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A folyóirat a Károli Gáspár Református Egyetem Állam- és Jogtudományi Doktori Iskolájának a közleménye. A szerkesztőség célja, hogy fiatal kutatók számára színvonalas tanulmányaik megjelentetése céljából méltó fórumot biztosítson.
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END-OF-LIFE DECISIONS UNDER ANGLO-SAXON LAW
ÉLETVÉGI DÖNTÉSEK AZ ANGOLSZÁSZ JOGBAN

Dávid Köbel[1]

Absztrakt ■ Ez a tanulmány az angolszász jogrendszert alkalmazó országokban vizsgálja az életvégi döntések jogi státuszát. A tanulmány keretén belül röviden tisztázom az életvégi döntésekkel kapcsolatos fogalmi kérdéseket, majd pedig megvizsgálom az életvégi döntések szabályozását az egyes országokban. A tanulmány célja annak megállapítása, hogy a vizsgált országokban megjelenik-e bizonyos mintázat az életvégi döntések szabályozásának módszereiben, és hogy ez a mintázat összefüggésben áll-e az országok jogrendszerével. Végül összehasonlítom a jogi megoldásokat, és levonom a következtetéseket.

Kulcsszavak: eutanázia, orvosi halálba segítés, asszisztált öngyilkosság, életvégi döntések, angolszász jog

ABSTRACT ■ This study will attempt to examine the legal status of end-of-life decisions in countries which use the Anglo-Saxon legal system. I will briefly attempt to define end-of-life decisions for the purpose of this paper, and then examine the current legal status of end-of-life decisions in each country. I wish to ascertain, whether a certain pattern emerges in the examined countries regarding the manner in which they regulate end-of-life, and whether any pattern that emerges is in relation to their legal system. Finally, I will compare the legal solutions and draw conclusions.

Keywords: euthanasia, medical assistance in dying, voluntary assisted dying, end of life, Anglo-Saxon law

1. End-of-life decisions

End-of-life decisions and their legality are one of the most important issues today. International practice on the matter is moving towards more leniency and certainly towards more formal regulation. This new wave of legislation prompts the need to thoroughly examine currently existing laws using differing methods. The aim

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of this study is to review whether Anglo-Saxon law has any unique methods or approaches towards regulating end-of-life. Before this examination begins, we must briefly touch on the core subject of this paper – end-of-life decisions.

Generally speaking, there is no universally accepted definition for end-of-life decisions, however the most commonly understood institutes that fall under this grouping are euthanasia, (physician) assisted suicide, withdrawal of (lifesaving/sustaining) treatment, refusal of (lifesaving/sustain) treatment and palliative care. Common legal terms which refer to end-of-life decisions that intend to assure a terminally ill patient may choose to end their life when they wish to, are either medical aid/assistance in dying (MAID)[2] or voluntary assisted dying (VAD).[3] For ease of understanding, this paper will primarily use the term medical assistance in dying.

2. End-of-life under UK law

Within the current legal system of the United Kingdom, there is no formal legal framework for end-of-life decisions. Instead, there exists a chaotic combination of common law principles, individual judgements and certain provisions of the Suicide Act of 1961 as well as the Human Rights Act of 1998.

2.1. The Suicide Act and the Bland Case

The only concrete legislation concerning end-of-life in a major way is the aforementioned Suicide Act, which decriminalized suicide itself, but simultaneously criminalized any action that would aid or encourage a person to commit suicide, whether or not such an attempt occurs in the first place.[4] Some attempts at partial decriminalization were made, however the law has remained unchanged since its enactment in 1961. There are however some important rulings on the matter that essentially shaped the legality of end-of-life decisions.

The first major case in modern English law regarding this matter was the Bland[5] case, which concerned a 17-year-old boy, who – after a crowd rush in

2 American Association of Suicidology. Suicide Is Not the Same as Physician Aid in Dying.

3 Katherine Waller – Katrine Del Villar – Lindy Willmott – Ben White: Voluntary assisted dying in Australia: A comparative and critical analysis of state laws. *University of New South Wales Law Journal*, 2023 (4), 1421-1470.

4 Suicide Act 1961.

5 *Airedale National Health Service Trust v Bland* [1993] AC 789.

the Hillsborough Stadium[6] – was left in a persistent vegetative state. After three years of living in this state, the hospital – with the consent of the family – began the process for withdrawal of treatment. The House of Lords eventually decided to permit the withdrawal, on the grounds that whilst it was not *"in [...] his best interest to die, but that it was not in his best interests to keep him alive [...]".*[7] The House of Lords felt it necessary to point out, that withdrawal of treatment is an omission rather than an act, as the latter would constitute euthanasia and be legally classified as murder.[8]

2.2. The Pretty Case

The next major case arose after the enacting of the Human Rights Act of 1998, which reaffirmed the European Convention on Human Rights (ECHR). The Pretty case, known in the UK as Pretty v DPP,[9] and internationally after it reached the European Court of Human Rights (ECtHR) as Pretty v UK,[10] is perhaps one of the most important cases regarding end-of-life decisions.

The applicant, Diane Pretty, was a woman diagnosed with amyotrophic lateral sclerosis, an incurable illness which leads to rapid deterioration of muscles, the eventual loss of all motor control and finally death through suffocation. In front of the domestic courts, the legal question was whether the provisions of the Suicide Act needed revision after the enactment of the Human Rights Act. Specifically, Pretty was seeking legal immunity for her husband, in case he helped her commit suicide. In this, she relied on provisions of the Human Rights Act – indirectly the ECHR – regarding the right to life. Both the lower courts and the House of Lords rejected her arguments and held, that the Act does not afford a right to die with dignity, instead only the right to *"live with as much dignity as possible, until life reaches its natural end".*[11]

The main argument in her application to the ECtHR was that Article of the ECHR 2 *"protects the right to life, not life itself"* and as such her husband should be able to help her commit suicide, and not be punished for it. The Court unanimously

6 https://www.britannica.com/event/Hillsborough-disaster.

7 Nicholas Liddane: Abandoned to principle: an overview of the law on euthanasia & assisted suicide in the UK and Ireland & the case for reform. *Cork Online Law Review*, 2013 (12), 79-103.

8 *Bland,* para 880.

9 *R (Pretty) v DPP* (2002) 66 BMLR 147.

10 *Pretty v the United Kingdom* App no 2346/02 (ECtHR, 29 April 2002).

11 Deidre Madden: *Medicine, Ethics and the Law.* 2nd Ed. Dublin, Bloomsbury, 2011, 544, quoted by Liddane 2013.

rejected this, stating that Article 2 could not be interpreted as conferring on individuals *"a right to die as well"*.[12] In addition, the Court heard arguments based on Articles 3, 5, 8, 9, and 14, rejecting all of them, but noting that it refuses to rule out the possibility that such a decision could be protected by Article 8 ECHR, the right to privacy.[13]

2.3. The Purdy Case

The last major case on this matter is the Purdy case,[14] which concerned a woman suffering from multiple sclerosis, who expressed that she wishes *"to be able to ask for and receive assistance to end my life, should living it become unbearable"*.[15] In this case, Purdy and her husband turned to the Director of Public Prosecutions (DPP) to *"disclose his policy in relation to the circumstances in which he will consent (or not consent) to a prosecution"*[16] in cases of assisted suicide. Whilst unsuccessful in lower courts, the Purdy case concluded with some success in the House of Lords, which ordered the DPP to issue a policy to clarify as to when he would decide to prosecute regarding the Suicide Act. This policy notes clearly, that it is not a guideline for immunity in the offence of assisted suicide, merely a clarification of procedure. Nevertheless, it lists the sole motivation of compassion as one the factors, which make *"prosecution [...] less likely to be required"*, thus formally opening the door for prosecutorial immunity in individual cases.[17]

As a result of all these cases, the situation in the United Kingdom is rather chaotic. The quasi-legality of withdrawal/refusal of treatment is based on the much-criticized acts versus omissions distinction and cases of assisted suicide may on occasion avoid prosecution through a barely formalized policy. Legislative efforts to formalize these institutions have remained unsuccessful.

12 *Pretty*, para 39.
13 *Pretty*, para 67.
14 *R (Purdy) v DPP* [2009] EWCA Civ 92.
15 *Purdy*, para 6.
16 *Purdy*, para 12.
17 The Director of Public Prosecutions. Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide.

3. End-of-life in Ireland

In Ireland, the legal status of end-of-life is similar to that of the United Kingdom, but perhaps with even more confusion. Similar to the UK, the Irish Criminal Law (Suicide) Act of 1993[18] enacts a blanket ban on physician assisted dying and assisted suicide. When it comes to the jurisprudence, there are only two cases regarding end-of-life in Irish law.

The first one is the Re a Ward of Court case,[19] which concerned the withdrawal of treatment for a patient in persistent, more than two decade long vegetative state. The family sought permission for the withdrawal of life sustaining nourishment, which the High Courts allowed. During the appeal, the main legal question in front of the Supreme Court was that albeit a person of full mental and legal capacity has the right and thus may refuse any treatment, the patient had minimal to no capacity to recognize those around them, let alone make conscious decisions. Eventually the Supreme Court decided to uphold the decision of the High Courts but emphasized, that allowing *"nature to take its course"*[20] by ceasing life-sustaining treatment was not the same as euthanasia. This distinction of acts and omissions mirrors that of Bland.

The next and final case in Irish case-law is Fleming v Ireland.[21] Similar to Purdy, the case concerned a woman diagnosed with multiple sclerosis. She argued that the absolute prohibition regarding assisted suicide was unconstitutional and violated her right to personal autonomy. Beyond this, she petitioned the courts to order the Irish DPP to issue similar guidelines like the ones in the UK. The High Court chose to uphold the precedent set by Re a Ward of Court and held, that the absolute ban was proportional. Additionally, it declared, that – contrary to the decision in Purdy – the DPP had no obligation to issue guidelines, yet confusingly stated, that if one would be able to prove to the DPP, that they were compliant with the aforementioned English guidelines, *"the Court feels sure that the Director, in this of all cases, would exercise her discretion in a humane and sensitive fashion"*.[22]

The Fleming case essentially solidified the case-law of Re a Ward of Court, which meant, that the majority of end-of-life decisions remain under a general ban and are decided on a case-by-case basis either by the Courts or by the DPP.

18 Criminal Law (Suicide) Act 1993.
19 *Re a Ward of Court* [S.C. Nos. 167, 171, 175 and 177 of 1995].
20 *Re a Ward*, para 426.
21 *Marie Fleming v Ireland and the Attorney General* [2013] IEHC 2 5.
22 *Fleming*, para 175.

Renewed attempts at legislation aiming to legalize these institutions started in 2020, but ultimately lapsed in 2024.[23]

4. End-of-life in Canada[24]

Canadian end-of-life regulation has undergone a major shift in the last decade following the Carter v Canada[25] case. Prior to this decision, section 241(b) of the Canadian Criminal Code[26] criminalised assisted suicide, under which Canadian jurisprudence included euthanasia.

The Carter case began in 2011, when a Canadian woman – diagnosed with amyotrophic lateral sclerosis two years prior – brought an action challenging, inter alia, the unconstitutionality of the above-mentioned provision of the Criminal Code.[27] The Court of First Instance in this case examined the level of public perception of end-of-life decisions in Canada, and more specifically the difference between palliative care and euthanasia and assisted suicide, and then went on to examine the global regulatory practice of end-of-life decisions.[28] On the basis of the evidence available, it concluded that the danger inherent in legalising these legal instruments could be minimised by a strong system of safeguards which strictly and consistently enforced the conditions.[29] The Court of First Instance then addressed the conditions for overruling the Rodriguez Decision,[30] finding, inter alia, that the Rodriguez Decision did not address in any depth the provisions of Article 7 of the Canadian Charter of Fundamental Rights and Freedoms (hereinafter: the Charter).[31]

23 Dying with Dignity Bill 2020.

24 This chapter is a revision and translation of a chapter in an earlier study by the author. See Dávid Köbel: Az önrendelkezési jog és az életvégi döntések jogdogmatikájának nemzetközi összehasonlítása. *Jog-Állam-Politika*, 2024 (1).

25 *Carter v. Canada* (Attorney General), 2015 SCC 5, [2015] 1 S.C.R. 331.

26 Criminal Code (R.S.C., 1985, c. C-46).

27 *Carter,* I. [11].

28 *Carter,* IV. [23]-[25].

29 *Carter,* IV. [27].

30 In common-law systems, the revision of a previous decision, i.e., precedent, can take two forms: distinguishing or overruling. In the first form, *"[t]he appellate court accepts the previous precedent but limits its applicability and establishes a new rule for circumstances in which the previous precedent no longer applies"*. In our case, it is the second form, where *"[t]he appellate court simply substitutes a new rule for the precedent"*. See Nicola Gennaioli – Andrei Shleifer: Overruling and the Instability of Law. *Journal of Comparative Economics*, 2007 (2), 309-328.

31 Canadian Charter of Rights and Freedoms Article 7. Everyone has the right to life, personal liberty and security of person and not to be deprived of it except in accordance with the principles of fundamental justice.

Furthermore, it found that significant social and legal developments have taken place since the decision was adopted, in particular a 'substantive change' in the jurisprudence of the Supreme Court of Canada in interpreting the guarantee of the fundamental rights and freedoms set out in the first paragraph of the Charter.[32] On the merits of the application, the Court of First Instance held that the absolute prohibition of euthanasia and assisted suicide was unnecessary and violated Article 7 of the Charter. On this basis, the Court of First Instance found the provisions of the Criminal Code on assisted suicide to be unconstitutional.[33] The woman who brought the action died of illness before the decision of the Court of First Instance.

The British Columbia Court of Appeal, in overturning the first instance decision,[34] held that neither legal nor social changes had provided sufficient grounds to override precedent. The case was finally referred to the Supreme Court in October 2014, which agreed with the first instance. On the issue of stare decisis, the panel, referring to one of its own previous decisions,[35] outlined that for a precedent to be overridden, two conjunctive conditions must be met: first, a *"new legal issue is raised"* and, second, the circumstances or evidence change in such a way that it *"fundamentally shifts the parameters of the debate"*.[36] The Supreme Court held that both conditions were met and turned to the question of whether the right to life, liberty and security under Article 7 of the Charter was affected and infringed.

On most of the issues raised in relation to the right to life, the Supreme Court agreed with the Court of First Instance, highlighting among these the finding that a total ban could have the effect of putting people in a position, where because of their fear that when their illness reaches the point where their suffering is unbearable they will no longer be in a state to end their lives, they commit a 'premature' suicide in order to avoid this.[37] The right to liberty and security of the person were considered together by the Supreme Court, and in this connection, in addition to what was said in an earlier judgment,[38] it was said that *"It is clear that anyone who seeks death by euthanasia because he is suffering intolerably as a result of a serious and incurable disease does so out of a deeply personal and fundamental conviction as to how he wishes to live or die"*.[39] The test for prejudice in Canadian jurisprudence

[32] *Carter,* IV [28].
[33] Supreme Court of British Columbia, 2012 BCSC 886, 287 C.C.C. (3d) 1; Carter v. Canada. IV. [32].
[34] British Columbia Court of Appeal, 2013 BCCA 435, 51 B.C.L.R. (5th) 213.
[35] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, [2013] 3 S.C.R. 1101, at para. 42.
[36] *Carter,* VI [44].
[37] *Carter,* VIII [57].
[38] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181.
[39] *Carter,* VIII [68].

is the test of 'The Principles of Fundamental Justice', which considers whether the prejudice is arbitrary, overbreadth in its effect[40] or grossly disproportional. In relation to the first, given that the law is primarily intended to protect vulnerable persons from ending their lives in times of "infirmity", the Supreme Court has held that the total prohibition achieves this objective and that there can be no question of arbitrariness. In the case of broadness, however, the panel found that the total ban, by applying to persons who are able, informed and uninfluenced, is too broad. Due to this previous finding making it no longer necessary, gross disproportionality was not examined and the Supreme Court of Canada found a violation of Article 7 of the Charter. Canadian jurisprudence applies Article 1 of the Charter to determine whether a particular prohibition is *"manifestly justified in a free and democratic society"*.[41] In this regard, the jurisprudence has established a threefold test[42] that a law is proportionate if (1) the means employed are rationally related to the end in view; (2) the right in question is minimally infringed; and (3) the positive and negative effects of the law must be proportionate to each other. With respect to the first condition, the Supreme Court briefly held that a rational connection existed, but only examined the second condition in detail. It is not within the scope of this paper to examine this line of reasoning in detail, but in a nutshell, in answer to the question whether a lesser restriction than a total ban can achieve the legislative intent, the Supreme Court, agreeing with the First Instance, held that it can. On this basis, the Supreme Court declared section 241(b) of the Criminal Code of Canada unconstitutional and therefore of no force or effect and suspended its enforcement, giving the Canadian legislature 12 months to enact legislation to reflect its decision.[43]

The Canadian literature in reaction to the decision was limited but sharply critical.[44] Most studies criticized the decision for being selective in both the trial judge and the Supreme Court's finding and interpretation of the evidence on the safeguards for euthanasia and assisted suicide, downplaying the danger

[40] The principle of 'overbreadth' was developed in the Supreme Court of Canada decision in *R v Heywood* ([1994] 3 SCR 761) and is essentially a test of whether a law affects society only to the extent necessary or whether it affects, for example, a class of persons for whom the restriction is unjustified.

[41] Canadian Charter of Rights and Freedoms 1.

[42] *R. v. Oakes*, [1986] 1 S.C.R. 103.

[43] *Carter,* XIII [147].

[44] Benny Chan – Margaret Somerville: Converting the 'Right To Life' to the 'Right To Physician-Assisted Suicide and Euthanasia': An Analysis of Carter v Canada (Attorney General), Supreme Court Of Canada. *Medical Law Review*, 2016 (2), 143-175.

of a slippery slope to legalization.[45] The Canadian legislature, after some delay, amended the Criminal Code in June 2016, greatly expanding the sections regulating suicide and introducing a section on 'Medical Assistance in Dying', which details the conditions for euthanasia and assisted suicide. The section also sets out a number of other, more specific conditions and guarantees[46] and details the exceptional, non-punishable circumstances in which the inducement or assistance to suicide – the predicate offence of which is, of course, still punishable – may be made.[47]

5. End-of-life in the United States

When examining this aspect of the US legal framework, I shall divide this chapter in two parts. First, I will look at any existing federal regulation or Supreme Court decision on the matter, and after, I will analyse the legislation of states that have – at least in some form – legalized such institutions.

5.1. Federal legislation and case-law

There are two major cases on the issue of end-of-life decisions, that were significant enough to reach the Supreme Court, and both stem from the late 90's. Both cases arose from constitutional challenges on laws that criminalized assisted suicide.

The first case, Compassion in Dying v Washington,[48] succeeded in the first instance but was reversed in front of the appeals court, and as such went to the Supreme Court. Vacco v Quill[49] travelled an inverse path to Compassion but ended in the same way. The trials court in New York did not consider the ban on assisted suicide unconstitutional with the Second Circuit overturning this decision, which was also appealed. Due to their similarity, the Supreme Court decided to combine the two cases. Ultimately, they decided that *"there was no federal constitutional right to have a physician provide competent, terminally ill patients with a prescription for a lethal dose of medication"*.[50] It was not a complete loss however, because the Court

45 John Keown: A Right to Voluntary Euthanasia? Confusion in Canada in Carter. *Notre Dame J.L. Ethics & Pub. Pol'y*, 2014 (1), 29-32.

46 Criminal Code (R.S.C., 1985, c. C-46) 241.2 (3)-(9).

47 Ibid. (1)-(7).

48 *Compassion in Dying v. State of Wash.*, 850 F. Supp. 1454 (W.D. Wash. 1994).

49 *Vacco v. Quill*, 521 U.S. 793 (1997).

50 Alan Meisel: A history of the law of assisted dying in the United States. *SMU L. Rev.*, 2020 (1), 119.

also stated, that whilst there is no constitutional right to medical assistance in dying, there is also no constitutional prohibition. This in turn gave ground for the failure of the constitutional challenge of the Oregon law.[51]

5.2. State legislation and case-law

Currently, medical assistance in dying is legal in the following states (in order of enactment): Oregon, Montana, Washington, Vermont, California, Colorado, the District of Columbia, Hawai'i, New Jersey, Maine, New Mexico and to a certain extent also North Carolina.[52] Of these, ten did so through voter initiative or legislation and two in differing methods.[53] In the following, I will present only the most pivotal solutions.

5.2.1. Voter initiative or legislation

The state of Oregon became the first state to legalize medical assistance in dying.[54] The voter initiative, titled the 'Death with Dignity Act', narrowly passed the ballot in 1994 but it did not enter into force for a further three years due to a lengthy legal challenge.[55] Several states attempted a similar path to Oregon in the early 2000's, however all of them failed due to strong opposing advertisements.[56] Oregon remains the only state to legalize medical assistance in dying through voter initiative and since 2023 is one of two states that does not require the patient to be a resident of the state.[57]

Many other states however successfully enacted end-of-life regulation through conventional legislative efforts. In 2009, Washington became the first state to follow 'the Oregon trail' by enacting the similarly named 'Washington Death with Dignity Act', and since then most states that legalized MAID used the Oregon act as a blueprint for their own laws. The latest state to enact legislation was New Mexico in 2021,[58] and there are currently 14 states with pending legislation on the matter.[59] Whilst sharing a common basis, the statutes in the ten states with

51 Ibid. 146.
52 Death with Dignity National Center.
53 Thaddeus Mason Pope: Medical Aid in Dying: Key Variations Among U.S. State Laws. *Journal of Health and Life Sciences Law*, 2020 (1), 25-59.
54 Meisel 2020, 147.
55 Oregon Death With Dignity Act 1997.
56 Ibid. 147.
57 Ibid. 144.
58 Death with Dignity National Center, New Mexico.
59 Death with Dignity National Center.

legislation show some variability primarily in the qualification of patients who may receive MAID, residency requirements, waiting periods, data collection and conscientious objection.[60]

5.2.2. Litigation and the non-statutory approach

In Montana, legalisation stems from a State Supreme Court decision that reaffirmed an exemption within the state's criminal law.[61] These statutes regarding homicide contain an exemption regarding 'consent', and the Montana Supreme Court found it to be applicable to medical assistance in dying.[62] As such, whilst there is no specific statute legalizing end-of-life care in Montana, it is simply not criminal to do so. Whilst this precedent has indeed not been overturned in nearly fifteen years, the Death with Dignity organisation nevertheless lists it as 'under threat', as legislative efforts continue to be repelled.[63]

In North Carolina, the situation – at least from a legal perspective – is even more unclear: no statute or litigation of any kind exists on the matter, and as such end-of-life care is only subject to the regular standard-of-care requirements. As long as these are met, technically any end-of-life care is de facto legal to carry out.[64]

6. End-of-life in Australia

Prior to a recent reform on end-of-life, Australia had more than two decades of legislative attempts relating to this issue, all ending with failure.[65] In 2017 however, the state of Victoria enacted the Voluntary Assisted Dying Act legalising a broad spectrum of medical assistance in dying. In similar fashion as in the US with the Oregon statute other states followed suit – albeit in a much quicker timespan, with the last one being the state of New South Wales in 2022.[66] Both the overall success and quickness of this reform, as well as the general approach of the final statutes was predicted by experts as there was a noticeable increase legislative activity.[67]

60 Pope 2020, 36-54.
61 *Baxter v. Montana* 2009 MT 449.
62 *Baxter*, para 42-50.
63 Death with Dignity National Center, Montana.
64 Pope 2020, 35.
65 Lindy Willmott et al.: (Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics. *UNSW Law Journal*, 2016 (1).
66 Waller – Del Villar – Willmott – White 2023, 39.
67 Willmott 2016, 42-43.

Compared to the US, these Australian laws are much more similar to each other, with all of them fitting into the *"broad Australian model"*, although they aren't uniform.[68] Some common features of this model are a *"carefully prescribed request and assessment process"*, which includes amongst other safeguards *"contemporaneous reporting at all stages of the process"*; mandatory training for medical personnel *"to ensure thorough understanding of the legislation"*; and eligibility requirements, which are limited to terminally ill patients.[69] Variation within these laws are mostly limited to residency requirements, the actual wording regarding the incurability of the patients illness and the persistence of the patient in their decision.[70]

All jurisdictions included clauses their laws regarding a mandatory review of effectiveness and workings of the acts. All of them include the requirement of at least one mandatory review after 3 to 8 years, and most – with the exception of South Australia and Queensland – require this to repeat every five years after the first review.[71]

7. End-of-life in New Zealand

Similarly to Australia, New Zealand enacted the End of Life Choice Act in 2021.[72] The act was passed by New Zealand parliament in 2019 and ratified through a public referendum in 2020.[73] The Act is similarly detailed and structured as the Australian statutes, and it can be generally said, that it follows the 'broad Australian model'. The Act limits eligibility of the patients to those who are *"in an advanced state of irreversible decline in physical capability; and be experiencing unbearable suffering that cannot be relieved in a way that is acceptable to them"*.[74]

Initial challenges concerns regarding the implementation were raised especially about the proper training for healthcare professionals and the lack of detailed

68 Ibid. 44.
69 Ibid. 39-40.
70 Ibid. 5.
71 Victoria Voluntary Assisted Dying Act 2017, Art. 116; Western Australia Voluntary Assisted Dying Act 2019, Art. 164; Tasmania End-of-Life Choices (Voluntary Assisted Dying) Act 2021, Art. 145; Queensland Voluntary Assisted Dying Act 2021 Art. 154; South Australia Voluntary Assisted Dying Act 2021, Art. 129; New South Wales Voluntary Assisted Dying Act 2022, Art. 186.
72 End of Life Choice Act 2019.
73 Jessica Young et al.: The End of Life Choice Act: a proposed implementation and research agenda. *New Zealand Medical Journal*, 2021 (1544), 145-146.
74 Ibid. 146-148.

regulation regarding conscientious objection.[75] However, a mandatory review of the act conducted in 2024 revealed that the Act has *"largely been operating well, and has achieved its primary purpose"*. Furthermore, it stated, that compliance with the act from medical personnel has been *"very high"* and that the *"Ministry* [of Health] *is confident that everyone who has received an assisted death met the eligibility requirements set out in the Act and had chosen an assisted death"*.[76]

8. Summary

In the United Kingdom, end-of-life decisions are treated with caution and hesitancy. Firm legal precedent and a nearly 70-year-old law resulted in a near total ban on physician assisted dying and assisted suicide, with withdrawal/refusal of treatment being also limited. Legislative efforts to introduce end-of-life legislation are unlikely to succeed.

In Ireland, the current status quo of a blanket ban with limited, case-by-case exception stands on firm legal precedent, but is far from ideal. It is also uniquely reliant on UK guidelines, as the Courts in the Fleming case were hesitant to completely copy Purdy.

Canadian regulation on end-of-life has undergone major changes in the last decade. By completely overruling previous precedent, the case of Carter v Canada has de facto legalized MAID by halting all prosecution, which was followed by the change of the Canadian criminal code. This change created the exemption of medical assistance in dying. The more recent Canadian literature, which now examines the post-Carter practice and the provisions of the post-amendment Criminal Code, remains critical, mainly citing the seemingly rapid spread of the practice,[77] although it has to be noted that the percentage of people who opt for medical assistance in dying does not exceed that of other countries.[78]

In the US, the situation varies from state to state. While most states have similarities to the Oregon pilot law, there are clear differences in the solutions. As stated above, numerous states have pending legislation on the matter, although

[75] Bruce CH Tsai – David B. Menkes: New Zealand doctors and euthanasia-legal and practical considerations of the end of life choice act. *New Zealand Medical Journal*, 2020 (1522), 149-160.

[76] Review of the End of Life Choice Act by the Ministry of Health of New Zealand.

[77] Leonie Herx – Margaret Cottle – John Scott: The "Normalization" of Euthanasia in Canada: the Cautionary Tale Continues. *World Medical Journal*, 2020 (66).

[78] Owen Dyer: Assisted dying now accounts for one in 20 deaths in Canada, but rate of growth slows. *BMJ*, 2024; 387.

with the recent political shift across the US, predictions regarding future expansion of end-of-life legislation are bound to be inaccurate.

End-of-life decisions in Australia and New Zealand have both seen decriminalization in recent years. All Australian states and New Zealand chose a careful and lengthy legislative approach resulting in very detailed statutes with a remarkably high number of safeguards.

Whilst in some places a judicial decision acts as a sole basis for the legality of such acts like Montana, most other places have specific statutes in place. However, the legal background of the statutes also differs – some have lengthy judicial background like Canada and Washington, but some like Australia or New Zealand have legislation with no judicial background whatsoever. The United Kingdom, Ireland and most US states continue to have a near complete ban, despite generally higher societal support. Some places like North Carolina have no ban or regulation on the matter resulting in de facto legality. Regardless of the fact that in each of the countries analysed, support for end-of-life decisions has increased or at least remained high,[79] the emergence of this type of regulation seems

In conclusion, it can be said, that no discernible pattern of end-of-life legislation emerges from the study of the countries within the Anglo-Saxon legal system. The rapid enactment of legislation spurred on by a major shift in precedent, like in Canada, is seemingly an unfortunate path to legalization. Solutions implemented through long, careful and deliberate processes like in some US states, Australia and New Zealand seem to result in much more stable and clear systems. On the flip side, the situation in the United Kingdom and Ireland is much more problematic, where case-law exists, but is both inconsistent and generally unclear. However, these problems are not unique to these countries and their legal system, they are in fact similar problems other countries face when trying to regulate end-of-life.

[79] Public support in the United Kingdom has grown from ~50% in 2006 to ~80% in 2021 [Antony Takla et al.: British laypeople's attitudes towards gradual sedation, sedation to unconsciousness and euthanasia at the end of life. *PLoS One* 16.3 (2021)], in Ireland from ~30% in 2006 to ~60% in 2018 [Luke Barry et al.: Euthanasia, religiosity and the valuation of health states: results from an Irish EQ5D5L valuation study and their implications for anchor values. *Health and quality of life outcomes*, 2018 (16), 1-9.], a stagnating 75% support in the US [https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx] and 74% and 67% in Australia and New Zealand respectively [Graham Grove et al.: Content analysis of euthanasia polls in Australia and New Zealand: words do matter. *Internal medicine journal*, 2021 (10), 1629-1635.].

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