8], [19] (Barr J); *R v McLaren* [2011] NSWDC 115 (live-in home carer for an elderly man with motor neurone disease frustrated at having to care for him sentenced to 8 years imprisonment for attempted murder).

155 3 years imprisonment in the case of Nielsen, who was named the sole beneficiary under Mr Ward's most recent will: *Nielsen* (n 22) 1-5, 1-16 (Dalton J). The sentence was 20 months in the case of Justins, the deceased's long term partner, who procured changes to his will substantially in her favour, just weeks before his death, despite knowing that he lacked capacity at that time to alter his will: *Justins* (n 42) [19]–[21] (Howie J). See also Morant, who was sentenced to 10 years imprisonment, but who lacked any compassionate motive: *Morant* (n 33) [66] (Davis J).

financial motive negates the motive of compassion and care, and transforms a potentially altruistic act into one of self-interest.

4. Mental illness of the offender

Another ameliorating feature in many of the mercy killing cases was that the offender suffered from significant depression or other mental illness, which can affect decision-making and clarity of judgment. Sometimes the offender's mental state had organic causes,[156] but in many cases it was caused by a long period of caring for a loved one under difficult circumstances.[157] The sense of hopelessness about the future which is a feature of depression was a major factor in decisions to assist suicide,[158] as well as decisions to intentionally kill a loved one as part of a suicide pact,[159] and decisions to kill a spouse[160] or child[161] without request or consent.

5. Conclusion

The lack of moral culpability where the offender has a close relationship with the victim, has willingly shouldered the burden of care, and is motivated solely by compassion for the suffering of their loved one lessens the need for punishment to serve the traditional goals of rehabilitation, general or special deterrence. However, as will be discussed in section V.D below, the close relationship of trust and dependence may also serve as an aggravating factor in sentencing, particularly in situations where the offender is responsible for the care of a person who is ill or has a disability, and abuses that trust by seeking the death of the person. This is particularly the case where the person is vulnerable and has not requested assistance to die.

B. Community values

As we observed in Part IV, community values are important in assessing the moral culpability of the offender.[162] Sentencing 'involves a reaffirmation of society's values',[163] and the denunciation of conduct which falls outside those values.[164] Not only is sentencing practice often sensitive to public opinion,[165] but it has also been argued

156 Dowdle was described as having underlying bipolar disorder or possibly schizophrenia, which had been poorly treated in the past and was currently untreated: *Dowdle* (n 72) 4, 32 (Hamill J). Cooper also suffered from schizophrenia, and was not taking his medication at the time of the offending: *Cooper* (n 24) [61] (Hidden AJ). Mathers had a history of severe depression, and this was exacerbated by anxiety over his partner's planned suicide: *Mathers* (n 48) [64] (Hall J).

157 *Blaauw* (n 24); *Larkin* (n 23); *Marden* (n 21); *Maxwell* (n 21); *Nestorowycz* (n 25); *Nicol* (n 24); *Sutton* (n 75); *Riordan* (n 25); *Rolfe* (n 21).

158 *Larkin* (n 23); *Maxwell* (n 21); *Mathers* (n 48); *Walmsley* (n 21).

159 *Marden* (n 21); *Nicol* (n 24); *Rolfe* (n 21).

160 *Blaauw* (n 24); *Nestorowycz* (n 25); *Riordan* (n 25).

161 *Dowdle* (n 72); *Sutton* (n 75).

162 See Horder (n 134), 310; Warner et al (n 103), 27.

163 *WCB v The Queen* [2010] VSCA 230 (10 September 2010), [12(e)], (Warren CJ and Redlich JA).

164 'Central to the purposes of sentencing is public denunciation of the offending conduct and reinforcement of society's expectations. The sentence communicates society's condemnation of the offender's conduct. It signifies the recognition by society of the nature and significance of the wrong that has been done to affected members, the assertion of its values and the public attribution of responsibility for that wrongdoing to the perpetrator': *WCB v The Queen* [2010] VSCA 230 (10 September 2010), [35], (Warren CJ and Redlich JA).

165 Victorian Sentencing Advisory Council, *Public Opinion about Sentencing: A Research Overview* (Report, December 2018). See also Lorana Bartels, 'Sentencing Review 2018–2019' (2019) 3 *Criminal Law Journal* 355, 357.

that if sentencing reflects community views this will 'enhance the legitimacy of the law and promote compliance and co-operation.'[166]

A strong theme in the denunciation of the offending conduct is the sanctity or high value placed on human life by our society.[167] In several cases, judges referred to 'the community's entitlement to feel that justice has been done, particularly given the sanctity of human life.'[168]

The societal need for justice was, however, tempered with a stronger theme of mercy, also reliant on community values. In several cases, the societal value of mercy was invoked to justify the imposition of a suspended or non-custodial sentence. For example, in *Klinkermann*, King J stated:

> Our society is not a vengeful one, and the law recognises this and approves and even requires the exercise of mercy in certain cases and I am unable to see any benefit to you or society in general in incarcerating you for any period of time.[169]

In a few cases, judges in sentencing observed that offences of assisting suicide or mercy killing touch on issues raised in the community debate about the morality of euthanasia or voluntary assisted dying.[170] However, the courts were clear that their function is not to question the appropriateness of the criminal law framework, or whether there should be legislative change,[171] but to impose a sentence according to the 'current state of the law'.[172]

Consideration of community attitudes and values is relevant to the level of denunciation to be applied in sentencing in criminal cases. In the present selection of cases, judges balanced the societal interest in the sanctity of life against the community value of mercy towards those who have broken the law out of compassion, and sometimes mentioned changing community sentiment in relation to euthanasia. These considerations led to the overwhelming leniency in sentencing observed above.[173]

C. Autonomy/ choice

The theme of personal autonomy is not one which is usually emphasised in sentencing, but it was certainly relevant in cases of assisted suicide and voluntary mercy killing.

166 Warner et al (n 103), 27.

167 See Part IV.B.2.

168 *Nicol* (n 24) [27] (Hulme J). An identical phrase was used in *Mathers* (n 48) [101] (Hall J). See also *ANG* (n 61) [28] (Ireland AJ).

169 *Klinkermann* (n 25) [30] (King J). Similar sentiments were expressed in many other cases. See, eg *Maxwell* (n 21) [41] (Coldrey J); *Hood* (n 23) [55] (Coldrey J); *Sutton* (n 75) [42] (Barr J), *Hollinrake* (n 25) 42 (Coldrey J); *Mathers* (n 48) [101] (Hall J); *Godfrey* (n 22) 2 (Underwood J); *Pryor* (n 22) 2 (Hill AJ). See also Bartels and Otlowski (n 17) 547–8.

170 In *Klinkermann*, King J acknowledged that the 'issue of euthanasia is a very vexed question in our community and one that will have to be resolved in the not too distant future as we face an aging population.' *Klinkermann* (n 25) [26] (King J). See also *Godfrey* (n 22) 2 (Underwood J); *Attenborough* (n 2) 18 (Graham AJ); *Hood* (n 23); *Riordan* (n 25) 35 (Cummins J).

171 *Godfrey* (n 22) 2 (Underwood J); *Attenborough* (n 2) 18 (Graham AJ).

172 *Hood* (n 23). See also *Godfrey* (n 22) 2 (Underwood J).

173 See Part III.

1. Avoiding dependence

In several cases, the deceased's desire to avoid dependence was a major factor causing them to attempt suicide or request assistance to die.[174] In some cases, the deceased was concerned about the decline in capacities which is a natural feature of ageing.[175] In other cases, this desire for independence translated into views about that people should be able to choose to end their lives voluntarily.[176] Two of the women who committed suicide with the assistance of relatives were active members of pro-euthanasia organisations.[177] Other cases involved individuals who sought assistance from pro-euthanasia organisations about methods of ending one's life.[178]

2. Avoiding nursing home care

The desire to avoid dependence generated a specific desire to avoid being placed in a nursing home or palliative care. This was a major factor in four of the attempted murder-suicide cases described above,[179] and in several of the assisted suicide cases.[180] Additionally, in two cases where the victim was already in full-time care, the offender believed they were distressed at this situation,[181] and concluded that death would be preferable to life in an institution.

3. Ending pain and suffering

A recurring theme running through the cases of assisted suicide and voluntary mercy killing was that many involved strong-willed and determined individuals who planned to take their own lives. Some had made several previous attempts at this.[182] An extreme example was Mrs Maxwell who, suffering terminal cancer, planned to take her life by ceasing to eat and drink,[183] a plan which required great determination and perseverance.

174 For example, Frank Ward was described as having a 'great fear of ill-health' and a desire to avoid dependence, leading him to form the intention to take his own life: *Nielsen* (n 22) 1-13, 1-7, 1-18 (Dalton J).

175 In *Hollinrake*, the deceased, who had suffered a major stroke, was described as having a 'horror of an impaired life and … "almost a phobia" about not being in control of herself and her senses': *Hollinrake* (n 25) 38 (Coldrey J). See also See *Justins* (n 42) [9]–[11] (Howie J); *Nicol* (n 24) [2], [4] (Hulme J).

176 *Attenborough* (n 2) 3 (Graham AJ). See also *Pryor* (n 22); *Maxwell* (n 21).

177 Mrs Godfrey was an active member of the Tasmanian Euthanasia Society: *Godfrey* (n 22) 1 (Underwood J). Mrs Rijn was a member of Exit International: *Rijn* (n 22). In *Justins*, although it is not stated that the deceased was a member of Exit International, his partner's friend, Caryn Jennings, who travelled to Mexico to purchase the Nembutal from which he died was an officebearer in that organisation: *Justins* (n 42),

178 This included instructions about how to import pentobarbital from Mexico: *Nielsen* (n 22) 1–7 (Dalton J); instructions about asphyxiation using the helium balloon method they had read about in the 'Final Exit' book: *Rijn* (n 22)*; Maxwell* (n 21) [21] (Coldrey J).

179 *Klinkermann* (n 25) [4], [25] (King J); *Nicol* (n 2424) [9] (Hulme J); *Rolfe* (n 21) [7], [13], [14] (Cummins J); *Hollinrake* (n 25) 38 (Coldrey J).

180 For example, the need to go into care was described as a 'complete anathema' to the independent and strong-willed Mrs Godfrey: *Godfrey* (n 22) 1 (Underwood J); *Mathers* (n 48) [17]; *Nielsen* (n 22). See also *Tait* (n 137) 3 (Winneke CJ).

181 Mr Nestorowycz had repeatedly pleaded with his wife to take him home from the nursing home he had resided in for the past 8 years: *Nestorowycz* (n 25) [18] (Harper J). Mrs Hollinrake was pulling out her feeding tubes when hospitalised after a stroke, which her husband took as an indication that she did not want to go on living like that: *Hollinrake* (n 25) 39 (Coldrey J).

182 See, eg, *Mathers* (n 48); *Justins* (n 42), *Larkin* (n 23); *Carter 2003* (n 23) 3 (Mullins J); *Pryor* (n 22) (father); *Godfrey* (n 22).

183 *Maxwell* (n 21) [11] (Coldrey J).

Several cases referred to a decision to end one's life because of the severity of pain and suffering.[184] It was emphasized that these decisions were the autonomous decisions of the individual wishing to die, freely and autonomously chosen and (at least in assisted suicide cases) carried out by the deceased.[185] In some cases the assistance provided was at the deceased person's insistence, and with some reluctance on the part of the family member.[186]

D. Protection of vulnerable persons

By contrast, the vulnerability of the victim was not a theme often mentioned in the cases, although it is generally a significant factor which tends to favour a more stringent sentence. As we observed in Part IV, vulnerability is relevant to the gravity of the offence, which is important in considering the need for 'retribution'.[187] The categories of who may be considered 'vulnerable' in law are not settled.[188] Aside from children, who obviously have a special vulnerability,[189] adults are considered 'vulnerable' if they are unable to protect themselves from the harmful consequences of another's action.[190] This is common, although not universal, for the elderly,[191] people with disabilities,[192] those with physical illness[193] or mental illness[194] and those in special relationships of dependence.[195]

Many of the cases described here involved determined individuals who were physically ill or in pain, but otherwise were not especially vulnerable.[196] Most cases involved

184 *Attenborough* (n 2) 22 (Graham AJ); *Mathers* (n 48) [51] (Hall J); *Maxwell* (n 21) [17]–[19] (Coldrey J); *Cooper* (n 24) [76] (Hidden AJ).

185 See *Godfrey* (n 22) 2 (Underwood J).

186 For example, Maxwell's eventual assistance to help his wife end her life was provided to honour a promise she had forced him to make: *Maxwell* (n 21) [13], [20] (Coldrey J). See also *Rijn* (n 22) 2 (Magistrate Lethbridge); *Mathers* (n 48) [78(4)] (Hall J).

187 Bartels (n 165), 360, quoting Queensland Sentencing Advisory Committee, *Sentencing for Criminal Offences Arising from the Death of a Child: Final Report* (2018).

188 For a general discussion of vulnerability, without an attempt to classify vulnerable groups, see Jane Stapleton, 'The golden thread at the heart of tort law: Protection of the vulnerable' (2003) 24(2) *Australian Bar Review* 135, 142; Paul Finn, 'The Courts and the Vulnerable' (1996) 162 *Law Society of the Australian Capital Territory Gazette* 61.

189 *X v The Sydney Children's Hospitals Network* [2013] NSWCA 320, [60] (Basten JA); *Cattanach v Melchior* (2003) 199 ALR 131, [492] (Heydon J).

190 *Woolcock Street Investments Pty Ltd v CDG Pty Ltd* (2004) 216 CLR 515, [23] (Gleeson CJ, Gummow, Hayne and Heydon JJ), [80] (McHugh J) ('*Woolcock Street Investments*'). This case was decided in the context of tort liability for economic loss caused to vulnerable persons.

191 This was discussed in depth in Department of Health and Human Services, Government of Victoria, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) ('*Victorian Panel Report*') 88–90. The WA Branch of the RANZCP also considered 'older isolated women' to be a group particularly vulnerable to seeking voluntary assisted dying: Department of Health, Government of Western Australia, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, 27 June 2019) 97. See also Martha Albertson Fineman, '"Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20(1) *Elder Law Journal* 71, 85–6.

192 Ibid 84, 91.

193 *Woolcock Street Investments* (n 189) [168] (Kirby J), citing *Hodgkinson v Simms* [1994] 3 SCR 377, 412.

194 Ibid 82.

195 *Woolcock Street Investments* (n 189) [168] (Kirby J), citing *Hodgkinson v Simms* [1994] 3 SCR 377, 412.

196 As was remarked in *Attenborough*, although the 82 year old father 'did have significant and challenging physical circumstances which would certainly render him vulnerable', it was clear

elderly people,[197] and four were in their 80s,[198] although a significant minority were young people.[199] However, several cases did involve people who were particularly vulnerable, either by reason of mental illness, dementia, or significant disability.

1. Mental illness

As shown in Table 1, eight cases of assisted suicide or mercy killing involved a victim with serious mental illness.[200] People with mental illness who are suicidal are obviously in an extremely vulnerable and often irrational state, and the legal prohibition on assisted suicide is 'designed to protect a vulnerable person who opts for suicide' at such a time.[201] Although the vulnerability of the deceased was emphasised in sentencing in *Hood*,[202] the vulnerability of suicidal people with mental illness was not mentioned in other cases.[203] This may have been expected particularly in the case of *Larkin*, a nurse who had voluntarily taken a psychotically unwell patient into her home to care for, and then became involved in assisting him to commit suicide.[204]

2. Dementia

Five of the cases involved elderly relatives with advanced dementia or Alzheimer's disease.[205] In *Justins*, Howie J remarked that 'in the weeks preceding his death, the deceased was completely vulnerable and, to a very substantial degree, reliant upon the offender in a way foreign to their previous relationship'.[206] However, similar comments about the special vulnerability of a person with dementia who is dependent on the care of others were *not* made in other cases. Judges tended to focus instead on the devotion and care of the spouse.[207]

3. Disability

The final category of vulnerable people is adults with disabilities. In *Sutton,* the son had severe disabilities since birth,[208] and was completely dependent on his parents. Barr J did observe that his parents had 'the [legal] responsibility to care for a severely disabled and vulnerable person,'[209] but the overwhelming focus of the sentencing remarks was

he retained mental capacity to make decisions, and had formed a desire to end his pain and suffering: *Attenborough* (n 2) 16 (Graham AJ).

197 *Rijn* (n 22); *Nielsen* (n 22); *Justins* (n 42); *Mathers* (n 48); *Marden* (n 21); *Rolfe* (n 21); *Hollinrake* (n 25); *Riordan* (n 25); *Nestorowycz* (n 25).

198 *Godfrey* (n 22) 2 (Underwood J); *Nicol* (n 24); *Attenborough* (n 2); *Klinkermann* (n 25).

199 *Hood* (n 23); *Karaca & Price* (n 23); *Carter 2003* (n 23); *Walmsley* (n 21); *ANG* (n 61); *Larkin* (n 23); *Sutton* (n 75); *Dowdle* (n 72).

200 *Walmsley* (n 21)*; Hood* (n 23); *Karaca & Price* (n 23); *Larkin* (n 23); *ANG* (n 61); *Johnstone* (n 24); *Carter 2003* (n 23); *Blaauw* (n 24).

201 *Hood* (n 23) [32] (Coldrey J).

202 Coldrey J emphasised the responsibility of the offender to assist the victim to seek counselling or medical assistance, rather than assist him in his suicide plan: ibid [35] (Coldrey J).

203 We leave to one side the cases in which there was evidence that the suicidal deceased was dominant over the offender, and exerted duress on them to be involved in the suicide plan: *ANG* (n 61); *Karaca & Price* (n 23).

204 *Larkin* (n 23).

205 *Justins* (n 42); *Pryor* (n 22) (mother); *Klinkermann* (n 25); *Nestorowycz* (n 25); *Riordan* (n 2525).

206 *Justins* (n 42) [36] (Howie J).

207 See especially *Riordan* (n 25); *Klinkermann* (n 25).

208 Matthew Sutton had Trisomy 13 syndrome, was blind, substantially deaf, and had an intellectual disability.

209 *Sutton* (n 75) [36] (Barr J).

on the parents' mental states, not the vulnerability of their son. Four other cases involved adults with significant disability as a result of accident[210] or illness.[211] The vulnerability and dependence of the victims was not mentioned in passing sentence.[212]

4. Conclusion

In many of the cases analysed here, victims were aged, had dementia or a disability, and their vulnerability was accentuated by their dependence on the offender for their care. Others were vulnerable by reason of mental illness. In such cases, assisting suicide or mercy killing was a breach of the trust reposed in the offender by virtue of the relationship of care. Despite this, vulnerability and dependence were not expressly considered in sentencing in the majority of cases. This constitutes a failure of the law to exercise its protective jurisdiction. The lack of public commentary on this omission[213] stands in stark contrast to the outcry in Canada over the lenient sentencing of a father who killed his daughter who had a disability.[214]

VI. IMPLICATIONS

As previously observed, analysis of the cases demonstrates a marked level of leniency across the whole spectrum of assisted suicide and mercy killing cases. This highlights 'a serious discrepancy between the law as it stands in theory and as it is applied in practice.'[215] Particularly where the accused has been convicted of murder or manslaughter, there is a yawning gap between the nominal head sentence and the actual sentence imposed.

As has been discussed above, there are legitimate considerations which may justify or explain leniency in some cases of compassionate involvement in another's death: including the presence of a close and loving relationship, the fact that the offender is frequently suffering from depression or other mental illness, and the lack of any need to rehabilitate the offender or prevent reoffending. However, the 'exceptional degree of leniency'[216] shown in many cases threatens to bring the law into disrepute. We identify three reasons for this claim. Firstly, leniency in sentencing reflects the fact that the law

210 Dowdle's son suffered a serious accident: *Dowdle* (n 72).

211 *Nestorowycz* (n 25) (double amputee); *Hollinrake* (n 25) (major stroke); *Nicol* (n 24) (partial amputee).

212 *Dowdle* (n 72).

213 A notable exception is Rosemary Kayess and Phillip French, 'Deadly Currents Beneath Calm Waters: Persons with Disability and the Right to Life in Australia', in L Clements and J Read (eds), *Disabled People and the Right to Life: The Protection and Violation of Disabled People's Most Basic Human Rights*, (Routledge, 2008).

214 See, for example, Barney Sneiderman, 'The Latimer Mercy-Killing Case: Rumination on Crime and Punishment' (1997) 5(1-26) *Health Law Journal*; M David Lepofsky, 'The Latimer Case: Murder Is Still Murder When the Victim is a Child with a Disability' (2001) 27(1) *Queen's Law Journal* 319; H Archibald Kaiser, 'Latimer: Something Ominous is Happening in the World of Disabled People' (2001) 39(2) *Osgoode Hall Law Journal* 555; Barney Sneiderman, 'Latimer in the Supreme Court: Necessity, Compassionate Homicide, and Mandatory Sentencing' (2001) 64(2) *Saskatchewan Law Review* 511.

215 Legal and Social Issues Committee, Parliament of Victoria Legislative Council, *Inquiry into end of life choices: Final Report* (Parliamentary Paper No 174, 9 June 2016) 176 ('*Victorian Inquiry into end of life choices'*). See also Otlowski (n 7) 32–3.

216 This phrase is Otlowski's: Otlowski (n 7) 31.

is out of step with current community values concerning the moral reprehensibility of the offender in these cases. Secondly, inconsistencies in charges and sentences between similar cases detrimentally affect consistency, certainty and equality, which are fundamental components of the rule of law. And thirdly, in failing to distinguish between vulnerable and non-vulnerable persons, the law fails to protect those most in need of its protection.

A. Law is out of step with community values

The level of leniency identified in charges brought and sentences imposed in practice demonstrates the gulf that exists between the criminal law on the statute books, and the law in action.[217] Homicide is traditionally regarded as one of the most serious criminal offences, punishable by life imprisonment. However, in almost all of the cases examined in this paper, those convicted of murder or manslaughter received sentences of one to three years, wholly suspended. In this respect, the law in practice (the sentences imposed) is in line with contemporary community attitudes towards mercy killing.[218] Research on community attitudes to homicide in the United Kingdom[219] clearly demonstrates that mercy killing is regarded as the 'least serious' of all the types of homicide considered, either not deserving of prosecution,[220] or worthy of only a short sentence of imprisonment.[221] However, the law on the books (the serious nature of the offence charged and the head sentence) bears no relationship to the community's lack of denunciation of the conduct.

Further, the stigma associated with homicide, and particularly murder, does not reflect community values. It is often stated that mercy killers do not deserve to be labelled as

217 These phrases stem from Yale Kamisar, 'Some Non-Religious Views against Proposed Mercy-Killing Legislation' (1958) 42 *Minnesota Law Review* 969, 971. See also CG Schoenfeld, 'Mercy Killing and the Law—A Psychoanalytically Oriented Analysis' (1978) 6 *Journal of Psychiatry and Law* 215, 234.

218 Clough, for example, considers a life sentence for murder would be disproportionate to the social heinousness of a genuine mercy killing case: Amanda Clough, 'Mercy Killing, Partial Defences and Charge Decisions: 50 Shades of Grey' (2020) 84(3) *Journal of Criminal Law* 211, 212.

219 There is no research directly concerning community attitudes to mercy killings in Australia. As discussed in Part V.B, some judges have referred to community values when passing sentence, and the ACT Director of Public Prosecutions referred to community attitudes in exercising the discretion not to prosecute in O'Riordan's case: *Police v O - CC2019/3260* (n 4). The following discussion focusses on important research conducted on community attitudes in the United Kingdom.

220 Professor Barry Mitchell conducted two important surveys of community opinion on sentencing in homicide cases, in 1995 and in 2003. On both occasions, a bare majority of the English public surveyed (51% in the 1995 survey and 59.7% in 2003) recommended that the offender in such cases should not be prosecuted, at least where the victim requested help to die: Barry Mitchell, 'Public Perceptions of Homicide and Criminal Justice' (1998) 38(3) *British Journal of Criminology* 453; Barry Mitchell, 'Brief Empirical Survey of Public Opinion Relating to Partial Defences to Murder' (Appendix C to Final Report No LC 290, Law Commission (UK), 6 August 2004), [58]. See also Barry Mitchell and Julian V Roberts, 'Public Attitudes to Sentencing in Cases of Murder', *Exploring the Mandatory Life Sentence for Murder* (Hart Publishing, 2012) 88.

221 Only 14 out of 62 respondents favoured imprisonment, and 11 preferred a term of less than 10 years: Mitchell, 'Brief Empirical Survey of Public Opinion Relating to Partial Defences to Murder' (n 220), [54].

'murderers' for acting out of compassion for the suffering of a loved one.[222] The desire not to stigmatise a person as a 'murderer' has led, in many cases, to the exercise of prosecutorial discretion to proceed with alternative, lesser, charges, such as 'assisting suicide'[223] or 'manslaughter by reason of diminished responsibility'.[224] But these alternative charges do not always fit the facts. In many cases, the offender's role is more active than merely assisting a suicide, and the offender does not always suffer from a mental condition which would meet the criteria of diminished responsibility.[225]

Finally, the emphasis given in the law to the sanctity of life also appears out of step with community values. The criminal law insists that the sanctity of life is a principle of such inviolability that a person cannot voluntarily give permission to someone else to end their own life.[226] However, research on public opinion from the United Kingdom demonstrates that the person's autonomous choice to end their life is relevant. In fact, the victim's request to die was the single most significant factor affecting public opinion that a mercy killing was of lower culpability.[227] The recent passage of legislation permitting voluntary assisted dying in Victoria, Western Australia and Tasmania[228] may also reflect contemporary community values on this point.

The task of law reform is to bring criminal offences 'into line with current community perceptions of justice.'[229] Community attitudes demonstrate considerable sympathy towards mercy killings, particularly in cases where the deceased has voluntarily requested assistance to die. This sympathy is not reflected in the significant stigma and

222 Clough (n 218), 213; Ben Livings, 'A New Partial Defence for the Mercy Killer: Revisiting Loss of Control' (2014) 65(2) *Northern Ireland Law Quarterly* 187, 188; M Gibson, 'Pragmatism Preserved? The Challenges of Accommodating Mercy Killers in the Reformed Diminished Responsibility Plea' (2017) 81(3) *Journal of Criminal Law* 177, 178; Glenys Williams, 'Provocation and Killing with Compassion' (2001) 65(2) *Journal of Criminal Law* 149, 149-150. This was recognised by Justice John Coldrey, a former Victorian Director of Public Prosecutions and the sentencing judge in *Hood* and *Maxwell*, who stated: 'These cases don't sit comfortably in a court setting. The person goes out into society labelled a murderer when their motive has been compassion and love.' *Victorian Inquiry into end of life choices* (n 206) 175.

223 *Larkin* (n 23); *Maxwell* (n 21); *Godfrey* (n 22); *Pryor* (n 22). See also Lindsay Lincoln, 'How the Legalization of Assisted Suicide Should Inform a More Principled and Ethical Treatment of Mercy Killings' (2017) 30(4) *Georgetown Journal of Legal Ethics* 873, 888 referring to the case of Carol Carr in the United States.

224 *Mathers* (n 48); *Dowdle* (n 72); *Sutton* (n 75); *Nicol* (n 24).

225 Amanda Clough, 'Mercy Killing: Three's A Crowd?' (2015) 79(5) *Journal of Criminal Law* 358; Livings (n 222), 191. In the United Kingdom, it has been suggested that the charge of manslaughter by diminished responsibility is frequently preferred to murder as part of a 'benign conspiracy' between psychiatrists and the courts to ensure that those who kill from compassionate motives are not subject to the full force of the law of murder: RD Mackay, 'Diminished Responsibility and Mentally Disordered Killers' in Andrew Ashworth and Barry Mitchell (eds), *Rethinking English Homicide Law* (Oxford University Press, 2000); B Mitchell and R Mackay, 'Loss of Control and Diminished Responsibility: Monitoring the New Partial Defences' (2011) 3 *Archbold Review* 5. Dargue refers to it as an 'uneasy truce': Paul Dargue, 'Mercy Killers and the Sentencing Rules—An Uneasy Fit?' (2011) 75(2) *Journal of Criminal Law* 105, 106. The partial defence is not as frequently employed in the Australian cases, except in cases which seem to genuinely fit the defence: *Mathers* (n 48); *Dowdle* (n 72); *Sutton* (n 75).

226 *Justins* (n 42) [30] (Howie J).

227 66% of respondents (41 out of 62) identified this as an important factor: Mitchell, 'Brief Empirical Survey of Public Opinion Relating to Partial Defences to Murder' (n 220), [55]. See also Lincoln (n 223), 889.

228 *VAD Act* (Vic) (n 6); *VAD Act* (WA) (n 6); *EOLC Act* (Tas) (n 6).

229 Law Reform Commission Victoria, *Homicide* (Report No 40, 1991), [111].

grave maximum penalty attached to the crime of murder. Rather than continue to rely on the exercise of prosecutorial discretion to prefer lesser charges to murder, or the exercise of judicial discretion in sentencing, it would be preferable to change the law on the books to reflect community attitudes. For this reason, this paper suggests consideration should be given to explicitly including a specific, lesser offence or partial defence for mercy killing or completing a suicide.[230]

B. Inconsistent outcomes offend the rule of law

The gap between the law on the books and the law as applied in practice in cases of mercy killing also results in inconsistent outcomes in individual cases.[231] Because the law does not reflect community attitudes concerning culpability, in most cases of mercy killing or assisted suicide, the offender either avoids criminal liability or receives a very light sentence, often wholly suspended.[232] However, the outcomes in these cases depend not on the predictable application of clear legal rules, but rather on prosecutorial discretion to bring lesser charges, or judicial discretion in sentencing. This discretion is not universally applied, and in a small number of cases, the criminal law is strictly applied. This is concerning, because the principle of equality before the law (a hallmark of the rule of law) requires that similar cases should be punished alike.[233] Consistency of sentencing is of utmost importance to the administration of criminal justice and the maintenance of public confidence in the legal system.[234]

Table 1 reveals some concerning inconsistencies in both charging and sentencing. In relation to charging, an almost identical action by the offender—suffocating a loved one (who has taken an overdose) with a plastic bag—led to Mathers being charged with murder,[235] whereas Maxwell and Pryor were charged only with assisting suicide.[236] *Larkin* and *Carter* provide further illustrations of inconsistencies in both charging and sentencing. Lynda Larkin injected her lover with insulin at his request, because he had a mental illness and wanted to die. Despite this act satisfying all elements of the crime of murder, Larkin was charged only with assisting suicide, and received a 3 year suspended sentence.[237] But when Stephen Carter injected Gail Marke with heroin because she had a mental illness and wanted to die, he was charged with murder and received a life sentence.[238] Finally, the 11 year sentence of imprisonment imposed in *Blaauw* for killing his wife who had schizophrenia[239] stands in stark contrast to the

230 Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 361.

231 Hon Maryan Street, 'Live and Let Die: The Legalisation of Euthanasia in New Zealand' (thesis, University of Otago, 2014), 4. The Victorian Legal and Social Issues Committee also recognised this gap between the law on the books and the law in practice, noting that 'if our law enforcement agencies, those investigating deaths and those presiding over cases, do not believe that a just outcome would be achieved by enforcing the law, then it is time to question the law': *Victorian Inquiry into end of life choices* (n 206) 176.

232 Otlowski's summary of the cases prior to 1993 remains apposite to describe the more recent cases outlined in the present paper: see Otlowski (n 7) 33.

233 Gabriel Hallevy, *The Right to Be Punished: Modern Doctrinal Sentencing* (Springer, 2013), 108. See generally Brian Z Tamanaha, *On the Rule of Law* (Cambridge University Press, 2004).

234 *R v MacNeil-Brown* (2008) 20 VR 677, [37].

235 *Mathers* (n 48). The charge was later reduced to manslaughter on the ground of diminished responsibility.

236 *Maxwell* (n 21); *Pryor* (n 22).

237 *Larkin* (n 23).

238 *Carter 2001* (n 23); *Carter 2003* (n 23). Similarly, when Cooper injected his partner with heroin at her request because she suffered intolerable pain and wanted to die, he was also charged with murder and sentenced to 13 and a half years in jail: *Cooper* (n 24).

239 *Blaauw* (n 24).

short or suspended sentences imposed in other cases of non-voluntary killing[240] or attempted killing[241] of a loved one.

The inconsistencies in charges brought and sentences imposed for similar actions taken in very similar circumstances offend the clarity and consistency principles of the rule of law. These principles require that offences accurately and clearly state the punishment for committing them,[242] and that outcomes in individual cases follow from the predictable and consistent application of clear legal rules.[243] Inequality in the treatment of offenders is a clear violation of 'the internal morality of the law.'[244] It creates uncertainty, and affects the ability of the criminal law to exercise effective social control, ensuring individuals know what the consequences of committing an offence will be.[245]

However, when the law in action depends to a significant degree on prosecutorial discretion in charging, and judicial discretion in sentencing, consistency of outcomes cannot be ensured.[246] The existence of inconsistent outcomes undermines the principle of equality before the law and has the potential to undermine public confidence in the administration of justice.[247] These inconsistencies underscore the pressing need for law reform in this area.[248]

Another way that the law offends the clarity and consistency principles of the rule of law is that sentences do not reflect the gravity of the charge. The law draws a sharp distinction between homicide, punishable by life imprisonment, and assisting suicide, punishable by significantly lesser sentences.[249] However, in cases of mercy killings, the line between assisting suicide and homicide can be particularly difficult to draw.[250] Some cases are prosecuted as assisting suicide (despite meeting the criteria for murder),[251] and others are prosecuted as murder or attempted murder.[252] However, in almost all cases, short suspended sentences were imposed regardless of the crime charged. The lack of proportionality in sentencing to reflect the gravity of the charge undermines the rule of law and threatens to bring the law into disrepute. For this reason we have recommended the introduction of specific offences, such as completing a

240 *Sutton* (n 75); *Dowdle* (n 72).

241 See, eg, *Klinkermann* (n 25); *Riordan* (n 25); *Hollinrake* (n 25); *Nestorowycz* (n 25).

242 Gabriel Hallevy, *A Modern Treatise on the Principle of Legality in Criminal Law* (2010), 8–14.

243 Thomas Bingham, *The Rule of Law* (Penguin, 2010); Law Council of Australia, *Rule of Law Principles* (Policy Statement, March 2011).

244 Fuller states that the morality of law requires congruence between official action and the declared rules of law: Lon Fuller, *The Morality of Law* (Yale University Press, 1977 (rev ed)), 81.

245 Gabriel Hallevy, *The Right to Be Punished: Modern Doctrinal Sentencing* (n 233), 108.

246 Kamisar (n 217), 971. See also Alec Samuels, 'The Compassionate Taking of Life and Assisted Suicide' (2014) 54(1) *Medicine, Science and the Law* 35, 39.

247 *Victorian Inquiry into End of Life Choices* (n 206) 173.

248 This recommendation is not new, having been made in 1993—see Otlowski (n 7) 34—and earlier by Glanville Williams in 1958—see *Larkin* (n 23) 41 (Nicholson J). See also the discussion in Ben White and Lindy Willmott, 'How should Australia regulate voluntary euthanasia and assisted suicide?' (2012) 20(2) *Journal of Law and Medicine* 410, 427–30.

249 See Part II of this paper.

250 See Table 1, where we introduce the term 'completing a suicide' to more accurately describe the conduct in some cases.

251 *Larkin* (n 23); *Maxwell* (n 21), *Godfrey* (n 22), *Pryor* (n 22).

252 *Karaca & Price* (n 23); *Carter 2001* (n 23); *Carter 2003* (n 23). Mathers was charged with manslaughter, but would have been charged with murder if his pre-existing mental illness had not made a plea of diminished responsibility possible: *Mathers* (n 48).

suicide or mercy killing, punishable by lesser sentences, to remedy this inconsistency and bring clarity to the criminal law.

C. Law does not sufficiently protect vulnerable people

We have argued that the leniency in sentencing evident in Table 1 generally reflects community attitudes that compassionately motivated killings are less morally reprehensible than other killings. However, there is a serious discrepancy between the law on the books and the law as practised by judges. The reliance on prosecutorial discretion in charging and judicial discretion in sentencing, rather than legal rules, leads to inconsistent outcomes in a minority of cases. We suggest that these reasons justify reform of the law, to more accurately represent community attitudes and prevailing sentencing practices.

However, we would qualify this recommendation in one respect: in relation to non-voluntary mercy killings. In these cases, rather than reform the law to reflect current practice, sentencing practice should be amended to more closely reflect the purposes of the criminal law. In these cases, the level of leniency in sentencing described above fails to convey a level of punishment which is proportionate to the crime. This is also in accordance with community values concerning the protection of vulnerable people.

It is well established that sentencing in criminal cases should be both adequate and proportionate to the crime.[253] In determining the type of punishment to be imposed on a person, courts are required to balance the impersonal facts of the offence (*in rem*) (that is, the social harm caused by the action), and the personal characteristics of the offender (*in personam*), which influences the offender's culpability.[254] Our analysis of sentencing remarks demonstrates considerable focus on the characteristics of the offender. Emphasis was placed on early acknowledgement of guilt, cooperation with the police and prosecution, the compassionate desire to relieve suffering, and willingness to accept the often onerous task of caring for a loved one.[255] These factors were common to offenders both in cases of assisting suicide or voluntary mercy killing, and cases of non-voluntary mercy killing. They are factors deserving of judicial sympathy and meriting lenient sentencing, as they demonstrate that several of the purposes of the criminal law – namely, rehabilitation, specific deterrence, or retribution[256] — are not apposite in these cases.

By contrast, very little attention was devoted to the characteristics of the offence, including circumstances of violence and the need to protect vulnerable people within the community from harm, which is another key function of the criminal law.[257]

253 David Lanham et al, 'The Purposes of Criminal Law', *Criminal Laws in Australia* (Federation Press, 2006) 1, 2-3; Gabriel Hallevy, *The Right to Be Punished: Modern Doctrinal Sentencing* (n 233), 60.

254 Gabriel Hallevy, *The Right to Be Punished: Modern Doctrinal Sentencing* (n 233), 57, 60.

255 See Part V.A above.

256 See Part IV.

257 See above, Part IV. Indeed, as Herring has stated, the 'very existence of the criminal law acknowledges that we are vulnerable to harms at the hands of others and need protection from it.' Jonathan Herring, 'Criminal Law and the Protection of Vulnerable Adults' in Jonathan Herring, *Vulnerable Adults and the Law* (Oxford University Press, 2016), 222. Protection of the vulnerable is a major theme in many branches of contemporary law: Paul Finn, 'The Courts and the Vulnerable' (1996) 162 *Law Society of the Australian Capital Territory Gazette* 61, 62. Sometimes the criminal law is the only protection available to the innocent: *R v Collins; Ex parte A-G (Qld)* [2009] QCA 350, [35] (Keane JA, Holmes JA agreeing). See also *R v KU & Ors; Ex parte A-G (Qld)* [2008] QCA 154, [114].

Denunciation and general deterrence assume a key role in deterring others in similar situations from assisting their loved ones to die.[258]

We recognise that not all who died in the assisted suicide and mercy killing cases were vulnerable. One of the themes noted in sentencing was autonomy and choice.[259] Many mercy killings and assisted suicides were voluntary – where individuals consciously and deliberately requested their relatives or friends to assist with their death, for reasons which can be considered rational and enduring. However, in cases where a suicidal person with serious mental illness requests assistance to die,[260] doubts may be entertained as to whether that person's request is truly voluntary and enduring. Persons with serious mental illness who are suicidal are, by definition, vulnerable.[261] In some cases, assistance was provided by the person whose duty it was to care for the deceased.[262] Cases where a person with mental illness requests help to die are more complex, and it might not be possible to simply assume that an explicit request to help in a suicide attempt is a voluntary and settled rational decision.[263] Any law reform in this area needs to be drafted with care in order to protect those with mental illness who may be suicidal and vulnerable.

In addition to those who requested to die who may be vulnerable and in need of protection, some cases considered in this article involved vulnerable adults who had not requested to die. The cases show a disturbing number of those deceased or injured were vulnerable by reason of dementia, disability, or illness, were dependent on others for their care, and were subject to killing or attempts on their life without their request.[264] Because the sentencing remarks focussed so heavily on the offender's moral culpability, they largely ignored the victim's vulnerability. In our view, the law should clearly distinguish, both in charges laid and sentences imposed, between voluntary mercy killing on request (at the request of persons who are not vulnerable, and autonomously request assistance to die), and non-voluntary mercy killing (of people who are vulnerable and have not voluntarily asked to die[265]). This would also accord

258 See Part IV above.

259 See Part V.C.

260 *Larkin* (n 23); *ANG* (n 61); *Johnstone* (n 24); *Hood* (n 23); *Karaca & Price* (n 23); *Carter 2001* (n 23); *Carter 2003* (n 23); *Walmsley* (n 21).

261 See Part V.D.

262 For example, Larkin was a nurse, who had formed a romantic attachment to an extremely unwell psychiatric patient, and accepted him into her home, before later assisting him complete his suicide attempt: *Larkin* (n 23) 42–3 (Nicholson J); *Johnstone* (n 24).

263 Ibid 44. But compare comments in *Larkin* (n 23) 41 (Nicholson J), which were sympathetic to a nurse who assisted her mentally ill lover commit suicide. See also Isra Black, 'Suicide Assistance for Mentally Disordered Individuals in Switzerland and the State's Positive Obligation to Facilitate Dignified Suicide: Haas c. Suisse, Cour européenne des droits de l'homme' (2012) 20(1) *Medical Law Review* 157.

264 See Part V.D. For example, see *Klinkermann* (n 25); *Sutton* (n 75); *Riordan* (n 25); *Nestorowycz* (n 25); *Dowdle* (n 72); *Hollinrake* (n 25); *Pryor* (n 22).

265 Especially those with disability, dementia or incapacity. It is possible that in some cases an elderly person with dementia may have requested assistance to die in anticipation of later losing capacity. Although not expressly stated, this may have been the case in *Pryor* (n 22). Although this does not affect the legal position, it does make the position of the family member who helps fulfil that request ethically more complex. The moral burden such requests places on family members was most clearly articulated in *Attenborough* (n 2), where a son who had refused his mother's request to end her life when she had terminal cancer 'could see how disappointed she was in his response to that request. He felt like a coward … ': at 13 (Graham AJ).

with community values, which consider mercy killing more serious where the victim has not requested to die.[266]

VII. REFORM OPTIONS

From the foregoing analysis, it is clear that law reform is needed. At least in the case of voluntary mercy killings and assisted suicide, the substantial penalties and significant stigma attached to a homicide conviction demonstrate that the law is out of step with community values.[267] Although prosecutorial discretion in charging and judicial discretion in sentencing can be used to avoid these undesirable results, and to express the relative lack of moral condemnation from the community of this conduct, this is inadequate. Reliance on discretion inevitably leads to inconsistent outcomes in some cases, which undermine the principles of clarity, consistency and equality before the law, all of which are essential components of the rule of law. Sentencing offenders is a particularly visible stage in the criminal process. Imposing lenient sentences for the most heinous crimes, such as a suspended sentence for murder, threatens to undermine public confidence in law, which in turn affects the ability of the law to effectively control social behaviour.[268] Although voluntary mercy killing is not justified and remains criminal conduct, we agree with Keating and Bridgeman that there is a distinctive wrong committed in these cases which ought to be reflected in the legal categorisation of the wrong done, not viewed as only relevant to the judge in sentencing.[269]

This final Part considers options for law reform. First, it considers whether legalising voluntary assisted dying will alleviate the problems identified above relating to the criminal law. Then it explores three non-mutually exclusive options for reform within the criminal law where the deceased person is not eligible for voluntary assisted dying but nevertheless requested assistance to die. These are: creating a less serious category of homicide called 'mercy killing'; introducing a specific statutory offence of 'completing a suicide'; and creating a partial defence to murder in cases of 'compassionate motive'.

266 Research in the UK found voluntary request was the single most important factor in community sympathy for mercy killers, ahead of compassionate motive and the suffering or poor quality of life of the victim: Mitchell, 'Brief Empirical Survey of Public Opinion Relating to Partial Defences to Murder' (n 220), [55]; Barry Mitchell, 'Public Perceptions of Homicide and Criminal Justice' (1998) 38(3) *British Journal of Criminology* 453, 460. Members of the public also considered a mercy killing more serious where the person has not requested to die, than where the killing took place at their explicit request: Appendix A (Report on Public Survey of Murder and Mandatory Sentencing in Criminal Homicides) to United Kingdom Law Commission, *A New Homicide Act for England and Wales?* (Consultation Paper No 177, 2005), [A13].

267 This was argued in Part VI.A.

268 See Part VI.B for a more detailed exposition of this argument. See also Mitchell and Roberts, 'Making the Case For and Against the Mandatory Life Sentence' (n 220), 57-59.

269 Heather Keating and Jo Bridgeman, 'Compassionate Killings: The Case for a Partial Defence' (2012) 75(5) *Modern Law Review* 697, 721. See also Law Reform Commission Victoria, *Homicide* (Report No 40, 1991), [116]; Livings (n 222), 203.

A. Decriminalise Assisted Suicide and Mercy Killing

There have been calls for many decades among academic commentators and others for law reform to decriminalise assisted suicide and mercy killing.[270] Recently, three Australian states (Victoria, Western Australia and Tasmania) passed legislation authorising voluntary assisted dying for people who are terminally ill and follow a prescribed statutory assessment and approval process.[271] However, these laws will not apply in the majority of the cases described above,[272] where the person has a disability, or is suffering from a physical or mental illness that is not terminal. Accordingly, the criminal law has an important and ongoing role to play in this area. Further, even if a person would have been eligible for voluntary assisted dying under those systems, it is appropriate that those acting outside those processes (which include safeguards to ensure appropriate decision-making) would be captured by the criminal law.

B. Specific Offence of Mercy Killing

Creating a specific offence of mercy killing – a separate category of homicide with a lower head sentence than murder – has been recommended by commentators in England and the United States.[273] It has also been considered on several occasions by law reform commissions, both in Australia[274] and in the United Kingdom.[275] This would enable the law to reflect the lower moral culpability[276] present in mercy killing cases because of the motive of compassion and the wishes of the deceased, and enable lenient sentences to be imposed in appropriate cases without bringing the law into disrepute, while still sending a clear message to the community that such conduct is criminal.

270 Glanville Williams, *The Sanctity of Life and the Criminal Law*, (Faber & Faber, 1958); Otlowski (n 7), 38-39; Bartels and Otlowski (n 17), 555. See also Clough, 'Mercy Killing, Partial Defences and Charge Decisions: 50 Shades of Grey' (n 218), 224-225.

271 *VAD Act* (Vic) (n 6); *VAD Act* (WA) (n 6); *EOLC Act* (Tas) (n 6). See also Bartels and Otlowski (n 17), 549.

272 Del Villar, Willmott and White (n 6).

273 Lincoln (n 223), 888; Clough, 'Mercy Killing: Three's A Crowd?' (n 225).

274 For over 40 years, Law Reform Commissions have engaged with this suggestion. See, eg, Victorian Law Reform Commission, *Law of Murder* (Report No 1, August 1974) ('*Law of Murder*'); Victorian Law Reform Commission, *Annual Report Year Ended 30 June 1984* (Report, 1985), 6; Criminal Law and Penal Methods Reform Committee (SA), *Fourth Report, The Substantive Criminal Law* (1977), 57-58; See also Otlowski (n 7) 34.

275 The Criminal Law Revision Committee (UK) *Working Paper on Offences Against the Person* (London, 1976), proposed a new offence of 'mercy killing', punishable by a maximum term of 2 years: at [79]-[87]. This offence was 'not well received', so was not recommended in the Committee's final report: Criminal Law Revision Committee, *Offences Against the Person* (Fourteenth Report, cmnd 7844, 1980). See also Dargue (n 225). In 1989, the Select Committee of the House of Lords on *Murder and Life Imprisonment* addressed the issue of "mercy" killing by sentencing reform rather than amending the substantive offence. It recommended that 'mercy killing' remain classified as murder, but that the mandatory sentence of life imprisonment should be removed. The recommendation has not been adopted. The 2006 report *Murder, Manslaughter and Infanticide* (Report No 304, 28 November 2006) considered the issue of mercy killings but declined to make any specific recommendations.

276 The Western Australian Law Reform Commission has commented that '[i]ntentional killing of another person for compassionate reasons and with that person's consent would generally be considered significantly less morally culpable' than killing for other reasons: Law Reform Commission of Western Australia, *Review of the Law of Homicide* (Final Report, September 2007) 4. See also Victorian Law Reform Commission, *The Forfeiture Rule* (Report, September 2014) [4.45], [4.49]; South Australian Law Reform Institute, *Review of the common law forfeiture rule* (Background Information and Consultation Questions, 5 March 2019) 2.

Murder has been described as an 'ancient and powerful word … carrying the strongest possible overtones of moral condemnation.'[277] As such, it represents the 'most serious level of culpability'.[278] In view of this, a person should not be convicted of murder unless their conduct is sufficiently heinous or blameworthy. Community surveys in the United Kingdom have shown that members of the public consider mercy killings the least culpable form of homicide, and many consider it to be 'in a class of its own', not as serious as murder.[279] The criminal law's principle of 'fair labelling' requires the law to employ appropriately labelled offences and distinct sentencing provisions, 'so that offenders can be formally stigmatized in proportion to their blameworthiness.'[280] In mercy killing cases, the motive of compassion for another's suffering reduces the blameworthiness of the killing, and this should be reflected by creating a separate offence distinct from murder.[281]

The most specific proposal in this regard was made in 1976 by the Criminal Law Revision Committee in the United Kingdom. It suggested the introduction of a specific offence of mercy killing, limited by two factors: the compassionate motive of the offender, and the grave physical condition of the victim.[282] This would encompass many of the mercy killing cases described in Table 1, both voluntary and non-voluntary,[283] with the exception of those suffering solely by reason of mental illness.[284] The introduction of a specific offence of mercy killing was also suggested by the Law Reform Commissioner of Victoria in 1984.[285] This proposal did not specify whether it

277 G Woods, 'The Sanctity of Murder: Reforming the Homicide Penalty in New South Wales' (1983) 57 *Australian Law Journal* 162. See also Mitchell, 'Public Perceptions of Homicide and Criminal Justice' (n 266), 454.

278 See the four guiding principles articulated by the Law Reform Commission Victoria, *Homicide* (Report No 40, 1991), [112].

279 In Mitchell's 1995 study, 403 out of 822 respondents placed mercy killing in a 'class of its own', and 43% rated it 1/20 on a scale of seriousness of homicide, with an average rating of 3.4/20, indicating that it ranks as one of the least serious homicides: Mitchell, 'Public Perceptions of Homicide and Criminal Justice' (n 266), 469. In fact, when committed in response to a voluntary request from the victim, many do not consider it should be prosecuted at all: See Mitchell, 'Brief Empirical Survey of Public Opinion Relating to Partial Defences to Murder' (n 220).

280 Mitchell, 'Public Perceptions of Homicide and Criminal Justice' (n 266), 454. See also James Chalmers and Fiona Leverick, 'Fair Labelling in Criminal Law' (2008) 71 *Modern Law Review* 217, 229; Thomas Crofts, 'Two Degrees of Murder: Homicide Law Reform in England and Western Australia' (2008) 8(2) *Oxford University Commonwealth Law Journal* 187, 195-200.

281 See Lord Justice Lawton, 'Do we need a new offence of 'mercy killing'' (1979) 72 *Journal of the Royal Society of Medicine* 460; Mitchell and Roberts, 'Making the Case For and Against the Mandatory Life Sentence' (n 220), 57.

282 The victim needed to be either: (i) permanently subject to great bodily pain or suffering; or (ii) permanently helpless from bodily and mental incapacity; or (iii) subject to rapid and incurable bodily or mental degeneration: Criminal Law Revision Committee (UK) *Working Paper on Offences Against the Person* (London, 1976), [82]. See also David Farrier, 'The Criminal Law Revision Committee Working Paper on Offences against the Person' (1977) 40(2) *Modern Law Review* 206, 211; Otlowski (n 7), 35.

283 See examples of both voluntary and non-voluntary killings given in Lawton (n 281). For criticisms both of the inclusion of non-voluntary killings and the exclusion of mercy killings of those with mental illness, see Farrier (n 282), 212.

284 Such as *Johnstone* (n 24); *Blaauw* (n 24); *Larkin* (n 23); *Karaca & Price* (n 23).

285 It had previously been considered and rejected in 1974: Victorian Law Reform Commission, *Law of Murder* (n 274).

would be restricted to deaths which were voluntarily requested, or to people suffering certain types of condition.[286]

Several European countries, such as Germany,[287] the Netherlands[288] and Switzerland,[289] already have a specific offence of voluntary killing carried out at the victim's 'express and earnest request'. These offences do not require a compassionate motive,[290] and carry a lower head sentence than traditional homicide offences.[291] They apply only where the killing was expressly requested by a competent person, not in cases of non-voluntary mercy killing. As noted above, in Australia a considerable minority of 'mercy killings' or attempted mercy killings are carried out without the request or consent of the victim.[292]

In our view, if a lesser class of homicide in the case of 'mercy killing' were to be introduced, it should combine elements from both of these models. First, like the European examples, it should be limited to deaths which are expressly and voluntarily requested by a person who has capacity and has an enduring desire to die. Although some commentators consider an offence of 'mercy killing' should apply in both voluntary and non-voluntary cases,[293] we consider that it is an essential function of the criminal law to protect vulnerable people who have not chosen to die from life-endangering acts at the hands of those closest to them.[294] Where the person has

286 Victorian Law Reform Commissioner, *Murder: Mental Element and Punishment* (Working Paper No 8, 1984), 27; Victorian Law Reform Commission, *Annual Report Year Ended 30 June 1984* (Report, 1985), 6. See also Otlowski (n 7), 35.

287 In Germany, 'Whoever is induced to kill at the express and earnest request of the person killed incurs a penalty of imprisonment for a term of between six months and five years.' *Strafgesetzbuch* [Criminal Code] (Germany) §216.

288 Article 293 of the *Criminal Code 1881* (Netherlands) states that 'Any person who terminates another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fifth-category fine'. This offence does not apply to a physician who terminates a person's life in accordance with article 2 of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (Netherlands),

289 In Switzerland, 'A person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and insistent request, will be sentenced to a term of imprisonment.' The minimum term is 3 days, and the maximum is 3 years. *Schweizerisches Strafgesetzbuch* 1937 (SR 311.0) 21 December 1937, in force since 1 January 1942 [Swiss Criminal Code] Art 114. See Christian Schwarzenegger and Sarah J Summers, *Criminal Law and Assisted Suicide in Switzerland*: *Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords*, (Report, Zurich, 3 February 2005). Similar offences exist in other jurisdictions, including Colombia: Sabine Michalowski, 'Legalising Active Voluntary Euthanasia Through the Courts: Some Lessons from Colombia' (2009) 17 *Medical Law Review* 183 and Japan: *Penal Code 1907* (Japan), art 202. See also Stanley Yeo, 'Right to Die' (2003) 28(2) *Alternative Law Journal* 89.

290 Although a compassionate motive is relevant in Switzerland, it is not a requirement, and is not specifically mentioned in the relevant offence in either Germany or the Netherlands.

291 It carries a maximum of 3 years imprisonment in Switzerland, 5 years in Germany, and 12 years in the Netherlands.

292 See Part III.D.

293 Clough, 'Mercy Killing: Three's A Crowd?' (n 225); Lincoln (n 223). A further unresolved issue is whether a voluntary request must be made at the time of death or whether it could be made at an earlier time when the deceased was competent, but acted upon at a later time when the deceased lacked capacity. This issue of a previous request for death arose, for example, in (*Pryor* (n 22) 1 (Hill AJ)).

294 As Mullock has observed, it is difficult to conceive of an act causing death being 'compassionate' unless the person has indicated a clear wish that death is preferable to ongoing suffering: Alexandra Mullock, 'Overooking the Criminally Compassionate: What Are the

persistently expressed a settled wish to die, the argument from vulnerability has less force than the argument from autonomy.[295]

Second, like the English model, the offence should only be available where there is clear evidence that the motive of killing is compassion or love.[296] This accords with community values,[297] and with existing practice in exercising discretion to press lesser charges, or impose lenient sentences in cases of compassionate motive.[298] It is commonly objected that it is difficult to translate the emotion of compassion into a precise legal definition.[299] Keating and Bridgeman's work constitutes an important first step towards an adequate definition of compassionate motive.[300] It may also be possible to define it negatively, as being an other-focussed motivation, not a self-focussed motivation (such as financial gain,[301] or relief from the burden of caring for a relative who is sick or has a disability[302]). Compassionate motive is also often objected to on the basis of difficulties of proof. While it is undeniably difficult to prove a motive of compassion in circumstances where the person who is uniquely positioned to bear witness to the suspect's true motives has died,[303] commentators believe juries and judges are experienced and equipped at finding facts in similar circumstances.[304] As was seen in *Ritchie's* case, the courts are prepared to reject the assertions of a family member that their loved one requested assistance to die, where the evidence on this point is equivocal.[305] To alleviate this concern, the circumstances of the death or the person's wishes may even be video recorded, as occurred in *Attenborough.*[306]

Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?' (2010) 18 *Medical Law Review* 442, 455. Crofts agrees that it should be limited to voluntarily requested killing: Crofts (n 280), 203.

295 See, in this regard, Barney Sneiderman, 'Latimer, Davis, and Doerksen: Mercy Killing and Assisted Suicide on the Op. Ed. Page' (1997) 25(3) *Manitoba Law Journal* 449, 464.

296 This would exclude neutral or disinterested motives, as in the case of *Carter 2001* (n 23); *Carter 2003* (n 23).

297 Focus group participants in the United Kingdom considered it was 'vital to know whether the case was a "genuine mercy killing" – had the victim truly and freely wanted to die, and was the killer's motive a "good" one?' Appendix A (Report on Public Survey of Murder and Mandatory Sentencing in Criminal Homicides) to United Kingdom Law Commission, *A New Homicide Act for England and Wales?* (Consultation Paper No 177, 2005), [A13]. See also United Kingdom Law Commission, *Report on Murder, Manslaughter and Infanticide* (Report No 206, 2006), [7.17].

298 For example, see the Director of Public Prosecutions (UK), *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (2010). This policy introduced guidelines not to prosecute those who assist a suicide particularly where the motive was compassionate, in response to the decision in *R (on the application of Purdy) v Director of Public Prosecutions* [2010] 1 AC 345: Mullock (n 294), 454.

299 Criminal Law Revision Committee*, Offences Against the Person* (Fourteenth Report, cmnd 7844, 1980), [115]; House of Lords, *Report of the Select Committee on Medical Ethics* (HL Paper 21-1 of Session 1993-1994), [260]. See also Mackay (n 225), 79-80; Lawton (n 281), 461.

300 See Keating and Bridgeman (n 269), 712-715,

301 As was the case in *Morant* (n 33); *Justins* (n 42) and *Nielsen* (n 22).

302 As occurred in *Ritchie* (n 34). See also Victorian Law Reform Commission, *Forfeiture Rule: Consultation Paper* (2014), [3.65].

303 Mullock (n 294), 453.

304 Lincoln (n 223), 889; Williams (n 226), 157; Sneiderman, 'Latimer in the Supreme Court' (n 214), 537-538.

305 *Ritchie* (n 34).

306 *Attenborough* (n 2).

Third, as in the United Kingdom proposal, the offence should be restricted to those with serious or chronic illness, pain or disability.[307] Although concern has been expressed by some that this offence would decrease the protection afforded by the criminal law to vulnerable people, particularly those with disability,[308] if the offence were restricted to those clearly and voluntarily wish to die, no one else is involved in assessing certain lives are intolerable or not worth living. It would also be important to consider, in the case of mental illness, whether a person was suicidal and lacking capacity, or the desire to die was competent, settled and enduring. This would alleviate the concern that vulnerable people are not being protected.

C. 'Compassionate Motive' as a Partial Defence to Murder

An alternative to recognising 'mercy killing' as a specific, lesser class of homicide would be to recognise 'compassionate motive' as a partial defence which reduces murder to manslaughter, analogous to the defence of provocation. This was suggested by the Law Reform Commissioner of Victoria in 1984,[309] and was considered briefly by the United Kingdom Law Commission in 2006, without leading to any recommendations.[310] It has also been suggested by several commentators, including Sneiderman in Canada, Clough in England, and Crofts in Australia.[311] The basis of this suggestion is parity with other emotional excuses recognised by the law. It is argued that the partial defence of provocation recognises the role played by anger in provoking criminal violence, and recognises the role of fear when 'battered women' kill their abusive partners when no immediate threat is present.[312] Compassion is no more morally blameworthy than anger and fear, since it is a moral virtue. Compassion is also one of the foundations of our system of justice, whereas fear or anger are not. Accordingly, so it is argued, introducing a partial defence of compassionate motive for cases of mercy killing would bring the law 'in line with other emotional response defences.'[313] To date, the only relevant model is the *Model Penal Code* (US), which

307 In the United States, the proposal articulated by Lincoln is limited to those with terminal illness or in severe, intractable pain: Lincoln (n 223), 888. Comments to this effect were made in *Hood* (n 23) [35] (Coldrey J) and *Blaauw* (n 24) [38] (Forrest J). Some judges have also expressed sympathy for people with disability who desire assistance to end their lives: *Godfrey* (n 22) 1 (Underwood J); *Nielsen* (n 22) 1-14 (Dalton J).

308 See, eg Lepofsky (n 214).

309 This recommendation had also been rejected in 1974: Victorian Law Reform Commission, *Law of Murder* (n 274).

310 Law Commission, *Murder, Manslaughter and Infanticide*, (Law Com Report No 304, London, 2006), 147-152.

311 Barney Sneiderman, 'Why Not a Limited Defence - A Comment on the Proposals of the Law Reform Commission of Canada on Mercy-Killing' (1985) 15(1) *Manitoba Law Journal* 85, 95 ('Why Not a Limited Defence'); Sneiderman, 'The Latimer Mercy-Killing Case' (n 214); Clough, 'Mercy Killing: Three's A Crowd?' (n 225); Clough, 'Mercy Killing, Partial Defences and Charge Decisions: 50 Shades of Grey' (n 218); Crofts (n 280), 203.

312 See Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 359. See also S Edwards, 'Anger and Fear as Justifiable Preludes for Loss of Self-Control' (2010) 74(3) *Journal of Criminal Law* 223; Suzanne Uniacke, 'Emotional Excuses' (2007) 26 *Law and Philosophy* 95.

313 Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 372. See also Mackay (n 225), 81, citing Joshua Dressler, 'Reflections on Excusing Wrongdoers: Moral Theory, New Excuses and the Model Penal Code' 19(3) *Rutgers Law Journal* 671; Keating and Bridgeman (n 269), 711; Sneiderman 'Why Not a Limited Defence' (n 311), 95. In 2006, the United Kingdom Law Commission stated: 'Under the current law, the compassionate motives of the "mercy" killer are in themselves never capable of providing a basis for a partial excuse. Some would say that this is unfortunate. On this view, the law affords more recognition to other less, or at least no more,

provides a partial defence in cases of 'extreme emotional disturbance'.[314] This covers a broad range of extreme emotions, including anger, fear and distress.[315]

A partial defence operates to reduce a charge of murder to manslaughter,[316] which would remove the stigma associated with a murder conviction, and lessen the disparity between the maximum head sentence and the lenient sentence which is usually imposed in practice in such cases, in line with community sentiment.[317] Although Jeremy Horder has asserted that compassionate motive should be a complete defence,[318] most commentators believe it should operate as a partial defence, akin to provocation, recognising that the conduct is morally wrong, but offender's culpability is reduced, given the emotional distress experienced by someone watching a loved one suffer.

The primary focus of a partial defence would be on the existence of clear compassionate motive.[319] According to Clough, the fact the offender has a close and personal relationship with the victim is an important part of developing compassion for the victim's suffering and willingness to assist them achieve their desire.[320] Sneiderman proposes that compassion should be tested both subjectively (from the perspective of the offender) and objectively (according to a 'reasonable ordinary person' test),[321] which Clough also supports.[322] Ultimately, it is a matter for the jury as finder of fact to distinguish genuine compassion from selfish or ignoble motives, as it does in other cases.[323]

This partial defence should also be available only in cases where the victim had serious or chronic illness, pain or disability.[324] Whether the victim has expressly and voluntarily requested assistance to die would be relevant in sentencing, but given the focus on the

understandable emotions such as anger (provocation) and fear (self-defence).' United Kingdom Law Commission, *Report on Murder, Manslaughter and Infanticide* (Report No 206, 2006), [7.7].

314 *Model Penal Code* s 210.3(1)(b). See also Dressler (n 313).

315 Indeed, Glenys Williams has recommended that mercy killing could be incorporated within the existing defence of provocation, in line with the recognition of battered women who kill. The defence of provocation has been expanded from crimes of passion and anger, to include loss of self-control arising from prolonged exposure to abuse. Williams suggests that the sense of futility, exhaustion, despair and pity experienced by watching a loved one suffer and repeatedly beg to be killed may cause a similar loss of control: Williams (n 226), 156. See also PR Taylor, 'Provocation and Mercy Killing' (1991) *Criminal Law Review* 111.

316 See Bronitt and McSherry (n 11) 307, 329.

317 This idea was considered, and rejected, by the Victorian Law Reform Commission in 1974: *Law of Murder* (n 251). See also Otlowski (n 7) 36.

318 Horder (n 134). Horder considers it should be a complete defence to both murder and assisted suicide. For a counter-argument, see Laing (n 135).

319 The same problem of defining 'compassionate motive' would apply as applies to a specific offence of mercy killing: United Kingdom Law Commission, *Report on Murder, Manslaughter and Infanticide* (Report No 206, 2006), [7.7].

320 Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 370-371. This may also explain why Carter was not considered a case of 'mercy killing': *Carter 2001* (n 23); *Carter 2003* (n 23).

321 Sneiderman, 'Latimer in the Supreme Court' (n 214), 538.

322 Clough agrees that it is necessary that the offender had a reasonable and genuine belief that the act was necessary to end the victim's suffering: Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 370-371.

323 Sneiderman, 'Latimer in the Supreme Court' (n 214), 538; Otlowski (n 7), 37; Horder (n 134), 312-313.

324 Sneiderman would limit his proposal to grievous suffering, not mere disability: Sneiderman, 'Latimer in the Supreme Court' (n 214), 537-538. Clough restricts hers to terminal illness or a disease/disability which would substantially impair both life expectancy and the quality of life: Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 370-371.

offender's emotional state, the defence may be available in some cases where the deceased had not requested to die.[325]

D. Specific Offence of Completing a Suicide

A third possibility, which has not been suggested in any law reform proposals or the academic literature, but which stems from an analysis of the facts of the mercy killing cases described above,[326] is creating a new offence of 'completing a suicide'. This would apply only in some instances of mercy killing. It would enable recognition that some conduct, for example, in suffocating a loved one who has already taken an overdose with the intention of ending his or her life, is less morally culpable than murder, but more culpable than merely assisting a suicide.[327] To ensure this offence is only charged in appropriate cases, it may be desirable to limit it to circumstances where the deceased had a serious or chronic illness, pain or disability; the deceased had a definite intention to die and had taken steps towards this end;[328] and the offender was motivated by compassion in completing the suicide attempt. As with the proposed offence of 'mercy killing', definitional issues would be critical to the workability of this suggestion.

E. Summary

The legalisation of assisted dying, at least in the narrow version introduced in Victoria and Western Australia, will not alleviate all the concerns raised in this paper. The majority of cases of assisted suicide and mercy killing determined by the courts did not involve a person in the final stages of a terminal illness.[329] Thus, there remains a need for regulation by the criminal law. However, the gulf between the head sentences and sentences typically imposed by judges demonstrates a significant discrepancy between community values in relation to mercy killing and the law on the books.

Reform of the criminal law to introduce a lesser class of homicide termed 'mercy killing', a specific offence of 'completing a suicide', or a partial defence of 'compassionate motive' (as described above), would enable the prosecution to effectively exercise discretion in charging to reflect the moral blameworthiness of the conduct. These offences are not mutually exclusive, and on the same facts the prosecution would have the discretion to charge a person with completing a suicide (as in *Pryor*), mercy killing (as in *Thompson*[330]), or murder (as in the case of *Ritchie*, where

325 Clough states that mercy killing could be a partial defence in both voluntary and non-voluntary situations (that is, where the person believes it is in the best interests of the victim to end their pain and suffering, as in the case of *R v Inglis* [2010] EWCA Crim 2637). However, she also considers it would be a relevant consideration if the victim had reached a clear and informed decision to die, and the actor had attempted to dissuade the person: Clough, 'Mercy Killing: Three's A Crowd?' (n 225), 371.

326 See Table 1.

327 See, eg, *Larkin* (n 23); *Maxwell* (n 21); *Pryor* (n 22); *Karaca & Price* (n 23); *Mathers* (n 48).

328 The requirement of a voluntary request to die, proposed in the context of a specific offence of 'mercy killing', is less relevant in the context of completing a suicide. This is because the deceased has already demonstrated an intention to die by taking action to end her life. It is suggested that the deceased would appreciate assistance to complete the suicide, even if that assistance was not expressly requested.

329 Del Villar, Willmott and White found that only 4 out of 27 cases met the criteria of terminal illness: Del Villar, Willmott and White (n 6).

330 Thompson suffocated his wife with a pillow, at her request. She had multiple sclerosis, her condition was progressively deteriorating, and she did not want to go into residential aged care

the suffocation was not an act of compassion for the suffering of the deceased).[331] Introducing these additional offences would also enable sentencing judges to impose suspended sentences where the circumstances were sympathetic,[332] but jail terms where the circumstances were less sympathetic,[333] without bringing the criminal justice system into disrepute.

However, because in our opinion a statutory offence of mercy killing should be limited to cases where the victim voluntarily requested to die, non-voluntary killings would generally continue to be dealt with by the ordinary law of homicide.[334] This clear distinction between voluntary and non-voluntary mercy killings may strengthen the argument for stricter sentences in non-voluntary cases, and would provide greater protection of vulnerable people.

VIII. CONCLUSION

Mercy killings are some of the most difficult cases dealt with by judges in sentencing. This is because they often involve a combination of aggravating features (such as a vulnerable victim, breach of trust, and often significant planning and premeditation), alongside the mitigating factor that the offender genuinely believed that the killing was an act of compassion.[335]

This article has shown how the criminal law simultaneously provides both too much protection and not enough protection for members of the community. By continuing to treat all actions causing death as murder, even where the deceased has requested assistance to die, the law is out of step with community values. Sentences showing sympathy for a person's actions in such cases are usually extraordinarily lenient, which undermines the rule of law principles of clarity and predictability. On the other hand, the lenient sentences handed down in cases of non-voluntary killings intended to relieve the perceived suffering of a loved one also bring the law into disrepute, by providing insufficient protection to some of the most vulnerable in our community. It is time to rethink the criminal law, to ensure it strikes a proper balance between protection of the vulnerable and mercy for those who act out of compassion to fulfil the requests of their loved ones.

or palliative care. Thompson had been her devoted carer for 15 years: *R v Thompson* (Local Court of NSW, Mag Railton, 21 February 2005) reported in Nick Cowdery, 'Dying with Dignity' (2011) 86 *Living Ethics* 12 and Sarah Steele and David Worswick, 'Destination death: a review of Australian legal regulation around international travel to end life' (2013) 21 *Journal of Law and Medicine* 415, 420

331 We are indebted to the anonymous reviewer for suggesting this point.

332 See, eg, *Maxwell* (n 21).

333 See, eg, *Nielsen* (n 22).

334 There may be limited exceptions if a partial defence of 'compassionate motive' is introduced, as that would be broad enough to apply to both killings of persons who voluntarily requested assistance, and those who were suffering but had not requested to die.

335 Keating and Bridgeman (n 269), 704. See also *R v Inglis* [2010] EWCA Crim 2637, [51] (Lord Judge CJ, Irwin J and Holroyde J)